State of Iowa

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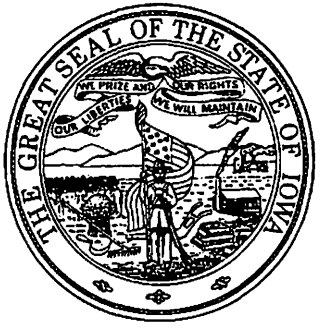
Biweekly
September 1, 2004



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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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September 1, 2004, Biweekly Supplement

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CHAPTER 68
DAIRY

[Prior to 3/9/88, see Agriculture Department 30—Ch 30]
[Prior to 7/27/88, see 21—Ch 30]

21—68.1(192,194) Definitions. In addition to the definition found in the Code of Iowa, the following terms shall mean:

"Habitual violator" is a producer or other dairy industry business entity that is regulated by the department, for whom the monthly official records for somatic cell counts, bacteria, cooling or added water show that the violation has occurred eight times in a 12-month period, including the accelerated testing counts; or that has received three, two-of-four warning letters in a 12-month period; or that has received a second three-of-five, off-the-market letter in a 12-month period; or that has been cited for unsanitary conditions three times in a 12-month period; or that has been found with a fourth positive antibiotic in a 12-month period.

"Imminent hazard to the public health" means any condition so serious as to require immediate action to protect the public health. It shall include, but is not limited to: pesticide, antibiotic, or any other substance in milk or milk products considered to be dangerous if consumed by humans.

"P.M.O." means the Grade A Pasteurized Milk Ordinance, 2003 Recommendations of the United States Public Health Service/Food and Drug Administration, a copy of which is on file with the department and is incorporated into this chapter by reference and made a part of this chapter.

"Public health hazard" means any condition which, if not corrected, could endanger the public health.

"Qualified personnel" means employees certified or approved by the department to perform certain tasks as required by the Code of Iowa. It shall include, but not be limited to, dairy industry inspectors and hearing officers.

21—68.2(192) Licenses and permits required.

68.2(1) *Milk plant permit.* A person who brings, sends into, or receives into this state, milk or milk products for storage, transfer, processing, sale or to offer for sale, shall possess a "milk plant" permit.

68.2(2) *Grade A farm permit.* A person who operates a dairy farm to produce "Grade A milk" shall possess a "Grade A farm" permit.

68.2(3) *Grade B farm permit.* A person who operates a dairy farm to produce milk to be used as "milk for manufacturing purposes" shall possess a "Grade B farm" permit.

68.2(4) *Hauler/grader license.* A person engaged in the transporting, transferring, sampling, weighing or measuring of milk or a person engaged as a sample courier shall possess a "hauler/grader" license.

68.2(5) *Tester license.* A person who tests a dairy product for fat content to establish a value of the product shall possess a "tester's" license.

68.2(6) *Milk truck license.* A vehicle used primarily for collecting or transporting milk or milk product in the bulk shall possess a "milk truck" license.

68.2(7) *Dairy distributor's permit.* A person primarily in the business of distributing dairy products shall possess a "dairy distributor" permit.

21—68.3(192) License application. Reserved.

21—68.4(192) Certification of personnel. Certification programs conducted by the department shall follow closely the procedures as outlined in the P.M.O., Appendix B.

68.4(1) *Dairy industry inspectors.* Reserved.

68.4(2) *Field representative.* The department shall provide a certification program for individuals who work as "quality control" officers in the dairy industry but are not employees of the department. An individual certified as a "field representative" may perform certain tasks for the department when authorized to do so by the department.

21—68.5(190,192,194) Milk tests. The department recognizes approved methods of testing milk or cream for milk fat and other dairy products as specified in Standard Methods for the Examination of Dairy Products (16th Edition). That publication is hereby incorporated into this rule by this reference and made part thereof insofar as applicable, a copy of which is on file with the department.

All milk, graded or tested, as provided by Iowa Code chapters 192 and 194 shall be graded and tested by samples which shall be taken in the following manner:

1. Samples may only be taken from vats or tanks which pass the required organoleptic test.
2. The temperature of milk in bulk tanks from which the sample is to be taken must not be higher than 45 degrees Fahrenheit for Grade A milk and 50 degrees Fahrenheit for manufacturing milk.
3. The temperature of the milk in the bulk tank shall be recorded on the farm milk room record, on the collection record, and on the sample container.
4. The volume of the milk in the bulk tank shall then be measured and the measurement shall be recorded.
5. Bulk tanks of less than 1,000-gallon size shall be agitated for a period of not less than five minutes. Bulk tanks of 1,000 gallons or greater shall be agitated for a period of not less than ten minutes. However, if the manufacturer of the bulk tank provides in writing that a lesser time for agitation is acceptable given the design of the bulk tank, then the lesser time is acceptable if the agitation is done in a manner and time consistent with the manufacturer's written instructions. In addition, the instructions must be conspicuously posted in the milk room. The instructions shall be laminated, framed under glass, or otherwise displayed so that the instructions will not deteriorate while displayed in the milk room.
6. The sample shall then be taken by using an approved sterile dipper and the milk shall be poured in an approved sterile sample container, until the sample container is three-quarters full.
7. The sample of milk shall then be immediately stored at a temperature of between 32 and 40 degrees Fahrenheit.
8. Grade A and Grade B milk shall not be picked up from a farm bulk milk tank when the milk volume in the tank is insufficient to completely submerge the bulk milk agitator paddle or, if there is more than one set of paddles, the lower set of agitator paddles into the milk.
9. No device, other than the bulk tank agitator, shall be used to agitate the milk in a farm bulk milk tank.
10. If the milk in a farm bulk milk tank cannot be properly agitated by the bulk tank agitator at the time of pickup by the milk hauler, the milk shall not be sold for human consumption.

This rule is intended to implement Iowa Code sections 194.4, 194.5, and 194.6.

21—68.6(190,192,194) Test bottles. Test bottles and pipettes as approved by the Standard Methods for the Examination of Dairy Products, 16th Edition, are approved for universal use in Iowa. All test bottles should be graduated to the half point.

This rule is intended to implement Iowa Code chapters 192 and 194.

21—68.7(190,192,194,195) Test transactions. Rescinded IAB 1/24/01, effective 2/28/01.

21—68.8(190,192,194,195) Cream testing. Rescinded IAB 1/24/01, effective 2/28/01.

21—68.9(192,194) Tester's license. The examination for a tester's license must be approved and administered by the department.

This rule is intended to implement Iowa Code sections 192.111 and 194.13.

21—68.10(192,194) Contaminating activities prohibited in milk plants. All "milk plants," "creameries," "transfer stations," "receiving stations," or any other facility for handling of bulk milk or milk products shall be a facility separated from any activity that could contaminate or tend to contaminate the milk or milk products.

21—68.11(192,194) Suspension of dairy farm permits.

68.11(1) Grade A and Grade B farm permit suspension and revocation. The department may temporarily suspend a Grade A or Grade B farm permit if the dairy farm fails to meet all the requirements as set forth in the P.M.O. or the Grade B United States Department of Agriculture document titled, "Milk for Manufacturing Purposes and Its Production and Processing, Recommended Requirements," effective June 17, 2002. A Grade A farm under temporary suspension of the Grade A permit may sell the milk as "milk for manufacturing purposes" until reinstated as a Grade A farm if the former Grade A farm meets the requirements necessary to sell Grade B milk. A Grade B farm under temporary suspension of the Grade B permit may sell milk as "Undergrade Class 3" until reinstated as a Grade B farm if the former Grade B farm meets the requirements of Undergrade Class 3. If an inspection reveals a violation which, in the opinion of the inspector, is an imminent hazard to the public health, the inspector shall take immediate action to prevent any milk believed to have been exposed to the hazard from entering commerce. In addition, the inspector shall immediately notify the department that such action has been taken. In other cases, if there is a repeat violation of a dairy standard as determined by two consecutive routine inspections of a dairy farm, the inspector shall immediately refer the violation to the department for action. The department may revoke the dairy permit of a person that the department determines is a habitual violator as defined in rule 21—68.1(192,194).

68.11(2) Summary suspension of dairy farm permits. If the department finds that the public health, safety or welfare imperatively requires emergency action, summary suspension of a permit may be ordered pending proceedings for revocation or other action. If a permit is summarily suspended, no milk or milk products may be sold or offered for sale until permit is reinstated.

The following situations or incidents are situations in which summary suspension is appropriate:

a. Unclean milk contact surfaces of equipment or utensils.

b. Filthy conditions in a milking barn or parlor or in a cattle housing area, including several days' accumulation of manure in the milking barn gutters, calf pens or in other areas.

c. Filthy conditions in a cow yard and very dirty cows.

d. Filthy conditions in a milk room/milk house.

e. Water supply, water pressure, or water heating facilities not in compliance with standard operating procedures.

f. No access to hand-washing facility in the milk room/milk house.

g. Violation of standards under this chapter related to well construction or potability of water supply, including any cross connections between potable and nonpotable water sources.

h. Lack of an approved sanitizer in the milk room/milk house or adjacent storage area to meet the sanitizing requirements.

i. Visibly dirty udders and teats on cows being milked.

j. Milk not cooled in compliance with subrule 68.22(4).

k. Rodent activity in the milk room/milk house, or severe rodent activity in a milking barn or milking parlor or in a feed storage room.

l. Dead animals in the milking barn, parlor or cow yard.

m. Other situations where the department determines that conditions warrant immediate action to prevent an imminent threat to the public health or welfare.

68.11(3) A Grade A dairy producer whose permit has been suspended for a period of 12 consecutive months shall be downgraded to the Grade B market and be issued a Grade B permit.

GRADE A MILK

21—68.12(192) Milk standards. Standards for the production, processing, distribution, transportation, handling, sampling, examination, grading, labeling, sale and standards of identity of Grade A pasteurized milk, Grade A milk products and Grade A raw milk, the inspection of Grade A dairy herds, dairy farms, milk plants, milk receiving stations and milk transfer stations, the issuing, suspension and revocation of permits and licenses to milk producers, milk haulers, and milk distributors shall be regulated in accordance with the provisions of the P.M.O., a copy of which is on file with the department and is incorporated into this rule by reference and made a part of this rule.

Where the mandatory compliance with the provisions of the appendixes therein is specified, the provisions shall be deemed a requirement of this rule.

Cottage cheese, dry curd cottage cheese and low fat cottage cheese bearing the Grade A label must conform to the standards of identity for Title 21, section 133 of the Code of Federal Regulations. However, cottage cheese, dry curd cottage cheese, and low fat cottage cheese shall not require a Grade A rating for sale within this state.

The discharge pipe on all gravity flow manure removal systems in milk barns shall be sufficient in size to handle the flow of manure generated by the cows using the system and any bedding materials or other materials that may enter the system.

Lighting systems shall be adequate to produce sufficient light as required by the Pasteurized Milk Ordinance. Such systems may include, but are not limited to, electrical powered lighting systems or pressurized white gasoline, pressurized kerosene, or battery powered lanterns. Such systems shall be designed and used in a manner that no odors can reasonably be expected to be emitted into the milk room unless there is sufficient ventilation to remove the odors. Lanterns shall be mounted on permanently affixed hooks and shall remain in place at all times.

If artificial lighting is provided by nonelectrical means, then a portable battery operated fluorescent light shall be made available for use and maintained in working order in the milk house. The fluorescent bulb shall either be shatterproof or shall be enclosed in a shatterproof enclosure.

Raw milk for pasteurization shall be cooled to 7° C (45° F) or less within two hours after milking. However, the blend temperature after the first milking and subsequent milkings shall not exceed 10° C (50° F). No specific bulk milk tank equipment is required in achieving this cooling standard; however, producers are expected to use all necessary diligence in achieving compliance.

This rule is intended to implement Iowa Code chapter 192.

21—68.13(192,194) Public health service requirements.

68.13(1) *Certification.* A rating of 90 percent or more calculated according to the rating system as contained in Public Health Service "Methods of Making Sanitation Ratings of Milk Shippers," 2003 Revision, shall be necessary to receive or retain a Grade A certification under Iowa Code chapter 192. That publication is hereby incorporated into this rule by this reference and made a part thereof insofar as applicable, a copy of which is on file with the department.

68.13(2) *Documents.* The following publications of the Public Health Service of the Food and Drug Administration are hereby adopted. A copy of each is on file with the department:

1. "Procedures Governing the Cooperative State-Public Health Service/Food and Drug Administration Program of the National Conference on Interstate Milk Shipments," 2003 Revision.
2. "Standards for the Fabrication of Single Service Containers and Closures for Milk and Milk Products," as incorporated in the P.M.O., Appendix J.
3. "Grade A Condensed and Dry Milk Products and Condensed and Dry Whey," Supplement I to the Grade A Pasteurized Milk Ordinance, 1995 Recommendations.
4. "Evaluation of Milk Laboratories," 1995 Revision.

This rule is intended to implement Iowa Code chapter 192.

21—68.14(190,192,194,195) Laboratories. Evaluation of methods and reporting of results for approval of a laboratory shall be based on procedures and tests contained in "Standard Methods for the Examination of Dairy Products, 16th Edition 1992," and "Methods of Analysis of the Association of Official Analytical Chemists, 15th Edition 1990." These publications are hereby incorporated into this rule by this reference and made a part thereof insofar as applicable; a copy of each being on file with the department. The health authority shall accept, without the imposition of a fee for testing or inspection, supplies of milk and milk products from an area or an individual shipper not under routine inspection provided they are delivered in closed and date-coded containers; provided further that if the code date has expired, reasonable inspection testing fees may be assessed the processor or establishment having care, custody and control of the milk and milk products.

This rule is intended to implement Iowa Code chapter 192.

GRADE B MILK

21—68.15(192,194) Milk standards. Standards for the production and processing of milk for manufacturing purposes shall conform to standards contained in the USDA document entitled "Milk for Manufacturing Purposes and Its Production and Processing, Recommended Requirements," dated June 17, 2002, which is hereby incorporated into this rule by reference and made a part thereof insofar as applicable, a copy of which is on file with the department.

21—68.16(194) Legal milk.

68.16(1) All milk delivered to a creamery, cheese factory or milk processing plant shall be subject to an examination, as provided in Iowa Code chapter 194, which shall be made at the plant if delivered in separate containers or before mixing with other milk collected in a bulk tank container and the examination shall be made by a licensed grader.

68.16(2) Every creamery, cheese factory or milk processing plant which gathers its milk by a bulk tank vehicle whether operated by an independent contractor or otherwise shall provide for a licensed grader in the operation of the bulk tank and for examination of the milk by the grader upon receipt thereof at the bulk tank.

68.16(3) The common change occurring in milk is the development of acidity, causing an acid flavor and odor, or even complete or partial coagulation. Other undesirable changes include sweet curdling, ropiness, gassiness and abnormal flavors, odors and colors. All milk showing any of these defects or any other defect must be rejected.

68.16(4) The presence of any insect in milk shall be sufficient cause for rejection.

This rule is intended to implement Iowa Code sections 194.2, 194.12 and 194.15.

21—68.17(194) New producers.

68.17(1) A "new producer" is a person selling milk for the first time who has not previously produced milk under Iowa Code chapter 194. A person who formerly produced farm-separated cream and is now selling, for the first time, whole milk for manufacturing purposes is considered a new producer. Similarly, a producer who previously supplied Grade A milk or sold milk in another state not reciprocating on quality transfers and offering manufacturing milk for sale in the state of Iowa for the first time shall be classified as a new producer. A new producer is also one who has not offered manufacturing milk for sale since the enactment of this milk grading law on July 4, 1959.

68.17(2) A licensed milk grader must examine, smell and taste the first lot of milk purchased from a new producer. This milk must also be tested immediately for extraneous matter or sediment content. However, it is not necessary to subject the milk of the new producer on the first delivery to a bacterial quality test. A test of this nature, however, must be made on a properly collected sample from this producer within 15 days thereafter.

68.17(3) If the sediment disc on the can of milk selected for test shows sediment in excess of 2.50 mg., all cans in the shipment shall be tested for sediment content in the same manner. Any milk showing sediment in excess of 2.50 mg. shall be rejected by the creamery, cheese factory or milk processing plant and not used for human consumption.

This rule is intended to implement Iowa Code section 194.2.

21—68.18(194) Testing and exclusion of Class III milk.

68.18(1) If a producer desires to change to another plant or factory, it is required that the first shipment of milk be accompanied by a written quality release form from the former purchaser. This quality release form must be requested by the producer in person or in writing from the manager of the plant previously purchasing the milk. (Plant being asked for quality release shall give it to person with written order or deliver to producer making the request.) The new buyer shall not accept the first delivery until receiving a copy of the record of the producer's milk quality covering the preceding 90 days.

68.18(2) If the quality release form of this producer shows that the last test for bacterial quality indicated Class III milk, the new purchaser must then test first shipment of the transferring producer's milk by:

a. Organoleptic grading (physical appearance, taste and smell).

b. Sediment or extraneous matter.

c. An estimate of bacterial quality must be run within seven days from the last test date entered on the transfer form.

68.18(3) In other words, the previous record of bacterial quality is transferred. For example, if a producer has had two consecutive Class III bacterial estimates at one plant and then decides to sell the milk to another plant, the producer may not start as a new producer without previous history. This rule requires that the milk be tested for four consecutive weeks if there is no improvement in the quality of the milk during this period. Upon transferring to a new plant, the next bacterial test is entered on the record as the third of the four required tests.

68.18(4) If the fourth consecutive test is still Class III, this producer's milk may not be purchased by any plant for human consumption. The plant refusing this milk is required to notify the area resident inspector of the dairy products control bureau of the Iowa department of agriculture and land stewardship, immediately, in writing.

This rule is intended to implement Iowa Code section 194.2.

21—68.19(194) Unlawful milk. Four weekly Class III bacterial tests or milk containing radioactive agents "deleterious to health" shall make rejection compulsory and that milk shall not be accepted thereafter by any plant or creamery until authorized by the secretary of agriculture.

This rule is intended to implement Iowa Code sections 194.4 and 194.9.

21—68.20(194) Price differential. All purchasers or receivers of milk shall maintain a price differential between the grades of milk as defined by bacterial estimate test.

21—68.21(194) Penalties for plants and producers.

68.21(1) The scope of this section is broad, covering all plant employees, operators and milk haulers.

68.21(2) A producer selling milk to a new purchaser without first obtaining a quality release form from the former buyer, would be an example of noncompliance with the law and these rules.

This rule is intended to implement Iowa Code section 194.20.

21—68.22(192,194) Farm requirements for milk for manufacturing.

68.22(1) *Milking facility and housing.* A milking barn or milking parlor of adequate size and arrangement shall be provided to permit normal sanitary milking operations. It shall be well lighted and ventilated, and the floors and gutters in the milking area shall be constructed of concrete or other impervious material. The facility shall be kept clean.

68.22(2) *Milk house or milk room.* A milk house or milk room conveniently located and properly constructed, lighted, and ventilated shall be provided for handling and cooling milk and for washing, handling, and storing the utensils and equipment. Other products shall not be stored in the milk room which would be likely to contaminate milk, or otherwise create a public health hazard.

It shall be equipped with wash and rinse vat, utensil rack, milk cooling facilities and have an adequate supply of hot water available for cleaning milking equipment.

68.22(3) *Utensils and equipment.* Utensils, milk cans, milking machines (including pipeline systems), and other equipment used in the handling of milk shall be maintained in good condition, shall be free from rust, open seams, milkstone, or any unsanitary condition, and shall be washed, rinsed, and drained after each milking, stored in suitable facilities, and sanitized immediately before use with at least 200 ppm. chlorine solution or its equivalent.

68.22(4) *Cooling.* Milk in farm bulk tanks shall be cooled to 45° F or 7° C or lower within two hours after milking and maintained at 50° F or 10° C or lower until transferred to the transport tank. Milk in cans shall be cooled immediately after milking to 50° F or 10° C or lower unless delivered to the plant within two hours after milking. The temperature requirement for milk placed in cans will be 50° F or 10° C or lower. The cooler, tank, or refrigerated unit shall be kept clean.

This rule is intended to implement Iowa Code chapter 192 and section 192A.28.

21—68.23 to **68.25** Reserved.

21—68.26(190,192,194) Tests for abnormal milk.

68.26(1) At least once every calendar month, all creameries, cheese factories, or milk processing plants, hereafter referred to as purchasers, shall test a herd milk sample from every producer in a certified or officially designated laboratory to determine the existence of abnormal milk.

68.26(2) A herd milk sample shall be deemed to be abnormal or adulterated if a test by direct microscopic examination, electronic somatic cell count, or equivalent technique, reveals a count greater than 750,000 somatic cells/ml.

68.26(3) Whenever two of the last four consecutive somatic cell counts exceed 750,000 cells/ml, the purchaser or regulatory authority shall send a written notice thereof to the person concerned. An additional sample shall be taken within 21 days of the sending of such notice, but not before the lapse of three days. Immediate suspension of permit shall be instituted whenever the standard is violated by three of the last five somatic cell counts.

68.26(4) Within one week following receipt of a written application from the producer, an inspection shall be made by the regulatory authority or the purchaser and a herd milk sample taken. If the test indicates a count of 750,000 or less somatic cells/ml, the producer's milk may be purchased for human consumption provided additional samples of herd milk are tested at a rate of not more than two per week. The producer shall be reinstated under the normal testing program when three out of four consecutive tests have counts of 750,000 or less somatic cells/ml.

This rule is intended to implement Iowa Code chapter 192 and Iowa Code sections 190.4, 194.4, and 194.6.

21—68.27(192,194) Standards for performing farm inspections. The August 1, 1976, manual prepared by USDA/AMS, Dairy Division, titled "General Instructions for Performing Farm Inspections According to USDA Recommended Requirements for Manufacturing Purposes and Its Production and Processing for Adoption by State Regulatory Agencies," is adopted in its entirety, and shall constitute the official standards for farms producing milk for manufacturing, with the following exception:

Strike from Rule 1c, Brucellosis Test, the words "Uniform Methods and Rules" for establishing and maintaining Certified Brucellosis Free Herds of Cattle, Modified Certified Brucellosis Area and Certified Brucellosis Free Areas which are approved by Animal Disease Eradication Division, Agricultural Research Service. . .", and insert in lieu thereof, "Brucellosis Eradication, Uniform Methods and Rules, effective February 1, 1998". The bacteriological standards for private water supplies used by dairy farms consist of an MPN (Most Probable Number of Coliform Organisms) of less than 2.2/100 ml by the multiple tube fermentation technique, or less than 1/100 ml by the membrane filter technique, or the results of any water test approved by the United States Food and Drug Administration or Environmental Protection Agency of less than 1/100 ml.

DAIRY FARM WATER

21—68.28 to **68.34** Reserved.

21—68.35(192) Dairy farm water supply.

68.35(1) Water for milk house and milking operations shall be from a supply properly located, protected, and operated and shall be easily accessible, adequate and of a safe, sanitary quality.

68.35(2) A Grade A permit shall not be issued to an applicant when the water well supplying the dairy facility is located in a well pit.

68.35(3) New well construction or the reconstruction of an existing well supplying the dairy facility shall be constructed according to 567—Chapter 49, Iowa Administrative Code.

68.35(4) Frost-free hydrants shall be located at least ten feet from the well that supplies the water for the dairy facility unless a written variance is granted by the department.

68.35(5) The department encourages the use of high-pressure washers for use in the dairy facility. However, they can create a negative pressure and contaminate the water supply system because of their capability to pump at a faster rate than water can be supplied if not properly installed and operated.

The dairy facility water supply system shall be protected from overpumping by a high-pressure washer by one of the following:

1. A separate water supply.
2. By supplying the high-pressure washer from a surge tank that is isolated from the main water supply system by an air gap.
3. A low-pressure cutoff switch.
4. A device built into the high-pressure washer by the manufacturer and approved by the department.
5. Any other device installed in the system to prevent a negative pressure to the supply system that is approved by the department.

This rule is intended to implement Iowa Code chapter 192.

21—68.36(192) Antibiotic testing.

68.36(1) The dairy industry shall screen all Grade A and Grade B farm bulk milk pickup tankers and farm can milk loads for beta lactam drug residues or other residues as designated by the department. A sampling method shall be used with can milk loads to ensure that the sample includes raw milk from every milk can on the vehicle.

68.36(2) When loads are found to contain drugs or other inhibitors at levels exceeding federal Food and Drug Administration established "safety levels," the department's dairy products control bureau shall be notified immediately of the results and of the ultimate disposition of the raw milk. Disposition shall be in a manner approved by the bureau. The producer samples from the violative load shall be tested for tracing the violation back to the violative producer. The primary responsibility for tracing the violation back to the violative producer shall be that of the initial purchaser of the raw milk.

68.36(3) In every antibiotic incident, pickups of milk from the violative individual producer(s) shall be immediately discontinued and the permit shall be suspended until such time that subsequent testing by a certified industry supervisor establishes that the milk does not exceed safe levels of inhibitory residues. In addition, in every antibiotic incident except when the load is negative and the milk can be used, the violative producer shall pay the purchaser for the contaminated load of milk and the producer will not be paid for the producer's share of milk on the load.

68.36(4) The dairy products control bureau staff shall monitor the dairy industry inhibitor load testing activities by making unannounced, on-site inspections to review the load sampling records. The inspector may also collect load samples for testing in the department's dairy laboratory.

68.36(5) For the first violative occurrence within a 12-month period, a department dairy products inspector shall conduct an investigation.

68.36(6) For the second violative occurrence within a 12-month period, a department dairy products inspector shall make an appointment with the producer and a dairy industry representative to meet at the dairy facility within 10 working days of the violative occurrence to inspect the drug storage and to determine the cause of the second violation. In addition, the producer shall review the "Milk and Dairy Beef Residue Prevention Protocol" with a veterinarian within 30 days of the violative occurrence. The protocol certificate shall be signed by the producer and the veterinarian. The producer shall send the dairy products control bureau a copy of the signed certificate within 35 days of the violation. Failure to complete the course or to submit a copy of the certificate to the dairy products control bureau is grounds for suspension or revocation of a violative producer's permit to sell raw milk.

68.49(5) The department shall grant or deny a license application within the 45-day interim period.

68.49(6) The department shall not issue a milk hauler license if court action is in progress against the applicant for operating without an interim or regular license.

21—68.50(192) Supplies required for milk collection and sampling. A milk hauler who collects milk in bulk from a dairy farm shall have all of the following supplies available:

1. An adequate supply of sample containers.
2. A sample dipper.
3. A sample dipper storage container.
4. A sanitizing solution in the sample dipper storage container of 200 ppm of chlorine or equivalent.
5. An insulated carrying case with a rack to hold samples.
6. A certified thermometer, accurate to plus or minus 2°F, that can be used to check the temperature of the milk in the farm bulk tank, the accuracy of the farm bulk tank thermometers and the temperature of the commingled load.
7. A marking device to identify samples collected.
8. A watch or timing device.
9. An adequate supply of forms needed for milk collection and records.
10. A writing device to write on the forms and records.
11. Access to an adequate supply of single-service paper towels.

21—68.51(192) Milk hauler sanitization.

1. A milk hauler shall wear clean clothing.
2. A milk hauler shall maintain a high degree of personal cleanliness.
3. A milk hauler shall observe good hygienic practices.
4. A milk hauler shall not measure, sample or collect milk if the hauler has a discharging or infected wound or lesion on the hauler's hands or exposed arms.

21—68.52(192) Examining milk by sight and smell.

68.52(1) Before a milk hauler receives or collects milk from a dairy farm, the hauler shall examine the milk by sight and smell and shall reject all milk that has any of the following characteristics:

1. Objectionable odor.
2. Abnormal appearance and consistency.
3. Visible adulteration.

68.52(2) A milk hauler who rejects milk from a farm shall collect only a sample of the rejected milk.

68.52(3) If a dairy farmer disputes a milk hauler's rejection of the milk, the milk hauler shall contact the operator of the dairy plant to which the milk would ordinarily be delivered, and the plant operator or the plant field person shall examine the rejected milk to determine whether the milk was properly rejected.

21—68.53(192) Milk hauler hand washing. A milk hauler shall wash and dry hands before performing any of the following:

1. Using a thermometer.
2. Measuring the milk.
3. Collecting a milk sample.

21—68.54(192) Milk temperature.

68.54(1) Before a milk hauler collects milk at a dairy farm, the milk hauler shall record the temperature of the milk to be collected.

68.54(2) If the milk is collected more than two hours after the last milking, the milk hauler shall reject the milk if the milk temperature exceeds 45°F or 7°C.

68.54(3) If milk from two or more milkings is collected within two hours of the last milking, the milk hauler shall reject the milk if the milk temperature exceeds 50°F or 10°C.

68.54(4) If the farm bulk tank thermometer is working, at least once each month, and more often if necessary, a milk hauler shall check the accuracy of each dairy farm bulk tank thermometer by taking the temperature of the milk in the bulk tank with the milk hauler's thermometer and shall record the temperature on the milk pickup record card. This procedure shall be done at every pickup if the farm bulk tank thermometer is not working.

68.54(5) Before a milk hauler uses the milk hauler's thermometer to take the temperature of the milk in a bulk tank, the hauler shall sanitize the stem of the thermometer in 200 ppm chlorine or its equivalent for a minimum of 60 seconds.

68.54(6) A milk hauler shall immediately notify the milk producer and the dairy field person if the dairy farm bulk tank is not cooling properly or if the bulk tank thermometer is not recording the temperatures accurately.

21—68.55(192) Connecting the milk hose.

68.55(1) Before the milk hauler connects a tanker hose to a bulk tank, the hauler shall examine the fittings of the tanker hose and the bulk tank outlet and shall clean and sanitize as necessary.

68.55(2) The milk hauler shall attach the milk hose to the bulk tank outlet in a manner that does not contaminate the hose or the hose cap.

68.55(3) The hose shall be connected through the milk room hose port.

21—68.56(192) Measuring the milk in the bulk tank.

68.56(1) Before milk is transferred from a bulk tank to a bulk milk tanker, the milk hauler shall measure the amount of milk in the bulk tank.

68.56(2) The milk hauler shall measure the milk using a clean gauge rod or other measuring device that is specifically designed and calibrated to measure milk in the bulk tank.

68.56(3) Immediately before using the gauge rod or measuring device, the milk hauler shall wipe it dry with a clean, single-service disposable towel.

68.56(4) A milk hauler shall not measure the amount of milk in a dairy farm bulk tank until the milk in the tank is motionless.

68.56(5) If the milk is being agitated, the milk hauler shall turn off the agitator and wait for the milk to become completely motionless before measuring the milk.

68.56(6) After measuring the milk with a gauge rod or other device, the milk hauler shall use that measurement to calculate the weight or volume of milk in the bulk tank with the manufacturer's conversion chart.

68.56(7) The milk hauler shall record that weight or volume on a written collection record.

21—68.57(192) Milk sample for testing.

68.57(1) Before milk is transferred from a dairy farm bulk tank to a bulk milk tanker, a milk hauler shall collect a representative sample of that milk from the dairy farm bulk tank for testing. If there is more than one bulk tank, a sample from each tank shall be taken and identified.

68.57(2) The collected sample shall be filled only ¾ full in the sample container so that the sample can be agitated in the lab.

21—68.58(192) Milk collection record.

68.58(1) Whenever a milk hauler collects a milk shipment from a dairy farm, the milk hauler shall make a written record for that shipment.

68.58(2) One copy of the collection record shall be posted in a dairy farm milk room.

68.58(3) The collection record shall be initialed by the milk hauler.

68.58(4) The record shall include all of the following:

1. The milk producer identification number.
2. The milk hauler's initials.
3. The date when the milk was sampled and collected.
4. The temperature of the milk when collected.
5. The weight or volume of milk collected as determined by the milk hauler.
6. The time of pickup, including whether A.M. or P.M. or military time.

21—68.59(192) Loading the milk from the bulk tank to the milk tanker.

68.59(1) After a milk hauler has sampled milk from the dairy farm bulk tank and prepared a complete collection record, the hauler may transfer the milk from that bulk tank to the milk tanker.

68.59(2) A milk hauler shall not collect milk from any other container on a dairy farm other than from a bulk tank.

68.59(3) Partial pickup of milk shall be avoided whenever possible.

68.59(4) After a milk hauler has collected all of the milk from a bulk tank, the milk hauler shall disconnect the milk hose from the bulk tank, cap the hose and return the hose to its cabinet in the bulk milk tanker.

68.59(5) The milk hauler shall inspect the empty dairy farm bulk tank for abnormal sediments and shall report any abnormal sediments to the dairy producer and the dairy plant field person.

68.59(6) After the milk hauler has disconnected the milk hose and inspected the empty farm bulk tank for abnormal sediments, the milk hauler shall rinse the bulk tank with cold or lukewarm water.

21—68.60(192) Milk samples required for testing.

68.60(1) The milk hauler shall collect a sample of milk from each dairy farm bulk tank before that milk is transferred to a bulk milk tanker.

68.60(2) A milk sample collected from a dairy farm bulk tank shall not be commingled with a sample collected from any other bulk tank.

21—68.61(192) Bulk milk sampling procedures. A milk hauler shall comply with all of the following procedures when collecting a milk sample:

1. Shall collect the sample after the bulk tank milk has been thoroughly agitated.
2. Shall agitate a bulk tank of less than a 1000 gallon size, in the presence of the milk hauler, for at least five minutes before the milk sample is taken.
3. Shall agitate a bulk tank of a 1000 gallon size or larger, in the presence of the milk hauler, for at least ten minutes before the milk sample is taken. If there are stamped printed instructions on the bulk tank, giving explicit agitation instructions that are different from ten minutes, the bulk tank shall then be agitated according to the written instructions.

4. Shall collect the sample using a sanitized sample dipper that is manufactured for the purpose of taking a milk sample from a bulk tank. The milk hauler shall not use the sample container to collect a milk sample.
5. Shall rinse the sanitized sample dipper in the milk, in the bulk tank, at least two times before the dipper is used to collect the sample.
6. After rinsing the sample dipper in the milk, shall pour the sample from the dipper into a sample container until the sample container is ¾ full and shall securely close the sample container.
7. Shall not fill the sample container over the bulk tank, but shall fill the sample container off to the side of the bulk tank, over the floor of the milk room.
8. Shall handle the sample container and cap aseptically.
9. After collecting the milk sample, shall immediately place the sample on a rack or floater, on ice in the insulated sample container, and rinse the sample dipper with clean potable water.

21—68.62(192) Temperature control sample.

68.62(1) The milk hauler shall collect two milk samples at the first farm on each milk route.

68.62(2) One of the two samples collected from the first farm shall be used for a temperature control (TC) sample.

68.62(3) The temperature control (TC) sample shall remain in the rack with the other samples pertaining to that load.

68.62(4) The temperature control (TC) sample container shall be marked in a legible manner identifying the sample as the TC sample and shall also be marked with the other following information:

1. The producer identification number.
2. The initials of the milk hauler.
3. The date the sample was collected.
4. The time the sample was collected.
5. The temperature of the milk in the farm bulk tank from which the TC sample was collected.

21—68.63(192) Producer sample identification. Immediately before a milk hauler collects a milk sample, but before the milk hauler opens the sample container, the milk hauler shall, unless that sample container is prelabeled with the producer information, clearly and indelibly label the sample container with all of the following information:

1. The producer identification number.
2. The date when the sample was collected.
3. The temperature of the milk in the bulk tank.

21—68.64(192) Care and delivery of producer milk samples.

68.64(1) Immediately after a milk hauler collects a milk sample, the milk hauler shall place the sample container in a clean, refrigerated carrying case in which the temperature is kept at from 32°F to 40°F.

68.64(2) If the sample containers are packed in ice or cold water to keep the samples refrigerated, the ice or water shall cover no more than ¾ of each sample container.

68.64(3) The milk hauler shall promptly deliver the samples to the place designated by the milk purchaser.

21—68.65(192) Milk sample carrying case. The carrying case shall be constructed to have all of the following characteristics:

1. Shall be constructed of rigid metal or plastic.
2. Shall be effectively insulated and refrigerated to keep the samples at the required temperature.
3. Shall have a rack or floater designed to hold samples in the upright position.

21—68.66(192) Bulk milk delivery.

68.66(1) If milk is unloaded or transferred at any location other than a licensed facility, the person having custody of the milk shall notify the department of that unloading or transfer before that milk is processed or shipped to any other location.

68.66(2) Air entering a bulk milk tanker when the tanker is unloading shall be filtered to prevent contamination of the milk when the door to the receiving area is open.

21—68.67(192) False samples or records. The department may take enforcement action against a person doing or conspiring to do any of the following:

1. Falsely identify any milk sample.
2. Submit a false or manipulated milk sample.
3. Submit a milk sample collected in violation of this chapter.
4. Misrepresent the amount of milk collected from a dairy farm.
5. Misrepresent or falsify any record or report required under this chapter.

21—68.68(192) Violations prompting immediate suspension. A person violating any of the following shall have the person's milk hauler license suspended for the first full five weekdays following the violation. Administering the violation in this manner will allow a licensed field representative or a person employed by the plant with a milk hauler's license to ride with a suspended milk hauler and to perform all of the bulk milk pickup procedures which the suspended milk hauler shall not perform while the license is suspended. This rule will also allow a dairy co-op or a proprietary establishment the ability to recover the cost of the employee of the business establishment while the employee is working with the suspended milk hauler.

1. Not measuring the milk before pumping.
2. Not collecting a sample from the farm bulk tank.
3. Collecting milk from a container other than the farm bulk tank or an approved milk can.
4. Not collecting a milk sample before pumping or opening the valve to the milk tanker.
5. Mixing the contents of milk samples with other milk samples.
6. Collecting a sample before proper agitation.
7. Not using proper sample collection equipment.
8. Falsely identifying a milk sample.
9. Submitting a false or manipulated milk sample or a false sample collection record.

21—68.69(192) Milk grader license required.

68.69(1) A person shall not be employed as a dairy field person or a milk intake person and shall not collect a raw milk sample from a farm bulk tank or collect a load sample from a bulk milk tanker in Iowa without first being evaluated by a department dairy inspector and making application for a milk grader license. A milk grader license will not be needed by a temporary milk plant intake person that is under the direct supervision of a licensed milk grader.

68.69(2) The department may take an enforcement action against a person engaged in activities of a dairy field person or milk intake person or a person collecting milk samples from a farm bulk tank or from a bulk milk tanker if the department determines that the applicant has engaged in such activities without first obtaining a valid Iowa milk grader license or a valid 45-day interim license or has procured another person to operate without a license.

68.69(3) The cost of a milk grader license is $10.

68.69(4) A milk grader license obtained pursuant to this rule expires June 30 annually and is not transferable between persons.

68.69(5) As a condition of relicensing:

a. A milk grader license renewal applicant for collecting a milk sample from a farm bulk tank shall have had an on-the-farm evaluation of milk collecting and care of milk sample procedures by a department inspector within two years immediately prior to relicensure and shall have attended a milk hauler school within three years immediately prior to relicensure, if a hauler school was made available within that three-year period.

b. A milk grader license renewal applicant for collecting a milk sample from a bulk milk tanker at a milk plant shall have had an in-the-plant evaluation of milk collecting procedures by a department inspector within the last two years prior to relicensure.

c. If the milk grader has had an evaluation within the last two years and, if required, has attended a milk hauler training school within the last three years, a milk grader renewal application and a return envelope will be mailed annually in April to the milk grader by the dairy products control bureau office in Des Moines.

21—68.70(192) New milk grader license applicant.

68.70(1) The department may issue a 45-day interim license to a new applicant for a milk grader license if the department determines that the new applicant has been trained by a licensed milk grader.

68.70(2) An applicant for a milk grader license to collect a milk sample from a farm bulk tank shall follow the procedures outlined in subrules 68.49(2) to 68.49(4).

68.70(3) An applicant for a milk grader license to collect a milk sample from a bulk milk tanker at a milk plant shall contact the dairy products control bureau office in Des Moines, telephone (515)281-3545, and request a sampling procedure review by a department inspector and a milk grader application.

The inspector will fill out "Inspection Form Short Form 009-0293/TS" for verification of the sampling procedure review and give a signed copy to the applicant. The applicant shall mail the signed copy, the completed application and the $10 license fee to the dairy products control bureau office for a "Restricted Milk Grader License."

21—68.71(192,194) Can milk truck body.

68.71(1) A can milk truck body used for the purpose of picking up milk in milk cans from dairy farms for delivery to a milk plant shall not operate in the state of Iowa without first being issued a valid license from the department. This rule is intended to include can milk truck bodies that are commercially licensed in Iowa.

68.71(2) The can milk truck body vehicle license applicant shall include a description of the body, the make, model, year and color of the truck, a description of the can milk truck body, including the make, serial number, can capacity and the address at which the can milk truck body is customarily kept when not being used. The applicant shall also furnish any other information which the department reasonably requires for identification and licensing.

68.71(3) A license pursuant to this rule expires June 30 annually and is not transferable between truck bodies.

68.71(4) The department may take enforcement action against a person operating a can milk truck body if the department determines that the person has operated without a license or a person has procured another person to operate without a license.

68.71(5) The cost of the can milk truck body license is $25 per year.

68.71(6) The applicant shall have received an annual inspection by a department inspector and shall make the vehicle available for inspection prior to receiving the license.

These rules are intended to implement Iowa Code chapter 192.

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CHAPTER 76
MEAT AND POULTRY INSPECTION
[Prior to 7/27/88 see Agriculture Department 30—Ch 43]

21—76.1(189A) Federal Wholesome Meat Act regulations adopted. Part 301 of Title 9, Chapter III, of the Code of Federal Regulations, revised as of May 1, 2004, is hereby adopted in its entirety by reference; and in addition thereto, the following subsections shall be expanded to include:

1. Sec. 301.2(a) therein defining the term "Act" shall include the Iowa meat and poultry inspection Act, Iowa Code chapter 189A.
2. Sec. 301.2(b) therein defining the term "department" shall include the Iowa department of agriculture and land stewardship.
3. Sec. 301.2(c) therein defining the term "secretary" shall include the secretary of agriculture of the state of Iowa.
4. Sec. 301.2(e) therein defining the term "administrator" shall include the supervisor of the Iowa meat and poultry inspection service or any officer or employee of the Iowa department of agriculture and land stewardship.
5. Sec. 301.2(t) therein defining the term "commerce" shall include intrastate commerce in the state of Iowa.
6. Sec. 301.2(u) therein defining the term "United States" shall include the state of Iowa.

21—76.2(189A) Federal Wholesome Meat Act regulations adopted. Part 303, Part 304, Part 305, Part 306, Parts 308 through 320, Part 329, Part 416, Part 417, Part 424, Part 430, and Part 441 of Title 9, Chapter III, of the Code of Federal Regulations, revised as of May 1, 2004, are hereby adopted in their entirety by reference. Part 307 except Sections 307.5 and 307.6 and Part 325 except Sections 325.3 and 325.12 of Title 9, Chapter III, of the Code of Federal Regulations, revised as of May 1, 2004, are hereby adopted in their entirety by reference. Part 500 of Title 9, Chapter III, of the Code of Federal Regulations, revised as of May 1, 2004, is adopted by reference, except that references in Sections 500.5, 500.6, 500.7, and 500.8 to the federal Uniform Rules of Practice are not adopted.

21—76.3(189A) Federal Poultry Products Inspection Act regulations adopted. Part 381, Title 9, Chapter III, of the Code of Federal Regulations, revised as of May 1, 2004, is hereby adopted in its entirety with the following exceptions: 381.96, 381.97, 381.99, 381.101, 381.102, 381.104, 381.105, 381.106, 381.107, 381.128, Subpart R, Subpart T, Subpart V, Subpart W; and in addition thereto, the following subsections shall be expanded to include:

1. Sec. 381.1(b)(2) therein defining the term "Act" shall include the Iowa meat and poultry inspection Act, Iowa Code chapter 189A.
2. Sec. 381.1(b)(3) therein defining the term "administrator" shall include the supervisor of the Iowa meat and poultry inspection service, or any officer or employee of the Iowa department of agriculture and land stewardship.
3. Sec. 381.1(b)(10) therein defining the term "commerce" shall include intrastate commerce in the state of Iowa.
4. Sec. 381.1(b) therein defining the term "department" shall include the Iowa department of agriculture and land stewardship.
5. Sec. 381.1(b)(47) therein defining the term "secretary" shall include the secretary of agriculture of the state of Iowa.
6. Sec. 381.1(b)(53) therein defining the term "United States" shall include the state of Iowa.

These rules are intended to implement Iowa Code sections 189A.3 and 189A.7(8).

21—76.4(189A) Inspection required. Every establishment except as provided in Section 303.1(a), (b), (c) and (d) of Title 9, Chapter III, Subchapter A, of the Code of Federal Regulations, revised as of May 1, 2004, in which slaughter of livestock or poultry, or the preparation of livestock products or poultry products is maintained for transportation or sale in commerce, shall be subject to the inspection and other requirements of those parts of Title 9, Chapter III, Subchapter A, of the Code of Federal Regulations, revised as of May 1, 2004, enumerated in rules 21—76.1(189A), 21—76.2(189A) and 21—76.3(189A).

This rule is intended to implement Iowa Code sections 189A.4 and 189A.5.

21—76.5(189A) Custom/exempt facilities sanitation standard operating procedures. Iowa inspected custom/exempt facilities shall develop and implement a sanitation standard operating procedure (SSOP) in a manner consistent with Section 416.12, Title 9, Chapter III, Code of Federal Regulations.

21—76.6(189A) Forms and marks. Whenever an official form is designated by federal regulation, the appropriate Iowa form will be substituted and whenever an official mark is designated, the following official Iowa marks will be substituted:

76.9(2) Decharacterizing shall be done to an extent acceptable to the department. Decharacterization shall be done in such a manner that each piece of material shall be decharacterized so as to preclude its being used for, or mistaken for, product for human consumption.

76.9(3) All containers for decharacterized inedible meat or carcass parts shall be plainly marked with the word "inedible" in letters no less than two inches high.

76.9(4) Decharacterized inedible meat and carcass parts shall be frozen or held at a temperature of 40°F or less in the processing plant or during transportation to the final processor.

This rule is intended to implement Iowa Code section 189A.8.

21—76.10(189A,167) Transportation of decharacterized inedible meat or carcass parts. No person engaged in the business of buying, selling or transporting in intrastate commerce, dead, dying, disabled or diseased animals, or any parts of the carcasses of any animals that died otherwise than by slaughter, or any other inedible product not intended for use as human food, shall buy, sell, transport, offer for sale or transportation or receive for transportation in such commerce, any dead, dying, disabled or diseased livestock or poultry or the products of any such animals that died otherwise than by slaughter, or any other inedible product not intended for use as human food, unless such transaction or transportation is made in accordance with Iowa Code chapters 167 and 189A and 21—Chapters 61 and 76.

76.10(1) All carcasses and other inedible material received for processing, and all decharacterized inedible material shipped from the plant, shall be transported and delivered in closed conveyances. The conveyance shall be constructed in such a manner as to prevent the spillage of liquids and material and in accordance with rules 21—61.15(163) and 61.16(163), Iowa Administrative Code.

76.10(2) Rendering plants and pet animal food processing plants outside the state of Iowa, from which decharacterized inedible meat or carcass parts are shipped into the state of Iowa, shall be certified by the proper public officials of the state of origin that the processing plants meet at least the minimum standards as set forth in these rules.

This rule is intended to implement Iowa Code sections 189A.8 and 167.15.

21—76.11(189A) Records. Records which fully and correctly disclose all transactions involved in their business shall be kept and retained for a period of no less than two years by the following classes of persons:

Any person that engages in intrastate commerce in the business of slaughtering any livestock or poultry, or preparing, freezing, packaging or labeling, buying or selling, transporting or storing any livestock or poultry products for human or animal food;

Any person that engages in intrastate commerce in business as a renderer or in the business of buying, selling or transporting any dead, dying, disabled or diseased carcasses of such animals or parts of carcasses of any such animals, including poultry, that died otherwise than by slaughter.

76.11(1) All such persons shall afford the secretary and authorized representatives access to such business and opportunity at all reasonable times to examine the facilities, inventory and records thereof, to copy the records and to take reasonable samples of the inventory, upon payment of the reasonable value therefor.

76.11(2) Records shall include the following:

a. The name and address of the owner, the approximate time of death of the animal and the date the animal was received for processing shall be recorded for all animals to be inspected for processing into pet animal food.

b. The number of cartons or containers and the approximate weight of other material received from slaughterhouses, packing plants and other sources to be used in the processing of pet animal food.

c. The number of cartons, packages or containers of processed inedible meat and carcass parts and the weight of each carton stored.

d. Date of shipment, number of containers or boxes, weight of each shipment and name and address of the consignee of all inedible and decharacterized material shipped from the plant.

This rule is intended to implement Iowa Code section 189A.4(7).

21—76.12(189,189A) Movement of meat products into the state. Rescinded IAB 2/26/97, effective 4/2/97.

21—76.13(189A) Voluntary inspections of exotic animals. Every person wishing to obtain voluntary inspection of exotic animals shall comply with the regulations adopted in this rule.

Part 352 of Title 9, Chapter III, of the Code of Federal Regulations, revised as of May 1, 2004, is hereby adopted in its entirety by reference.

This rule is intended to implement Iowa Code chapter 189A.

21—76.14(189A) Federal Wholesome Meat Act regulations adopted for the regulation of farm deer.

1. All federal regulations adopted in 21—76.1(189A).
2. All federal regulations adopted in 21—76.2(189A), except Part 303 and Part 307.4(c) of Title 9, Chapter III, of the Code of Federal Regulations, revised as of May 1, 2004.

This rule is intended to implement Iowa Code chapter 189A and Iowa Code Supplement chapter 170.

21—76.15(189A) Fees. Rescinded IAB 7/21/04, effective 7/2/04.

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CHAPTERS 77 to 84
Reserved

281—79.9(256) Approval of program changes. Upon application by an institution, the director is authorized to approve minor additions to, or changes within, the curricula of an institution's approved practitioner or administrator preparation program. When an institution proposes a revision which exceeds the primary scope of its programs, the revisions shall become operative only after having been approved by the state board.

281—79.10(256) Unit governance and resources standards.

79.10(1) The professional education unit shall have primary responsibility for all programs offered at the institution for the initial and continuing preparation of teachers, administrators and other professional school personnel.

79.10(2) Unit faculty shall collaborate with members of the professional community, including the unit's advisory committee, to design, deliver, and evaluate programs to prepare school personnel.

79.10(3) Resources shall support quality clinical practice for all candidates, professional development for faculty, and technological and instructional needs of faculty to prepare candidates with the dispositions, knowledge, and skills necessary to support student learning.

79.10(4) Practitioner and administrator candidates' and faculty's access to books, journals, and electronic information shall support teaching and scholarship.

79.10(5) Sufficient numbers of faculty and administrative, clerical, and technical staff shall be available to ensure the consistent planning, delivery, and quality of programs offered for the preparation of school personnel.

79.10(6) The use of part-time faculty and graduate students in teaching roles shall be managed to ensure integrity, quality, and continuity of programs.

79.10(7) Institutional commitment shall include financial resources, facilities and equipment to ensure the fulfillment of the institution's and unit's missions, delivery of quality programs, and preparation of practitioner candidates.

79.10(8) Rescinded IAB 9/5/01, effective 10/10/01.

281—79.11(256) Diversity.

79.11(1) Recruitment, admissions, hiring, and retention policies and practices shall support a diverse faculty and candidate population in the unit.

79.11(2) Efforts toward racial, ethnic, and gender diversity among education 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.

79.11(3) Unit efforts in increasing or maintaining diversity shall be reflected in plans, monitoring of plans and efforts, and results.

79.11(4) The institution and unit shall maintain a climate that supports diversity in general as well as supporting practitioner candidates and faculty from underrepresented groups on the campus.

281—79.12(256) Practitioner preparation faculty performance and development.

79.12(1) Faculty shall be engaged in scholarly activities that relate to teaching, learning, or practitioner preparation.

79.12(2) Faculty members in professional education shall have preparation and have had experiences in situations similar to those for which the practitioner preparation students are being prepared.

79.12(3) Faculty members shall collaborate regularly and in significant ways with colleagues in the professional education unit and other college/university units, schools, Iowa department of education, area education agencies, and professional associations as well as community representatives.

79.12(4) The work climate within the unit shall promote intellectual vitality, including best teaching practice, scholarship and service among faculty.

79.12(5) Policies and assignments shall allow faculty to be involved effectively in teaching, scholarship, and service.

79.12(6) The unit shall administer a systematic and comprehensive evaluation system and professional development activities to enhance the teaching competence and intellectual vitality of the professional education unit.

79.12(7) Part-time faculty, when employed, shall be identified and shall meet the requirements for appointment as full-time faculty or be employed to fill a need for staff to support instruction.

79.12(8) Faculty members in professional education shall maintain an ongoing, meaningful involvement in activities in preschools, elementary, middle, or secondary schools. Activities of professional education faculty members preparing preservice teachers shall include at least 40 hours of team teaching during a period not exceeding five years in duration at the preschool, elementary, middle, or secondary school level.

281—79.13(256) Practitioner preparation clinical practice standards.

79.13(1) Candidates admitted to a teacher preparation program shall participate in field experiences including both observation and participation in teaching activities in a variety of school settings and totaling at least 50 hours' duration, with at least 10 hours to occur prior to acceptance into the program and at least 40 hours after acceptance.

79.13(2) The student teaching experience shall:

a. Be a full-time experience for a minimum of 12 consecutive weeks in duration during the student's final year of the practitioner preparation program;

b. Consist of interactive experiences that involve the college or university personnel, the student teacher, the cooperating teacher, and administrative personnel from the cooperating teacher's school district;

c. Include prescribed minimum expectations and responsibilities, including ethical behavior, for the student teacher;

d. Include prescribed minimum expectations and responsibilities for cooperating teachers, the school district, and higher education supervising faculty members;

e. Include opportunities for the student teacher to become knowledgeable about the Iowa teaching standards, including a mock evaluation performed by the cooperating teacher or a person who holds an Iowa evaluator certificate (see rule 282—20.51(272) and Iowa Code section 284.10). The mock evaluation shall not be used as an assessment tool by the practitioner preparation program.

79.13(3) Practitioner candidates shall study and practice in settings that include diverse populations, students with disabilities, and students of different ages.

79.13(4) Clinical practice for teacher and other professional school personnel candidates shall support the development of knowledge, dispositions, and skills that are identified in the Iowa board of educational examiners' licensure standards, the unit's framework for preparation of effective practitioners, and standards from INTASC or other national professional organizations as appropriate for the licenses sought by candidates.

79.13(5) Practitioner candidates shall develop the capacity to utilize assessment data in effecting student learning in prekindergarten through grade 12.

79.13(6) Environments for clinical practice shall support learning in context, including:

a. Scheduling and use of time and resources to allow candidates to participate with teachers and other practitioners and learners in the school setting.

b. Practitioner candidate learning that takes place in the context of providing high quality instructional programs for children.

c. Opportunities for practitioner candidates to observe and be observed by others and to engage in discussion and reflection on practice.

d. The involvement of practitioner candidates in activities directed at the improvement of teaching and learning.

79.13(7) School and college/university faculty shall share responsibility for practitioner candidate learning, including, but not limited to, planning and implementing curriculum and teaching and supervision of the clinical program.

79.13(8) School and college/university faculty shall jointly provide quality clinical experiences for practitioner candidates. Accountability for these experiences shall be demonstrated through:

a. Jointly defined qualifications for practitioner candidates entering clinical practice.

b. Selection of college/university and school faculty members to demonstrate skills, knowledge, and dispositions of highly accomplished practitioners.

c. Selection of college/university and school faculty members who are prepared to mentor and supervise practitioner candidates.

d. Involvement of the cooperating teacher and college/university supervisor in the evaluation of practitioner candidates.

e. Use of a written evaluation procedure with the completed evaluation form included in practitioner candidates' permanent records.

79.13(9) The institution shall annually offer workshop(s) for prospective cooperating teachers to define the objectives of the student teaching experience, review the responsibilities of the cooperating teacher, and provide the cooperating teacher other information and assistance the institution deems necessary. The cumulative instructional time for the workshop(s) shall be a day or the equivalent hours, and the workshop(s) shall utilize delivery strategies identified as appropriate for staff development and reflect information gathered via feedback from workshop participants.

79.13(10) The institution shall enter into a written contract with the cooperating school providing field experiences, including student teaching.

281—79.14(256) Practitioner preparation candidate performance standards.

79.14(1) *Practitioner candidate knowledge and competence.*

a. Candidates for teacher and other professional education personnel roles in schools shall be expected to develop the knowledge, skills, and dispositions identified by the profession and reflected in the national guidelines for the appropriate field, including methods of teaching with an emphasis on the subject area and grade level endorsement sought.

b. Alignment shall exist between the unit's expectations for content, performance, and dispositions, content and pedagogy identified by national professional organizations, Iowa board of educational examiners' licensure standards, national advanced certification, and other standards appropriate for specific areas.

c. Teacher candidates shall acquire a core of professional education knowledge that includes social, historical, and philosophical foundations; human growth and development; student learning; diversity, including mobile students, students speaking English as a second language, and exceptionalities (students with disabilities and students who are gifted and talented); assessment methods including use of student achievement data in instructional decision making; classroom management addressing high-risk behaviors including, but not limited to, behavior related to substance abuse; teachers as consumers of research; law and policy, ethics, and the profession of teaching.

d. Teacher candidates shall acquire a core of liberal arts knowledge including but not limited to mathematics, natural sciences, social sciences, and humanities.

e. Teacher candidates shall acquire through a human relations course approved by the board of educational examiners knowledge about and skill in interpersonal and intergroup relations that shall contribute to the development of sensitivity to and understanding of the values, beliefs, life styles, and attitudes of individuals and the diverse groups found in a pluralistic society.

f. Teacher candidates in elementary education shall acquire knowledge about and receive preparation in elementary reading programs, including but not limited to reading recovery.

g. Teacher candidates in secondary education shall acquire knowledge about and receive preparation in the integration of reading strategies into secondary content areas.

h. Teacher candidates shall develop the dispositions, knowledge, and performance expectations of the INTASC standards embedded in the professional education core for an Iowa teaching license at a level appropriate for a novice teacher.

i. Teacher and other professional school personnel candidates shall demonstrate their dispositions and knowledge related to diversity as they work with student populations and communities.

j. Teacher candidates shall effectively integrate technology in their instruction to support student learning.

k. Experienced teachers in graduate programs shall build upon and extend their prior knowledge and experiences to improve their teaching and their effect on student learning as outlined in the national advanced certification propositions.

79.14(2) *Practitioner candidate assessment and unit planning and evaluation.*

a. The performance assessment system for teacher and other professional school personnel candidates shall be an integral part of the unit's planning and evaluation system.

b. Performance of teacher and other professional school personnel candidates shall be measured against national professional standards, state licensure standards, and the unit's learning outcomes.

c. Multiple criteria and assessments shall be used for admission at both graduate and undergraduate levels to identify teacher and other professional school personnel candidates with potential for becoming education practitioners.

d. The teacher candidate performance system shall include the administration of a basic skills test with program admission denied to any applicants failing to achieve the institution's designated criterion score.

e. Information on performance of teacher and other professional school personnel candidates shall be drawn from multiple assessments, including, but not limited to, institutional assessment of content knowledge, professional knowledge and its application, pedagogical knowledge and its application; teaching and other school personnel performance and the effect on student learning, as candidates work with students, teachers, parents, and professional colleagues in school settings; and follow-up studies of graduates and employers.

f. The design and implementation of the assessment system shall include all stakeholders associated with the unit and its practitioner preparation activities.

g. The unit's assessment system shall:

(1) Provide description of stakeholders' involvement in system development.

(2) Provide evidence that the assessment system reflects both the institution's mission and the unit's framework for preparation of effective teachers and other professional school personnel.

(3) Include a coherent, sequential assessment system for individual practitioner candidates that shall:

1. Provide evidence that the unit and Iowa licensure standards are shared with teacher and other professional school personnel candidates.

2. Utilize, for both formative and summative purposes, a range of performance-based assessment strategies throughout the program that shall provide teacher and other professional school personnel candidates with ongoing feedback about:

- What performance of teacher and other professional school personnel candidates is being assessed/measured. Examples include preentry understandings, skills and dispositions, including professional and pedagogical and content knowledge, teaching abilities and dispositions, and effect on student learning.
- How performance of teacher and other professional school personnel candidates is being assessed/measured. Examples include a specified grade point average at preentry, standardized test scores, authentic assessments of content and professional studies, and authentic assessments of teaching.

3. Have multiple summative decision points. Examples include admission to professional education, after completing introductory courses; prior to, during, and upon completion of student teaching/internship; and beginning performance on the job.

4. Clearly document teacher and other professional school personnel candidates' attainment of the unit and the board of educational examiners' licensure standards by providing evidence of:

- Content knowledge via multiple measures. Examples include content tests, lesson plans showing representation of knowledge structures, ability to apply principles of the discipline to problem solving in the classroom, written essays on content, evidence of being able to represent classroom/school problems in terms of abstract principles of the discipline.
- 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; 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 and other professional school personnel candidate accomplishment.

6. Demonstrate credibility 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 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 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.

281—79.15(256) Administrator preparation faculty performance and development.

79.15(1) The collective competence and background of the total administrator preparation faculty shall reflect a balance of theory, experience, and knowledge appropriate to the administrator preparation programs being offered.

79.15(2) Faculty members shall provide evidence of continuing and significant involvement with PK-12 schools.

79.15(3) Faculty members shall provide evidence of regular and significant collaboration with colleagues in the professional education unit and other units in the institution, Iowa department of education, area education agencies, and professional associations as well as community representatives.

79.15(4) The work climate within the unit shall promote intellectual vitality, including best teaching practice, scholarship and service among faculty.

79.15(5) Faculty shall be engaged in scholarly activities that relate to teaching, learning, leadership or administrator preparation.

79.15(6) Policies and assignments shall allow faculty to be involved effectively in teaching, scholarship, and service.

79.15(7) Part-time faculty, when employed, shall be identified and shall meet the requirements for appointment as full-time faculty or be employed to fill a need for staff to support instruction.

79.15(8) Full- and part-time faculty shall provide evidence of professional growth toward remaining current with research, issues, and trends.

79.15(9) The unit shall administer a systematic and comprehensive evaluation system and professional development activities to enhance the teaching competence and intellectual vitality of the professional education unit.

281—79.16(256) Administrator preparation clinical practice standards.

79.16(1) Administrator candidates shall study about and practice in settings that include diverse populations, students with disabilities, and students of different ages.

79.16(2) Clinical practice for administrator candidates shall support dispositions and the development of knowledge and skills that are identified in the Iowa board of educational examiners' licensure standards, the unit's framework for preparation of effective administrators, and standards from ISLLC or other national professional organizations as appropriate for the licenses sought by candidates.

79.16(3) Clinical practice for candidates shall include clearly stated expectations that tie the experiences to coursework.

79.16(4) Environments for clinical practice shall support learning in context, including:

a. Scheduling and use of time and resources to allow candidates to participate with administrators and other practitioners and learners in the school setting.

b. Administrator candidate learning that takes place in the context of providing high quality instructional programs for children.

c. Opportunities for administrator candidates to observe and be observed by others and to engage in discussion and reflection on practice.

d. The involvement of administrator candidates in activities directed at the improvement of teaching and learning.

79.16(5) School administrators and institution faculty shall share responsibility for administrator candidate learning, including, but not limited to, planning and implementing curriculum and teaching and supervision of the clinical program.

79.16(6) School administrators and institution faculty shall jointly provide quality clinical experiences for administrator candidates. Accountability for these experiences shall be demonstrated through:

a. Jointly defined qualifications for administrator candidates entering clinical practice.

b. Selection of institution faculty and school administration members who demonstrate skills, knowledge, and dispositions of highly accomplished practitioners.

c. Selection of school administrators and institution faculty members who are prepared to mentor and supervise administrator candidates.

d. Training and support for school administrators who mentor and supervise administrator candidates.

e. Joint evaluation of administrator candidates by the cooperating administrator(s) and institution supervisor.

79.16(7) The institution shall enter into a written contract with the cooperating school districts that provide field experiences, including administrator internships.

281—79.17(256) Administrator preparation candidate performance standards.

79.17(1) *Candidate knowledge and competence.*

a. Candidates for administrator roles in schools shall be expected to support dispositions and develop the knowledge and skills identified by the profession and reflected in the Iowa Standards for School Leaders embedded in the requirements for an Iowa administrator license at a level appropriate for a novice administrator.

b. Alignment shall exist between the administrator preparation program's expectations for content, performance, and dispositions, Iowa board of educational examiners' licensure standards, Iowa Standards for School Leaders, educational leadership, and other standards appropriate for specific areas.

c. Administrator candidates shall demonstrate their knowledge of:

(1) Administration, supervision, and evaluation for appropriate levels of schools.

(2) Curriculum development and management for appropriate levels of schools.

(3) Adult learning theory and its impact on professional development.

(4) Human growth and development for children in appropriate levels of schools.

(5) Family support systems, factors which place families at risk, child care issues, and home-school relationships and interactions designed to promote parent education, family involvement, and interagency collaboration for appropriate levels of schools.

(6) School law and legislative and public policy issues affecting children and families for appropriate levels of schools.

(7) Evaluator approval requirements.

d. Administrator candidates shall demonstrate their dispositions and knowledge related to diversity as they work with faculty, student populations and communities.

e. Administrator candidates shall demonstrate competency in:

(1) Facilitating the development, articulation, implementation, and stewardship of a vision of learning that is shared and supported by the school community.

(2) Advocating, nurturing, and sustaining a school culture and instructional program conducive to student learning and staff professional growth.

(3) Ensuring management of the organization, operations, and resources for a safe, efficient, and effective learning environment.

(4) Collaborating with families and community members, responding to diverse community interests and needs, and mobilizing community resources.

(5) Acting in an ethical manner with integrity and fairness.

(6) Understanding, responding to, and influencing the larger political, social, economic, legal and cultural context.

f. Administrator candidates shall understand what elements are needed to effectively integrate technology to enhance learning.

79.17(2) *Administrator candidate assessment and administrator preparation program planning and evaluation.*

a. The performance assessment system for administrator candidates shall be an integral part of the administrator preparation program's planning and evaluation system.

b. Multiple criteria and assessments shall be used for admission to identify administrator candidates with potential for becoming school leaders.

c. Assessments of administrator candidates' performance shall be aligned with ISLLC standards, ISSL, state licensure standards, and the administrator preparation program's learning outcomes.

d. Information on performance of administrator candidates shall be drawn from multiple assessments, including, but not limited to, institutional assessment of content knowledge, professional knowledge and its application, pedagogical knowledge and its application; teaching and other school personnel performance and the effect on student learning, as candidates work with students, teachers, parents, and professional colleagues in school settings; and follow-up studies of graduates and employers.

e. The design and implementation of the assessment system shall include all stakeholders associated with the administrator preparation program's activities.

f. The administrator preparation program's assessment system shall:

(1) Provide description of stakeholders' involvement in system development.

(2) Provide evidence that the assessment system reflects both the institution's mission and the administrator preparation program's framework for preparation of effective administrators.

(3) Include a coherent, sequential assessment system for individual administrator candidates that shall:

1. Provide evidence that the unit and Iowa licensure standards are shared with administrator candidates.

2. Utilize, for both formative and summative purposes, a range of performance-based assessment strategies throughout the program that shall provide administrator candidates with ongoing feedback about:

- What performance of administrator candidates is being assessed or measured.
- How performance of administrator candidates is being assessed or measured.

3. Require administrator candidates to demonstrate and provide evidence of what they have learned.

4. Have multiple summative decision points.

5. Clearly document administrator candidates' attainment of the unit and the board of educational examiners' licensure standards by providing evidence of:

- Content knowledge via multiple measures.
- Professional and pedagogical knowledge via multiple measures.
- Collection and analysis of data related to student achievement via multiple measures.

6. Include scoring rubrics or criteria for determining levels or benchmarks of administrator candidate accomplishment.

7. Demonstrate credibility 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 administrator 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 administrator preparation program'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 administrator 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.

g. An annual report including a composite of evaluative data collected by the administrator preparation program 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 sections 256.7, 256.16 and 272.25(1).

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FACILITY ASSESSMENTS

DIVISION I
ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

These rules describe the assessment of the fee authorized by Iowa Code section 249A.21. The rules explain how the fee is determined and paid, and under what conditions collection of the fee will be terminated.

441—36.1(249A) Assessment of fee. Intermediate care facilities for the mentally retarded (ICFs/MR) licensed in Iowa under 481—Chapter 64 shall pay a monthly fee to the department. The fee shall equal 6 percent of the total revenue of the facility for the facility's preceding fiscal year divided by the number of months of facility operation during the preceding fiscal year. For ICFs/MR operated by the state, the fee shall be retroactive to October 1, 2003.

441—36.2(249A) Determination and payment of fee for facilities certified to participate in the Medicaid program. For facilities certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.2(1) The assessment for each facility fiscal year shall be based on the financial and statistical report for the facility's preceding fiscal year submitted pursuant to rule 441—82.5(249A), as adjusted pursuant to 441—subrules 82.5(10) and 82.17(1).

36.2(2) The department shall notify each facility of the amount of the fee assessed for each fiscal year following submission of the financial and statistical report for the facility's preceding fiscal year. The fee is subject to adjustment based on adjustments to the financial and statistical report.

36.2(3) The department shall deduct the monthly amount due from medical assistance payments to the facility. The department shall also deduct from medical assistance payments any additional amount due for past months as a result of an adjustment to the assessment.

36.2(4) By August 15, 2004, the department shall notify each facility operated by the state of the amount of the fee assessed for the retroactive period of October 1, 2003, through August 31, 2004, subject to adjustment based on adjustment to the facility's financial and statistical report. State-operated facilities shall transfer the amount due for the retroactive period during state fiscal year 2004 (October 2003 through June 2004) to the medical assistance appropriation by August 31, 2004. The amount due for July and August 2004 shall be deducted from the quarterly medical assistance payments made to state-operated facilities in October 2004.

441—36.3(249A) Determination and payment of fee for facilities not certified to participate in the Medicaid program. For facilities not certified to participate in the Medicaid program, the fee shall be determined and paid as follows:

36.3(1) Any licensed ICF/MR in Iowa that is not certified to participate in the Medicaid program shall submit Form 470-0030, Financial and Statistical Report, as required for participating facilities by rule 441—82.5(249A), for purposes of determining the amount of the assessment. The department may audit and adjust the reports submitted, as provided for participating facilities in 441—subrules 82.5(10) and 82.17(1).

36.3(2) The assessment for each facility fiscal year shall be based on the financial and statistical report for the facility's preceding fiscal year as submitted and audited pursuant to subrule 36.3(1).

36.3(3) The department shall notify each facility of the amount of the fee assessed for each fiscal year following submission of the financial and statistical report for the facility's preceding fiscal year. The fee is subject to adjustment based on adjustments to the financial and statistical report.

36.3(4) The facility shall pay the assessed fee to the department on or before the fifteenth day of each month. Any additional amount due for past months as the result of an adjustment to the initial assessment is due 30 days after the department notifies the facility of the additional amount.

441—36.4(249A) Termination of fee assessment. If federal financial participation to match the assessed fee becomes unavailable under federal law, the assessment terminates on the date the federal statutory, regulatory, or interpretive change takes effect.

441—36.5 Reserved.

These rules are intended to implement Iowa Code section 249A.21.

DIVISION II
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

These rules describe the nursing facility quality assurance assessment authorized by the Eighties General Assembly in 2003 Iowa Acts, chapter 112, section 4. The rules explain how the assessment is determined and paid.

441—36.6(80GA,ch112) Assessment.

36.6(1) *Applicability.* All nursing facilities that are licensed in Iowa under Iowa Code chapter 135C and department of inspections and appeals rules in 481—Chapter 58 shall pay a monthly assessment to the department, as determined under this division, with the exception of:

a. Nursing facilities operated by the state.

b. Non-state-government-owned or non-state-government-operated nursing facilities.

36.6(2) *Definition.* For the purposes of this division, the Iowa Medicaid utilization rate is defined as the number of Iowa Medicaid patient days divided by the total number of patient days, as reported by each facility on Form 470-0030, Financial and Statistical Report.

36.6(3) *Assessment level.*

a. Facilities that have an Iowa Medicaid utilization rate of less than 10 percent are required to pay no assessment.

b. Facilities that have an Iowa Medicaid utilization rate greater than or equal to 10 percent and less than 42.5 percent or that have an Iowa Medicaid utilization rate greater than or equal to 10 percent and annual Iowa Medicaid patient days of 22,000 or more are required to pay a quality assurance assessment of $0.50 per non-Medicare patient day.

c. Facilities that have an Iowa Medicaid utilization rate of 42.5 percent or greater and fewer than 22,000 annual Iowa Medicaid patient days are required to pay a quality assurance assessment of $4.70 per non-Medicare patient day.

36.6(4) *Limit.* Notwithstanding subrule 36.6(3), the quality assurance assessment shall not exceed 6 percent of the facility's total revenue from nursing facility services.

441—36.7(80GA,ch112) Determination and payment of assessment for facilities certified to participate in the Medicaid program. For facilities that are certified to participate in the Medicaid program, the assessment shall be determined and paid as follows:

36.7(1) During each state fiscal year, the assessment shall be based on Form 470-0030, Financial and Statistical Report, submitted pursuant to rule 441—81.6(249A) for the facility's fiscal year ending in the preceding calendar year, as adjusted during the determination of the facility's Medicaid reimbursement rate. Nursing facilities that are newly licensed under 481—Chapter 58 shall not be required to pay an assessment until the effective date of a Medicaid rate calculated pursuant to 441—81.6(249A) based on Form 470-0030, Financial and Statistical Report.

36.7(2) The department shall calculate the monthly assessment amount due by:

a. Multiplying the facility's total non-Medicare patient days by the applicable assessment level, as determined in subrule 36.6(3); and

b. Dividing the result by the number of months covered by the Financial and Statistical Report.

36.7(3) The department shall notify each facility of the amount of the assessment due following the facility's submission of Form 470-0030, Financial and Statistical Report. The assessment is subject to adjustment based on adjustments to the Financial and Statistical Report.

36.7(4) The department shall deduct the monthly amount due from the Medicaid payments to the facility. The department shall also deduct from the Medicaid payments any additional amount due for past months as a result of an adjustment to the assessment.

441—36.8(80GA,ch112) Determination and payment of assessment for facilities not certified to participate in the Medicaid program. For facilities that are not certified to participate in the Medicaid program, the assessment shall be determined and paid as follows:

36.8(1) Any nursing facility subject to assessment under subrule 36.6(1) that is not certified to participate in the Medicaid program shall, upon request, submit Form 470-0030, Financial and Statistical Report, as required for participating facilities, for purposes of determining the amount of the assessment. The department may adjust the reports submitted in the same manner as used in the determination of the Medicaid reimbursement rate for participating facilities under rule 441—81.6(249A).

36.8(2) During each state fiscal year, the assessment shall be based on the facility's Form 470-0030, Financial and Statistical Report, as submitted and adjusted pursuant to subrule 36.8(1), for the facility's fiscal year ending in the preceding calendar year.

36.8(3) The department shall calculate the monthly assessment amount due by:

a. Multiplying the facility's total non-Medicare patient days by the applicable assessment level, as determined in subrule 36.6(3); and

b. Dividing the result by the number of months covered by the Financial and Statistical Report.

36.8(4) The department shall notify each facility of the amount of the assessment due for each fiscal year following the facility's submission of Form 470-0030, Financial and Statistical Report. The assessment is subject to adjustment based on adjustments to the Financial and Statistical Report.

36.8(5) The facility shall pay the monthly assessment to the department on or before the fifteenth day of each month. Any additional amount due for past months as the result of an adjustment to the initial assessment is due 30 days after the department notifies the facility of the additional amount.

These rules are intended to implement 2003 Iowa Acts, chapter 112, section 4.

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CHAPTER 37
STANDARDS FOR THE CARE OF AND SERVICES TO COUNTY CARE FACILITY RESIDENTS WITH MENTAL ILLNESS AND MENTAL RETARDATION

Rescinded IAB 5/5/99, effective 7/1/99

TITLE V
STATE SUPPLEMENTARY ASSISTANCE

CHAPTER 50
APPLICATION FOR ASSISTANCE

[Prior to 7/1/83, Social Services[770] Ch 50]
[Prior to 2/11/87, Human Services[498]]

441—50.1(249) Definitions.

"Aged" shall mean a person 65 years of age or older.

"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.

"Disabled" shall mean that a person is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or can be expected to last for a continuous period of not less than 12 months or can be expected to result in death. Exception: For the supplement for Medicare and Medicaid eligibles, being engaged in substantial gainful activity shall not preclude a determination of disability. A child under the age of 18 is disabled if the child suffers from any medically determinable physical or mental impairment of comparable severity. For purposes of state-administered payments, the department shall determine disability according to rule 441—75.20(249A).

"Payment for a dependent relative" shall mean payment to a recipient on behalf of a dependent relative as defined in Iowa Code section 249.3(3).

"Payment for a protective living arrangement" shall mean payment to a recipient living in a family life home. The payment shall be made in accordance with standards established by the department by rule in 441—Chapter 52.

"Payment for residential care" shall mean payment to a recipient living in a residential care facility who is determined to be in need of care and payment is made on a per diem basis.

This rule is intended to implement Iowa Code section 249.3 as amended by 2004 Iowa Acts, House File 2134, section 4.

441—50.2(249) Application procedures.

50.2(1) In order to be eligible for state supplementary assistance, an aged, blind, or disabled person with need for a living arrangement as defined in Iowa Code section 249.3 shall be receiving supplemental security income benefits or shall meet all eligibility requirements for the benefits other than income, but have less income than the standards for the living arrangements as set forth in 441—Chapter 52 and 441—Chapter 177.

a. Payments for mandatory supplementation, blind allowance, dependent relative allowance, and the family life home program shall be federally administered. Income excluded in determining eligibility for or the amount of a supplemental security income benefit shall be excluded in determining eligibility for or the amount of the state payment.

b. Payments for in-home, health-related care and residential care shall be state administered. Income excluded in determining eligibility for or the amount of a supplemental security income benefit, except the $20 exclusion of any income, shall be excluded in determining eligibility for or the amount of the state payment.

c. Payments for supplements for Medicare and Medicaid eligibles shall be state-administered. Income excluded in determining eligibility for the person's Medicaid coverage group shall be excluded in determining eligibility for the state payment.

50.2(2) Any person applying for payment for a protective living arrangement or payment for a dependent relative shall make application for supplemental security income at the Social Security Administration district office. The county office of the department of human services shall certify to the Social Security Administration as to the nature of the living arrangement or the status of the dependent.

50.2(3) Any person applying for payment for residential care shall make application at a local office of the department of human services or at the residential care facility where the person resides. Any person applying for a dependent person allowance or for payment for a protective living arrangement or in-home, health-related care shall make application at a local office of the department. An application may also be filed in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided.

The application shall be made on the Health Services Application, Form 470-2927. The application shall be signed by the applicant or the authorized representative. Someone acting responsibly for an incapacitated, incompetent, or deceased person may sign the application on the person's behalf.

a. Each individual wishing to do so shall have the opportunity to apply for assistance without delay.

b. An applicant may be assisted by other individuals in the application process; the client may be accompanied by the individuals in contact with the department, and when so accompanied, may also be represented by them. When the applicant has a guardian, the guardian shall participate in the application process.

c. The applicant shall immediately be given an application form to complete. When the applicant requests that the forms be mailed, the department shall send the necessary forms in the next outgoing mail.

d. The decision with respect to eligibility shall be based primarily on information furnished by the applicant. The department 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 refusal to authorize the department to secure the information from other sources shall serve as a basis for denial of assistance.

50.2(4) An application for Medicaid from a person who meets the requirements of rule 441—51.6(249) shall be considered as an application for the supplement for Medicare and Medicaid eligibles.

This rule is intended to implement Iowa Code section 249.4 as amended by 2004 Iowa Acts, House File 2134, section 5.

441—50.3(249) Approval of application and effective date of eligibility.

50.3(1) Payment for a federally administered payment category when the applicant is not an SSI recipient shall be effective the month following the month that an application is filed or, if later, the month following the month that all eligibility criteria are met, pursuant to 42 U.S.C. 1382(c)(7).

Payment for a federally administered payment category when the applicant is an SSI recipient shall be effective as of the first day of the month in which an application is filed or the first day of the month in which all eligibility criteria are met, whichever is later, notwithstanding 42 U.S.C. 1382(c)(7).

50.3(2) Payment for residential care shall be effective as of the date that eligibility first exists, notwithstanding 42 U.S.C. 1382(c)(7), but in no case shall the effective date be earlier than 30 days prior to the date of application.

50.3(3) The application for residential care shall be approved or denied within five working days after the Social Security Administration approves supplemental security income benefits. When supplemental security income benefits will not be received, the application shall be approved or denied within five working days from the date of establishment of all eligibility factors.

50.3(4) Payment for the supplement for Medicare and Medicaid eligibles shall be effective retroactive to October 1, 2003, or to the first month when all eligibility requirements are met, whichever is later.

This rule is intended to implement Iowa Code section 249.4 as amended by 2004 Iowa Acts, House File 2134, section 5.

441—50.4(249) Reviews.

50.4(1) Any eligibility factor shall be reviewed whenever a change in circumstances occurs.

50.4(2) All eligibility factors shall be reviewed at least annually.

50.4(3) For purposes of an annual review to be performed by the department, Form 470-2927, Health Services Application, shall be completed.

50.4(4) Rescinded IAB 10/31/01, effective 1/1/02.

This rule is intended to implement Iowa Code section 249.4.

441—50.5(249) Application under conditional benefits. When the client is seeking state supplementary assistance (SSA) under the conditional benefit policy of the supplemental security income (SSI) program, the client shall be required to do the following:

50.5(1) Sign Form 470-2909, Agreement to Sell Excess Property, in order to be eligible.

50.5(2) 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 benefits 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.

50.5(3) Sign an agreement to repay the state supplementary assistance granted during the conditional period using Form 470-2835, State Supplementary Assistance Agreement to Repay Conditional Benefits. The amount of repayment is limited to the lesser of:

a. The amount by which the revised value of resources (resources counted at the beginning of the conditional period plus the net value of resources sold) minus both the resource limit and the amount that SSI recovers for conditional benefits.

b. The amount of state supplementary assistance actually paid in the conditional period, minus the amount that SSI recovers for conditional benefits.

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

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CHAPTER 51
ELIGIBILITY

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

441—51.1(249) Application for other benefits. An applicant or any other person whose needs are included in determining the state supplementary assistance payment must have applied for or be receiving all other benefits, including supplemental security income or the family investment program, for which the person may be eligible. The person must cooperate in the eligibility procedures while making application for the other benefits. Failure to cooperate shall result in ineligibility for state supplementary assistance.

This rule is intended to implement Iowa Code section 249.3.

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

441—51.3(249) Eligibility for residential care.

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

51.3(2) *Physician's statement.* Payment for residential care shall be made only when there is on file an order written by a physician certifying that the applicant or recipient being admitted requires residential care but does not require nursing services. The certification shall be updated whenever a change in the recipient's physical condition warrants reevaluation, but no less than every 12 months.

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

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

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

This rule is intended to implement Iowa Code section 249.3.

441—51.4(249) Dependent relatives.

51.4(1) *Income.* Income of a dependent relative shall be less than $285. When the dependent's income is from earnings, an exemption of $65 shall be allowed to cover work expense.

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

51.4(3) *Living in the home.* A dependent relative shall be eligible until out of the recipient's home for a full calendar month starting at 12:01 a.m. on the first day of the month until 12 midnight on the last day of the same month.

51.4(4) *Dependency.* A dependent relative may be the recipient's ineligible spouse, parent, child, or adult child who is financially dependent upon the recipient. A relative shall not be considered to be financially dependent upon the recipient when the relative is living with a spouse who is not the recipient.

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

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

This rule is intended to implement Iowa Code section 249.3.

441—51.6(249) Eligibility for supplement for Medicare and Medicaid eligibles. The following eligibility requirements are specific to the supplement for Medicare and Medicaid eligibiles:

51.6(1) *Medicaid eligibility.* The recipient must be eligible for and receiving medical assistance benefits under Iowa Code chapter 249A without regard to eligibility based on receipt of state supplementary assistance under this rule, and without being required to meet a spenddown or pay a premium to be eligible for medical assistance benefits.

51.6(2) *SSI eligibility.* The recipient shall meet all eligibility requirements for supplemental security income benefits other than limits on substantial gainful activity and income.

51.6(3) *Not otherwise eligible.* The recipient must not be eligible for benefits under another state supplementary assistance group.

51.6(4) *Medicare eligibility.* The recipient must be currently eligible for Medicare Part B.

51.6(5) *Living arranagement.* A recipient may live in one of the following:

a. The person's own home.

b. The home of another person.

c. A group living arrangement.

d. A medical facility.

51.6(6) *Income.* Income of a recipient shall be within the income limit for the person's Medicaid eligibility group, but must exceed 135 percent of the federal poverty level.

This rule is intended to implement Iowa Code section 249.3 as amended by 2004 Iowa Acts, House File 2134, section 4.

441—51.7(249) Income from providing room and board. In determining profit from furnishing room and board or providing family life home care, $285 per month shall be deducted to cover the cost, and the remaining amount treated as earned income.

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

441—51.8(249) Furnishing of social security number. As a condition of eligibility applicants or recipients of state supplementary assistance must furnish their social security account numbers or proof of application for the numbers if they have not been issued or are not known and provide their numbers upon receipt.

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

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

441—51.9(249) Recovery.

51.9(1) *Definitions.*

"Administrative overpayment" means assistance incorrectly paid to or for the client because of continuing assistance during the appeal process.

"Agency error" means assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.

4. Mathematical errors.

5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the local office.

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

"Client" means a current or former applicant or recipient of state supplementary assistance.

"Client error" means assistance incorrectly paid to or for the client because the client or client's representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client's income, resources, or other eligibility and benefit factors. It also means assistance incorrectly paid to or for the client because of failure by the client or client's representative to timely report as defined in rule 441—76.10(249A).

"Department" means the department of human services.

51.9(2) *Amount subject to recovery.* The department shall recover from a client all state supplementary assistance funds incorrectly expended to or on behalf of the client, or when conditional benefits have been granted.

a. The department also shall seek to recover the state supplementary assistance granted during the period of time that conditional benefits were correctly granted the client under the policies of the supplemental security income program.

b. The incorrect expenditures may result from client or agency error, or administrative overpayment.

51.9(3) *Notification.* All clients shall be promptly notified when it is determined that assistance was incorrectly expended. Notification shall include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery, when known; and the reason for the incorrect expenditure.

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

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

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

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

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CHAPTER 52
PAYMENT

[Prior to 7/1/83, Social Services[770] Ch 52]
[Prior to 2/11/87, Human Services[498]]

441—52.1(249) Assistance standards. Assistance standards are the amounts of money allowed on a monthly basis to recipients of state supplementary assistance in determining financial need and the amount of assistance granted.

52.1(1) *Protective living arrangement.* The following assistance standards have been established for state supplementary assistance for persons living in a family life home certified under rules in 441—Chapter 111.

$645	Care allowance
$ 81	Personal allowance
$726	Total

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

a. Aged or disabled client and a dependent relative $849
b. Aged or disabled client, eligible spouse, and a dependent relative $1131
c. Blind client and a dependent relative $871
d. Blind client, aged or disabled spouse, and a dependent relative $1153
e. Blind client, blind spouse, and a dependent relative $1175

52.1(3) *Residential care.* Payment to a recipient in a residential care facility shall be made on a flat per diem rate of $17.86 or on a cost-related reimbursement system with a maximum per diem rate of $25. The department shall establish a cost-related per diem rate for each facility choosing this method of payment according to rule 441—54.3(249).

The facility shall accept the per diem rate established by the department for state supplementary assistance recipients as payment in full from the recipient and make no additional charges to the recipient.

a. All income of a recipient as described in this subrule after the disregards described in this subrule shall be applied to meet the cost of care before payment is made through the state supplementary assistance program.

Income applied to meet the cost of care shall be the income considered available to the resident pursuant to supplemental security income (SSI) policy plus the SSI benefit less the following monthly disregards applied in the order specified:

(1) When income is earned, impairment related work expenses, as defined by SSI plus $65 plus one-half of any remaining earned income.

(2) An $81 allowance to meet personal expenses and Medicaid copayment expenses.

(3) When there is a spouse at home, the amount of the SSI benefit for an individual minus the spouse's countable income according to SSI policies. When the spouse at home has been determined eligible for SSI benefits, no income disregard shall be made.

(4) When there is a dependent child living with the spouse at home who meets the definition of a dependent according to the SSI program, the amount of the SSI allowance for a dependent minus the dependent's countable income and the amount of income from the parent at home that exceeds the SSI benefit for one according to SSI policies.

(5) Established unmet medical needs of the resident, excluding private health insurance premiums and Medicaid copayment expenses. Unmet medical needs of the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall be an additional deduction when the countable income of the spouse at home is not sufficient to cover those expenses. Unmet medical needs of the dependent living with the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall also be deducted when the countable income of the dependent and the income of the parent at home that exceeds the SSI benefit for one is not sufficient to cover the expenses.

(6) The income of recipients of state supplementary assistance or Medicaid needed to pay the cost of care in another residential care facility, a family life home, an in-home health-related care provider, a home- and community-based waiver setting, or a medical institution is not available to apply to the cost of care. The income of a resident who lived at home in the month of entry shall not be applied to the cost of care except to the extent the income exceeds the SSI benefit for one person or for a married couple if the resident also had a spouse living in the home in the month of entry.

b. Payment is made for only the days the recipient is a resident of the facility. Payment shall be made for the date of entry into the facility, but not the date of death or discharge.

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

d. Payment shall not be made when income is sufficient to pay the cost of care in a month with less than 31 days, but the recipient shall remain eligible for all other benefits of the program.

e. Payment will be made for periods the resident is absent overnight for the purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 30 days during any calendar year, unless a family member or legal guardian of the resident, the resident's physician, case manager, or department service worker provides signed documentation that additional visitation days are desired by the resident and are for the benefit of the resident. This documentation shall be obtained by the facility for each period of paid absence which exceeds the 30-day annual limit. This information shall be retained in the resident's personal file. If documentation is not available to justify periods of absence in excess of the 30-day annual limit, the facility shall submit a Case Activity Report, Form 470-0042, to the county office of the department to terminate the state supplementary assistance payment.

A family member may contribute to the cost of care for a resident subject to supplementation provisions at rule 441—51.2(249) and any contributions shall be reported to the county office of the department by the facility.

f. Payment will be made for a period not to exceed 20 days in any calendar month when the resident is absent due to hospitalization. A resident may not start state supplementary assistance on reserve bed days.

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

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

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

52.1(4) *Blind.* The standard for a blind recipient not receiving another type of state supplementary assistance is $22 per month.

52.1(5) *In-home, health-related care.* Payment to a person receiving in-home, health-related care shall be made in accordance with rules in 441—Chapter 177.

52.1(6) *Minimum income level cases.* The income level of those persons receiving old age assistance, aid to the blind, and aid to the disabled in December 1973 shall be maintained at the December 1973 level as long as the recipient's circumstances remain unchanged and that income level is above current standards. In determining the continuing eligibility for the minimum income level, the income limits, resource limits, and exclusions which were in effect in October 1972 shall be utilized.

52.1(7) *Supplement for Medicare and Medicaid eligibles.* Payment to a person eligible for the supplement for Medicare and Medicaid eligibles shall be $1 per month.

This rule is intended to implement Iowa Code chapter 249 as amended by 2004 Iowa Acts, House File 2134, sections 4 and 5.

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61.15(6) *Fee schedule.* The bureau shall not be compensated for costs related to interpretation or translation services in excess of the maximum allowable under the schedule of fees prescribed pursuant to this subrule. Any moneys collected under this rule shall be used to reimburse the appropriation obligated and disbursed in payment for services.

a. Rate for services. The fee schedule for interpretation services shall be based on a portal-to-portal basis multiplied by the appropriate rate. The standard rate shall be $25 per hour, plus actual expenses not to exceed the state reimbursement rate for meals, lodging, parking, and ground or air transportation costs incurred in providing services.

When a single interpretation assignment exceeds six hours, a flat salary rate of $150 per day, plus actual expenses, not to exceed the state reimbursement rate, shall be charged.

The fee for translating documents shall be $25 per page for verbatim translations and $10 per page for summary translations.

b. Minimum charges. A minimum charge of one hour shall be charged for providing requested interpretation services. A minimum of one hour shall be charged for cancellations less than 12 hours prior to a prescheduled appointment. A minimum one-hour charge, plus incidental costs, shall be charged for party no-shows.

For any legal action preparatory to appearing before any court which is facilitated through a telephone interpretation, a minimum charge of 15 minutes shall be charged. A charge for each additional 15-minute increment, after the first 15 minutes, shall be billed at a prorated share of the scheduled standard rate of $25 per hour.

61.15(7) *Payment.* Payment for interpretation and translation services invoiced according to the fee schedule shall be issued to the bureau by the clerk of court, if the interpreter or translator is appointed by the presiding judicial officer, unless other state or federal statutory provisions preclude the payment. The presiding judicial officer may order that all or part of the salaries, fees, expenses and costs be apportioned between or among the parties or be taxed according to existing state or federal statutory provisions.

Invoices for interpretation and translation services shall be sent on the tenth of the month following the service date to the appropriate clerk of court. Information on this invoice form is considered confidential and shall include:

1. Name and address of party initiating the service request.
2. Date, time and location of assignment.
3. Description and rate.
4. Hours of service delivery.
5. Name of interpreter(s) and translator(s).
6. Detailed statement of related costs.

441—61.16(217) Pilot recredentialing services. The department shall make available, as a pilot program, recredentialing services for refugees who are graduates of a foreign school that qualifies its students for certification or licensure as registered nurses or licensed practical nurses. These pilot services shall be available to the extent that funding is available through the federal fiscal year 2001 Polk County targeted assistance grant (see 441—61.17(217) for definition) and through Office of Refugee Resettlement social services funds up to a maximum of $22,500. The pilot program shall end September 30, 2003.

61.16(1) *Services included in recredentialing services.* In addition to employability services as described in subrule 61.5(11), the department shall provide the following to participants in recredentialing services:

a. Practical assistance in securing documents and services needed to achieve evaluation of credentials earned outside the United States through appropriate United States professional credentials-evaluation organizations.

b. Payment of the initial fee for services of professional credentials-evaluation organizations.

c. Payment, to a maximum of $5,000 per eligible refugee, as contracted for or otherwise arranged or approved by the bureau, for professional refresher training or other education or training services to enable participants to achieve Iowa certification or licensure.

61.16(2) *Limitations on recredentialing services.* In addition to the policies described in rule 441—61.6(217), the following shall apply to participants in recredentialing services:

a. The department shall identify eligible participants for recredentialing services through the appropriate employability assessment services as provided in paragraph 61.5(11)*"b."*

b. The department shall deny eligibility for recredentialing services when the applicant cannot achieve acceptable levels in bureau-administered assessment tests of English literacy, spoken English proficiency, and math proficiency.

c. The department shall consider that eligibility for recredentialing services begins with payment of the fee to the appropriate professional credentials-evaluation organization.

d. The department shall deny or terminate eligibility for recredentialing services when it becomes clear that recredentialing cannot be achieved within the limitations as provided in rule 441—61.6(217). In addition to the appropriate professional credentials-evaluation organization, appropriate education and training institutions may be consulted to determine whether recredentialing may be achieved within these limitations.

e. The department shall limit eligibility for recredentialing services based on place of residence only so far as the source of recredentialing services funding requires such limitation.

441—61.17(217) Targeted assistance grants. "Targeted assistance grants" means U.S. Department of Health and Human Services formula allocation funding granted to the department for assistance to counties where, because of factors such as unusually large refugee populations (including secondary migration), high refugee concentrations, and high use of public assistance by refugees, there exists and can be demonstrated a specific need for supplementation of available resources for services to refugees.

61.17(1) *Administration of targeted assistance grants.* The department shall make 95 percent of the total award available to the designated county except when the designated county has agreed to let the department administer the targeted assistance grant in its stead.

61.17(2) *Eligibility for services under targeted assistance grants.* Services funded by targeted assistance grants are limited to refugees who reside in the designated county.

61.17(3) *Services and limitations for services funded by targeted assistance grants.* Rules of 441—Chapter 61 are applicable to services funded by targeted assistance grants, except for subrules 61.5(5) and 61.6(1).

61.17(4) *Priority of services.* Services funded by targeted assistance grants shall be provided in the following order of priority, except in certain individual extreme circumstances:

1. Cash assistance recipients, particularly long-term recipients.
2. Unemployed refugees who are not receiving cash assistance.
3. Employed refugees in need of services to retain employment or to attain economic independence.

441—61.18(217) Iowa refugee services foundation. An Iowa refugee services foundation is established to engage in refugee resettlement activities to promote the welfare and self-sufficiency of refugees who live in Iowa and are not citizens of the United States. The structure and authority of the foundation shall be as prescribed in 2004 Iowa Acts, Senate File 2298, section 146, and in the bylaws adopted by the board of directors.

61.18(1) *Board of directors.* The foundation board of directors shall perform the duties and functions necessary and proper to carry out the foundation's responsibilities.

a. Composition. The board shall consist of five members, one appointed by the governor and four appointed by the director of the department of human services.

b. Term. Members of the board shall be appointed to three-year terms, except as described in paragraph "*c.*" Terms shall begin on July 1 and end on June 30.

c. Initial term. The initial term of the members appointed by the director of the department of human services shall be as follows:

(1) One member appointed for three years.

(2) Two members appointed for two years.

(3) One member appointed for one year.

d. Equity. Not more than two members appointed by the director of the department of human services shall be of the same gender or of the same political party.

e. Vacancy. A vacancy on the board shall be filled in the same manner as the original appointment for the remainder of the term.

61.18(2) *Board meetings.* The board of directors shall meet at least once each year to elect one of its members as chairperson.

These rules are intended to implement Iowa Code section 217.6 and chapter 622A and 2004 Iowa Acts, Senate File 2298, section 146.

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CHAPTERS 62 and 63
Reserved

CHAPTER 64
RELIEF FOR NEEDY INDIANS
Rescinded IAB 9/1/93, effective 11/1/93

441—65.8(234) Deductions.

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

a. The standard allowance for utilities which include heating or air-conditioning costs is a single utility standard. This standard is $202 effective August 1, 1991.

b. Beginning October 1, 1992, this allowance shall change annually effective each October 1 using the percent increase reported in the consumer price index monthly periodical for January for fuels and other utilities for the average percent increases for the prior year for all urban consumers United States city average. Any numeral after the second digit following the decimal point will be dropped in this calculation. Any decimal amount of .49 or under will be rounded down. Any decimal of .50 or more will be rounded up to the nearest dollar. The cent amount will be included when calculating the next year's increase.

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

65.8(3) *Telephone standard.* When a household is receiving telephone service for which it is required to pay and the household is not entitled or chooses not to receive a single standard allowance, a standard allowance shall be allowed. This standard shall be $18 effective August 1, 1991. Beginning October 1, 1992, this allowance shall change annually effective each October 1 using the percent increase reported in the consumer price index monthly periodical for January for telephone service for the average percent increases for the prior year for all urban consumers United States city average. Any numeral after the second digit following the decimal point will be dropped in this calculation. Any decimal amount of .49 or under will be rounded down. Any decimal of .50 or more will be rounded up to the nearest dollar. The cent amount will be included when calculating the next year's increase.

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

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

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

b. Beginning October 1, 1992, this allowance shall change annually effective each October 1 using the percent increase reported in the consumer price index monthly periodical for January for electric service for the average percent increases for the prior year for all urban consumers United States city average. Any numeral after the second digit following the decimal point will be dropped in this calculation. Any decimal amount of .49 or under will be rounded down. Any decimal of .50 or more will be rounded up to the nearest dollar. The cent amount will be included when calculating the next year's increase.

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

65.8(7) *Excess medical expense deduction.*

a. Notwithstanding anything to the contrary in these rules or regulations, at certification, households having a member eligible for the excess medical expense deduction shall be allowed to provide a reasonable estimate of the member's medical expenses anticipated to occur during the household's certification period.

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

(2) Households giving an estimate shall not be required to report or verify changes in medical expenses that were anticipated to occur during the certification period.

b. Effective beginning June 1, 2004.

(1) A household member who receives the Medicare prescription drug credit shall be allowed a standard medical expense of $50 per month for the credit until the full value of the annual credit is realized.

(2) A household member who has a Medicare prescription drug discount card shall be allowed a standard medical expense of $23 per month for the discount.

(3) These standard medical expenses shall be added to any other eligible monthly out-of-pocket medical expenses.

c. Effective beginning June 1, 2004, a household member with a Medicare drug discount card may claim actual prediscount prescription drug expenses rather than use the standards if the expense is greater than the standards. To claim actual expenses, the person must verify either the prediscount expense or the discounted expense. If the discounted expense is verified, then prescription costs are multiplied by a discount factor of 1.25 to determine the prediscount expense.

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

65.8(9) *Standard deduction.* Each household will receive a standard deduction from income equal to 8.31 percent of the net income limit for food assistance eligibility. No household will receive an amount less than $134 or more than 8.31 percent of the net income limit for a household of six members.

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

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

This rule is intended to implement Iowa Code section 234.12.

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

441—65.10(234) Reporting changes. Households may report changes on the Change Report Form, 470-0321 or 470-0322 (Spanish). Households are supplied with this form at the time of initial certification, at the time of recertification whenever the household needs a new form, whenever a form is returned by the household, and upon request by the household.

Households which are exempt from filing a monthly report must report a change in total household gross earned income of more than $100 per month. Households exempt from filing a monthly report must report changes in income within ten days of the date the household receives the first payment reflecting the change.

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

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

441—65.13(234) Joint processing.

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

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

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

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

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

This rule is intended to implement Iowa Code section 234.12.

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

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

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

441—65.19(234) Monthly reporting/retrospective budgeting. This rule is effective only until the transition to simplified reporting is complete.

65.19(1) *Budgeting cycle.* Retrospective budgeting will base benefit calculation on the budget month which is the second calendar month preceding the issuance month.

65.19(2) *Reporting responsibilities of monthly reporting households.*

a. The department will supply the Public Assistance Eligibility Report, Form 470-0454 (computer issued), 470-0455 (manually issued), or 470-3719 (Spanish, manually issued) to the recipient as needed or requested. The department shall provide a postage-paid envelope for return of the Public Assistance Eligibility Report.

b. Households shall return the completed form to the local department office where the case is assigned by the fifth calendar day of the month which precedes the issuance month, when the form was issued in the department's regular end-of-month mailing. Households shall return the completed form to the local department office where the case is assigned by the seventh day after the date of the issuance of the form when the form was not issued in the department's regular end-of-month mailing.

c. Failure to return a completed form shall result in cancellation of assistance. A completed form is a form with all items answered, accompanied by verification as required in 65.19(14), and signed and dated by a responsible household member on or after the last day of the budget month. When the Public Assistance Eligibility Report is used and a person in the household is also required to report monthly for another public assistance program, the form shall also be signed by all individuals required to sign for that program to be considered complete.

65.19(3) *Determination of eligibility.* Eligibility will be determined on the basis of the household's prospective income and circumstances.

65.19(4) *Public assistance income.* The department shall consider family investment program and refugee cash assistance grants authorized for the issuance month in determining the household's eligibility and benefit level. The department shall count adjustive or corrective public assistance payments retrospectively.

65.19(5) *Suspension.* Suspension is not limited to households with a periodic increase in recurring income. Suspension may not occur for two consecutive months.

65.19(6) *Households required to submit monthly reports.* The following households must return monthly reports, unless exempted by federal regulation:

a. Households required to submit family investment program monthly reports.

b. Households with one or more members who have a recent work history.

c. Households with one or more members receiving countable unearned income which is not constant except when one or more of the following apply:

(1) The income is from job insurance benefits.

(2) The income is from educational income such as grants, scholarships, educational loans, fellowships or veterans' educational benefits.

(3) The income is from interest.

(4) The income is from occasional general assistance payments.

d. Households with one or more members receiving countable earned income except when one or more of the following apply:

(1) The earned income of each person is $75 or less per month.

(2) The earned income is annualized self-employment income.

(3) The only source of earned income of a person receiving Supplemental Security Income (SSI) or Social Security Disability is from a sheltered workshop program.

65.19(7) *Entering or leaving monthly reporting or a budgeting method due to a change in status.* Notwithstanding anything to the contrary in these rules or regulations, a monthly report will be required for the budget month after the month the household reported a status change. Retrospective budgeting will begin in the month after the household reported the status change.

The department shall notify households who become exempt from monthly reporting within ten days of the date the department becomes aware of the change. This notification shall inform the household that they no longer have to file future monthly reports and will tell them when the change in budgeting, if any, will occur. Prospective budgeting will begin the first issuance month the client does not submit a monthly report.

The department shall change the budgeting method of households who must report changes in ten days no later than the next month following the ten-day period for the worker to act and timely notice requirements.

65.19(8) *Prospective beginning months.* The department shall calculate benefits for eligible households prospectively for the two beginning months. When a household has applied for assistance from the family investment program or the refugee resettlement cash assistance program, and for food assistance benefits using Form 470-0462 or 470-0466 (Spanish), Public Assistance Application, the department shall allow a third food assistance beginning month. The department shall allow a third beginning month when the public assistance program's first "initial month" is the same calendar month as the second food assistance beginning month, and the third beginning month permits a simultaneous transition to retrospective budgeting.

65.19(9) *Disregarded income for the first months of retrospective budgeting.* Income considered prospectively for new household members or in the beginning months and not expected to continue shall not be considered again.

65.19(10) *Action on reported changes.* The agency will act on all reported changes for households required to submit monthly reports.

65.19(11) *Actual or converted income.* Calculation of benefits for households required to submit monthly reports will consider the actual income received or anticipated to be received in the budget month unless the income is annualized or prorated. Calculation of benefits for households not required to monthly report will use the actual or converted amount of income received on a weekly or biweekly basis for that benefit month.

65.19(12) *Mailing of notices.* All individual household notices of benefit amounts will be mailed separately from benefits.

65.19(13) *Reinstatement.* Reinstatement of the household canceled for failure to submit a complete monthly report will occur only when the otherwise eligible household submits a complete report by the end of the report month or by the extended filing date, whichever is later.

65.19(14) *Verification of income.* Notwithstanding anything to the contrary in these rules or regulations, a monthly report will be considered incomplete when it is not accompanied by verification of:

a. Gross nonexempt earned income, including when this earned income starts or stops.

b. Unearned income or prorated income or annualized income when this income starts, stops, or changes in amount. Verification of interest income, with a monthly report, is not required.

65.19(15) *Return of verification.* The agency will return all items of verification, submitted in the monthly reporting process, to the household.

65.19(16) *Notice regarding reinstatement.* The household which has received a Notice of Cancellation, Form 470-1968, shall be notified in writing of its status every time the department receives a monthly report form before the end of the "report month," or before the end of the extended filing period, whichever is later.

65.19(17) *Additional information and verification.* The household which has submitted a complete monthly report shall submit, or cooperate in obtaining, additional information and verification needed to determine eligibility or benefits within ten calendar days of the agency's written request.

65.19(18) *Household membership.*

a. Except for applications received during a period of time when the household was not certified to receive benefits, household membership shall be determined as it was or is anticipated to be on the first day of the issuance month. Changes in household membership occurring on or after the first day of the month which are reported during the month in which the change occurs will not be considered until the following month.

b. Except for qualified residents of a shelter for battered women and children, individuals shall not be added to the household before they are removed from another household where they were receiving benefits.

65.19(19) *Certification periods.* Households in which all members are receiving family investment program (FIP) cash assistance or family medical assistance program (FMAP)-related Medicaid will be assigned certification periods of 6 to 12 months. However, a certification period of less than 6 months may be assigned at application or recertification to match the food assistance recertification date and the public assistance review date.

Households in which one or more members are not receiving FIP cash assistance, or FMAP or FMAP-related medical assistance, and which are not required to file a monthly report will be assigned certification periods of one to six months based on the predictability of the household's circumstances except when the adult members are all 60 years of age or older with very stable income such as social security, supplemental security income, pensions or disability payments. These households shall be certified for up to 12 months.

65.19(20) *Households subject to retrospective budgeting.* Notwithstanding anything to the contrary in these rules or regulations, all households are subject to retrospective budgeting except:

a. Migrant or seasonal farm worker households.

b. Households whose adult members are all elderly or disabled with no earned income.

c. Households in beginning months as outlined in subrule 65.19(8).

d. Households in which all members are homeless individuals.

e. Households residing on a reservation.

65.19(21) *Self-employment income for less than a year.* Notwithstanding anything to the contrary in these rules or regulations, self-employment income received over a period of less than a year shall be prorated over that period and used to calculate benefits only retrospectively. This income will be used prospectively to determine eligibility.

441—65.20(234) Notice of expiration issuance.

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

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

441—65.21(234) Claims.

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

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

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

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

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

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

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

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

441—65.22(234) Verification.

65.22(1) *Required verification.*

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

1. Households are not required to verify the public assistance grant.
2. Households are not required to verify job insurance benefits when the information is available to the department from the department of employment services.
3. Households are only required to verify interest income at the time of application and recertification.

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

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

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

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

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

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

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

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CHAPTERS 66 to 70
Reserved

CHAPTER 71
EMERGENCY FOOD DISTRIBUTION PROGRAM
Rescinded, effective 11/1/86

CHAPTER 72
EMERGENCY FOOD AND SHELTER PROGRAM
Rescinded, effective 11/1/86

441—77.23(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

441—77.24(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

441—77.25(249A) Genetic consultation clinics. Rescinded IAB 6/28/00, effective 8/2/00.

441—77.26(249A) Nurse-midwives. Rescinded IAB 10/15/03, effective 12/1/03.

441—77.27(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

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

441—77.28(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the department of education.

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

441—77.29(249A) Case management provider organizations. Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

77.29(1) *Standards in 441—Chapter 24.* Providers shall meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case management services to persons with mental retardation, developmental disabilities or chronic mental illness.

77.29(2) *Standards in 441—Chapter 186.* Providers shall meet the standards in 441—Chapter 186 when providing child welfare targeted case management services as defined in 441—Chapter 186.

441—77.30(249A) HCBS ill and handicapped waiver service providers. HCBS ill and handicapped waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider. The following providers shall be eligible to participate in the Medicaid HCBS ill and handicapped waiver program if they meet the standards set forth below:

77.30(1) *Homemaker providers.* Homemaker providers shall be agencies which meet the home care standards and requirements set forth in department of public health rules, 641—80.5(135), 641—80.6(135), and 641—80.7(135) or which are certified as a home health agency under Medicare.

77.30(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.30(3) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

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

77.30(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Respite providers certified under the HCBS MR or BI waiver.

(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).

(8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(9) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

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

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

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

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

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

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

(1) At least 18 years of age.

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

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

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

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

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

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

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

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

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

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.30(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.30(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 321—4.4(231).

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

c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the mental retardation or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.30(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

77.30(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

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

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

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

d. Restaurants licensed and inspected under Iowa Code chapter 137B.
e. Hospitals enrolled as Medicaid providers.
f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
g. Medical equipment and supply dealers certified to participate in the Medicaid program.
h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.30(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a licensed dietitian:

a. Hospitals enrolled as Medicaid providers.
b. Community action agencies as designated in Iowa Code section 216A.93.
c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
d. Home health agencies certified by Medicare.
e. Licensed dietitians approved by an area agency on aging.

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

441—77.31(249A) Nurse anesthetists. Rescinded IAB 10/15/03, effective 12/1/03.

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

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

441—77.33(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards set forth below:

77.33(1) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

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

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

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

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

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

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

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

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

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

77.33(6) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the HCBS MR waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

441—77.34(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if 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 or BI waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

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

(8) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

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

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

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

c. Hospitals enrolled as Medicaid providers.

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

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

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

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

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

77.34(7) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

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

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

(1) At least 18 years of age.

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

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

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

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

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

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

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

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

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

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

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) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

77.36(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

77.36(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.36(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

441—77.37(249A) HCBS MR waiver service providers. Providers shall be eligible to participate in the Medicaid program as approved HCBS MR service providers if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)"*a*"(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

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

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

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

c. The organization establishes and maintains fiscal accountability.

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

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

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

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

(5) Individual consumer support needs.

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

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

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

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.
h. (Outcome 9) Consumers make informed choices about where they work.
i. (Outcome 10) Consumers make informed choices on how they spend their free time.
j. (Outcome 11) Consumers make informed choices about where and with whom they live.
k. (Outcome 12) Consumers choose their daily routine.
l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
m. (Outcome 14) Consumers have a social network and varied relationships.
n. (Outcome 15) Consumers develop and accomplish personal goals.
o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
p. (Outcome 17) Consumers maintain good health.
q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
s. (Outcome 20) Consumers have an impact on the services they receive.

77.37(3) *Contracts with consumers.* The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

77.37(4) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.37(5) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

77.37(6) *Research.* If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

77.37(7) *Abuse reporting requirements.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

77.37(8) *Incident reporting.* The provider shall document major and minor incidents and make the incident reports and related documentation available to the department upon request. The provider shall ensure cooperation in providing pertinent information regarding incidents as requested by the department.

a. Major incident defined. A "major incident" means an occurrence involving a consumer of services that:

(1) Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
(2) Results in someone's death;
(3) Requires emergency mental health treatment for the consumer;
(4) Requires the intervention of law enforcement;

(5) Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; or

(6) Constitutes a prescription medication error or a pattern of medication errors that could lead to the outcome in subparagraph (1), (2), or (3).

b. Minor incident defined. A "minor incident" means an occurrence involving a consumer of services that is not a major incident and that:

(1) Results in the application of basic first aid;

(2) Results in bruising;

(3) Results in seizure activity;

(4) Results in injury to self, to others, or to property; or

(5) Constitutes a prescription medication error.

c. Report form. Each major or minor incident shall be recorded on an incident report form that is completed and signed by the staff who were directly involved at the time of the incident or who first became aware of the incident. The report shall include the following information:

(1) The name of the consumer involved.

(2) The date and time the incident occurred.

(3) A description of the incident.

(4) The names of all provider staff and others who were present at the time of the incident or responded after becoming aware of the incident. The confidentiality of other consumers who are involved in the incident must be maintained by the use of initials or other means.

(5) The action that the staff took to handle the incident.

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

d. Reporting procedure for major incidents. When a major incident occurs, provider staff shall notify the consumer or the consumer's legal guardian within 72 hours of the incident and shall distribute the completed incident report form as follows:

(1) Forward the report to the supervisor within 24 hours of the incident.

(2) Send a copy of the report to the consumer's Medicaid targeted case manager and the department's bureau of long-term care within 72 hours of the incident.

(3) File a copy of the report in a centralized location and make a notation in the consumer's file.

e. Reporting procedure for minor incidents. When a minor incident occurs, provider staff shall distribute the completed incident report form as follows:

(1) Forward the report to the supervisor within 24 hours of the incident.

(2) File a copy of the report in a centralized location and make a notation in the consumer's file.

77.37(9) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

b. The provider shall ensure the rights of persons applying for services.

77.37(10) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

(3) The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties and the state to be served by the provider.

77.37(11) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable local county central point of coordination and other interested parties.

c. Providers applying for initial certification shall be offered technical assistance.

77.37(12) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS MR waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.37(13) *Review of providers.* Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13)*"e"* and 77.37 (13)*"f."*

h. The department may conduct a site visit to verify all or part of the information submitted.

77.37(14) *Supported community living providers.*

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.

2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. Living units designed to serve more than three supported community living consumers shall be approved as follows:

(1) The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of such programs in the area.

(2) The department may approve conversion of a total of 40 living units for five persons or fewer formerly licensed as residential care facilities for persons with mental retardation to living units designed to serve supported community living consumers. Upon approval, the living unit shall surrender the facility license and continue to operate under the medical assistance home- and community-based services waiver for persons with mental retardation.

Approvals of living units for five persons or fewer formerly licensed as residential care facilities for persons with mental retardation granted before July 1, 2002, shall remain in effect.

Applications for approval to be granted under this subparagraph after July 1, 2003, shall be submitted to the Department of Human Services, Bureau of Long-Term Care, 1305 E. Walnut Street, Fifth Floor, Des Moines, Iowa 50319-0114. The application shall include a letter of support from the county in which the living unit is located. The letter shall verify that the county will request sufficient waiver slots for the consumers to be served and provide necessary county funding.

The bureau of long-term care shall approve the application based on the letter of support from the county and the requirement to maintain the geographical distribution of supported community living programs to avoid an overconcentration of programs in an area.

(3) Subject to federal approval, a residential program which serves not more than eight individuals and is licensed as an intermediate care facility for persons with mental retardation may surrender the facility license and continue to operate under the home- and community-based services waiver for persons with mental retardation if the department has approved the timelines submitted by the residential program pursuant to subparagraph 77.37(14)*"d"*(1).

(4) The department shall approve a living unit for five persons subject to all of the following conditions:

1. Approval will not result in an overconcentration of such living units in an area.

2. The county in which the living unit is located submits a letter of support for approval to the bureau of long-term care.

3. The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following:

- The quantity of services currently available in the county is insufficient to meet the need.
- The quantity of affordable rental housing in the county is insufficient.
- Approval will result in a reduction in the size or quantity of larger congregate settings.

77.37(15) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

(7) Home care agencies that meet the home care standards and requirements set forth in department of public health rules 641—80.5(135) through 641—80.7(135).

(8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

(9) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) *Supported employment providers.*

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

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

(2) Procedures for payment schedules and pay scale.

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

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

(5) Department of labor requirements.

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

77.37(17) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the mental retardation or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.37(18) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.37(20) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

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

(1) At least 18 years of age.

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

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

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

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

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

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

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

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

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

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.37(22) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.37(23) *Residential-based supported community living service providers.*

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues.

Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.
- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.
2. Goals to be achieved to meet the needs of the child.
3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
4. Specific service activities to be provided to achieve the objectives.
5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
6. Date of service initiation and date of individual service plan development.
7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.
2. Progress toward goals and objectives is not being made.
3. Changes have occurred in the identified service needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.
4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) Rescinded IAB 8/7/02, effective 10/1/02.

(2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.
2. What physical change will need to take place in the living units.
3. How children and their families will be involved in the transitioning process.
4. How this transition will affect children's social and educational environment.

f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f"* and numbered paragraph 77.37(23)*"f"*(3)"4."

• The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)"*h*" and subparagraph 77.37(23)"*f*"(3).

• There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

77.37(24) *Transportation service providers.* The following providers may provide transportation:

a. Accredited providers of home- and community-based services.

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

c. Transportation providers that contract with county governments.

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

e. Nursing facilities licensed under Iowa Code chapter 135C.

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

77.37(25) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

77.37(26) *Prevocational services providers.* Providers of prevocational services must be accredited by one of the following:

a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.

b. The Council on Quality and Leadership.

77.37(27) *Day habilitation providers.* Day habilitation services may be provided by:

a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).

b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a"* or *"d."*

c. Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. Agencies accredited by the Council on Quality and Leadership.

e. Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

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—185.10(234) and 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. Providers and each of their staff involved in direct consumer service must have training regarding or experience with consumers who have a brain injury, with the exception of providers of home and vehicle modification, specialized medical equipment, transportation, and personal emergency response.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

77.39(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS BI providers are as follows:

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

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

c. The organization establishes and maintains fiscal accountability.

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

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

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

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

(5) Individual consumer support needs.

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

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

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

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.39(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.39(3) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.39(4) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

77.39(5) *Research.* If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

77.39(6) *Reporting requirements.*

a. Abuse reporting. 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.

b. Incident reporting. The provider shall document major and minor incidents and make the incident reports and related documentation available to the department upon request. The provider shall ensure cooperation in providing pertinent information regarding incidents as requested by the department.

(1) Major incident defined. A "major incident" means an occurrence involving a consumer of services that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in someone's death;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; or
6. Constitutes a prescription medication error or a pattern of medication errors that could lead to the outcome in numbered paragraph "1," "2," or "3."

(2) Minor incident defined. A "minor incident" means an occurrence involving a consumer of services that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(3) Report form. Each major or minor incident shall be recorded on an incident report form that is completed and signed by the staff who were directly involved at the time of the incident or who first became aware of the incident. The report shall include the following information:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or responded after becoming aware of the incident. The confidentiality of other consumers who are involved in the incident must be maintained by the use of initials or other means.
5. The action that the staff took to handle the incident.
6. The resolution of or follow-up to the incident.

(4) Reporting procedure for major incidents. When a major incident occurs, provider staff shall notify the consumer or the consumer's legal guardian within 72 hours of the incident and shall distribute the completed incident report form as follows:

1. Forward the report to the supervisor within 24 hours of the incident.
2. Send a copy of the report to the consumer's Medicaid targeted case manager and the department's bureau of long-term care within 72 hours of the incident.
3. File a copy of the report in a centralized location and make a notation in the consumer's file.

(5) Reporting procedure for minor incidents. When a minor incident occurs, provider staff shall distribute the completed incident report form as follows:

1. Forward the report to the supervisor within 24 hours of the incident.
2. File a copy of the report in a centralized location and make a notation in the consumer's file.

77.39(7) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.39(8) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

(3) The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties and the state to be served by the provider.

77.39(9) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable local county central point of coordination and other interested parties.

c. Providers applying for initial certification shall be offered technical assistance.

77.39(10) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11)*"d."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11)*"e."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11)*"f."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) *Departmental reviews.* Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11)*"c"* and *"d."*

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) *Case management service providers.* Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) *Supported community living providers.*

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

**e.* Living units designed to serve more than three supported community living consumers shall be approved as follows:

(1) The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of such programs in the area.

(2) The department may approve living units designed to serve more than four supported community living consumers under an exception to policy pursuant to rule 441—1.8(17A,217), subject to the following additional requirements:

1. The provider shall provide verification from the department of inspections and appeals that the program is not required to be licensed as a health care facility under Iowa Code chapter 135C.

2. The provider shall provide justification of the need for the service to be provided in a larger living unit instead of a living unit for four persons or less.

3. The geographic location of the program shall not result in an overconcentration of supported community living programs in the area.

77.39(14) *Respite service providers.* Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:

(1) Respite providers certified under the HCBS mental retardation waiver.

(2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).

(3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(4) Camps certified by the American Camping Association.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

*Effective date of December 15, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

(6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(8) Home health agencies that are certified to participate in the Medicare program.

(9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).

(10) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(11) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) *Supported employment providers.*

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

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

(2) Procedures for payment schedules and pay scale.

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

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

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

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

77.39(16) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

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

a. Providers shall be certified annually.

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

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

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

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

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

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

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

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

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

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

77.39(20) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

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

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

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

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

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

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

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

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

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

77.39(24) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

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

(1) At least 18 years of age.

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

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

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

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

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

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

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

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

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

h. Adult day service providers that meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and that have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.39(25) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

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(5), 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.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider.

77.41(1) *Enrollment process.* Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

c. The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties to be served by the provider.

77.41(2) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

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

(1) At least 18 years of age.

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

(3) Not the spouse or guardian of the consumer.

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

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

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

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

e. Community action agencies as designated in Iowa Code section 216A.103.

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

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

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.41(3) *Home and vehicle modification providers.* The following providers may provide home and vehicle modifications:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver or certified as home and vehicle modification providers under the mental retardation or brain injury waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

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

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

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

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

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

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

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

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

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

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

441—77.42(249A) Rehabilitation services to adults with chronic mental illness providers. Providers listed in this rule are eligible to participate in the Medicaid program for the provision of rehabilitation services to adults with chronic mental illness. All providers of rehabilitation services to adults with chronic mental illness shall provide services consistent with their scope of practice, state licensure, and applicable requirements in this rule and rule 441—78.48(249A).

77.42(1) *Eligible providers.* The following providers may provide rehabilitation services to adults with chronic mental illness and enroll for this purpose under the provider category "rehabilitation services for adults with chronic mental illness":

a. Physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa. Physicians in other states are also eligible if duly licensed to practice in that state.

b. Community mental health centers accredited pursuant to 441—Chapter 24.

c. Psychologists licensed to practice in Iowa and who meet the standards of the National Register of Health Service Providers in Psychology, 1981 edition, published by the council for the National Register of Health Service Providers in Psychology. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the standards of the National Register of Health Service Providers in Psychology.

d. Residential care facilities licensed by the department of inspections and appeals.

e. Supported employment service providers accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), certified to provide services under the HCBS waiver program pursuant to rule 441—77.37(249A) or 441—77.39(249A), or accredited by the Council on Quality and Leadership in Supports for People with Disabilities (the Council).

f. Supported community living providers accredited pursuant to 441—Chapter 24 or certified to provide services under the HCBS waiver program pursuant to rule 441—77.37(249A) or 441—77.39(249A).

g. Adult day care providers accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (the Council).

h. Providers of other mental health services accredited pursuant to 441—Chapter 24.

77.42(2) *Additional requirements.* Providers of rehabilitation services to adults with chronic mental illness shall:

a. Request criminal history record information on all employees and applicants to whom an offer of employment is made, as required by Iowa Code section 135C.33(5), and

b. Certify that any services delivered by either a paraprofessional or a licensed professional, as defined at 441—subrule 78.48(1), through a contract with or employment by the enrolled provider shall comply with the requirements that are applicable to the enrolled provider under this rule.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 8, subsection 11.

441—77.43(249A) Infant and toddler program providers. A public agency provider in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA) is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the following additional requirements are met.

77.43(1) *Licensure.* Services must be rendered by practitioners who meet any applicable professional licensure requirement, and local education agency and area education agency providers must meet the licensure (certification) requirements of the department of education as set forth at rule 281—41.8(256B,34CFR300).

77.43(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

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

441—77.44(249A) Local education agency services providers. School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

77.44(1) *Compliance with department of education rules and licensure requirements.* These providers must comply with applicable requirements under the department of education rules set forth at 281—41.8(256B,34CFR300), 281—41.9(256B,273,34CFR300), and 281—41.10(256B) and board of educational examiners rules at 282—subrules 14.20(5) and (6), and services must be rendered by practitioners who meet any applicable professional licensure requirements.

77.44(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

441—77.45(249A) Indian health service 638 facilities. A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) *Licensure.* Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.45(2) *Documentation.* Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

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◊Two ARCs
*December 15, 2002, effective date of 77.37(14)"*e*"(2) and 77.39(13)"*e*" delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, care coordination, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, additional care coordination services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessments using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's pregnancy.

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

78.25(1) *Provider qualifications.*

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Care coordination services shall be provided by a registered nurse; a person with at least a bachelor's degree in social work, counseling, sociology, family and community services, health or human development, health education, individual and family studies, or psychology; a person with a degree in dental hygiene; a licensed practical nurse; or a paraprofessional working under the direct supervision of a health professional.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Care coordination services, which shall include:

(1) Presumptive eligibility.

(2) Referral to WIC.

(3) Referral for dental services.

(4) Referral to physician or midlevel practitioners.

(5) Risk assessment.

(6) Arrangements for delivery, as appropriate.

(7) Arrangements for prenatal classes.

(8) Departmental multiprogram application.

(9) Hepatitis screen.

(10) Referral for eligible services.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the board of dental examiners at 650—paragraph 10.5(3)*"b."*

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Care coordination, the coordination of comprehensive prenatal services, which shall include:

(1) Developing an individual plan of care based on the client's needs, including pregnancy and personal and interpersonal issues. This package includes counseling (such as coaching, supporting, educating, listening, encouraging, and feedback), referral, and assistance for other specified services such as mental health.

(2) Ensuring that the client receives all components as appropriate (medical, education, nutrition, psychosocial, and postpartum home visit).

(3) Risk tracking.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

b. Rescinded IAB 1/8/03, effective 1/1/03.

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

78.33(2) Payment for services pursuant to 441—Chapter 90 to recipients under age 18 who have a primary diagnosis of mental retardation or developmental disabilities as defined in rule 441—90.1(249A) and are 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.

78.33(3) Payment will be approved for case management services pursuant to 441—Chapter 186 to recipients under 18 years of age who are receiving or are in need of child welfare services as defined in 441—Chapter 186.

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 consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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 and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions 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, guardian, or attorney in fact under a durable power of attorney for health care 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, guardian, or attorney in fact under a durable power of attorney for health care 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, parent, guardian, or attorney in fact under a durable power of attorney for health care and the 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 or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact 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.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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.

78.34(9) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,000 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $500 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response system.* A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency when the consumer is alone.

a. The required components of the system are:

(1) An in-home medical communications transmitter and receiver.

(2) A remote, portable activator.

(3) A central monitoring station with backup systems staffed by trained attendants at all times.

(4) Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each consumer.

b. The service shall be identified in the consumer's service plan.

c. A unit of service is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year shall be the initial installation and 12 months of service.

78.34(11) *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 that 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 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.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

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 consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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 physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

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.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact 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.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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 consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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 and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions 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, guardian, or attorney in fact under a durable power of attorney for health care 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, guardian, or attorney in fact under a durable power of attorney for health care 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, parent, guardian, or attorney in fact under a durable power of attorney for health care and the 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 or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact 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.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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

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

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

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

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

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

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

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review shall be conducted of Medicaid recipients who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the recipient lock-in program.

78.40(4) *Vaccine administration.* Advanced registered nurse practitioners who wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Advanced registered nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid recipients.

78.40(5) *Prenatal risk assessment.* Risk assessments, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

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

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

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

All services shall be billed in whole units.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the consumer's home and community, according to the individualized consumer need as identified in the service plan pursuant to rule 441—83.67(249A).

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are those activities which assist a consumer to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) "Individual advocacy services" means the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) "Community skills training services" means activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget; plan and prepare nutritional meals; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.

2. Socialization skills training services are those activities which assist a consumer to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a person to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) "Personal and environmental support services" means activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) "Transportation services" means activities and expenditures designed to assist the person to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work.

(6) "Treatment services" means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

2. Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the consumer and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to consumers living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of three consumers receiving community-supported alternative living arrangements or HCBS MR services may reside in a living unit except providers meeting requirements set forth in 441—paragraph 77.37(14)"*e.*"

(1) Consumers may live within the home of their family or legal representative or within other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

*(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living within the home of their family, legal representative, or foster families shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age appropriateness and individual attention span.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Transportation to and from a day program is not a reimbursable service. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. 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.

*Effective date of December 15, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

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 consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.
(5) Ramps, lifts, and door, hall and window widening.
(6) Fire safety alarm equipment specific for disability.
(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.
(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
(9) Keyless entry systems.
(10) Automatic opening device for home or vehicle door.
(11) Special door and window locks.
(12) Specialized doorknobs and handles.
(13) Plexiglas replacement for glass windows.
(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
(15) Motion detectors.
(16) Low-pile carpeting or slip-resistant flooring.
(17) Telecommunications device for the deaf.
(18) Exterior hard-surface pathways.
(19) New door opening.
(20) Pocket doors.
(21) Installation or relocation of controls, outlets, switches.
(22) Air conditioning and air filtering if medically necessary.
(23) Heightening of existing garage door opening to accommodate modified van.
(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

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.

78.41(7) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job.

(1) Covered services provided to or on behalf of the consumer associated with obtaining competitive paid employment are the following:

1. Initial vocational and educational assessment to develop interventions with the consumer or employer that affect work.
2. Job development activities.
3. On-site vocational assessment prior to employment.
4. Disability-related support for vocational training or paid internships.
5. Assistance in helping the consumer learn the skills necessary for job retention including skills to arrange and use supported employment transportation and job exploration.

(2) Except as provided in subparagraph (3), all services provided to an individual for the purpose of obtaining employment during a 12-month period are one unit of service.

(3) An individual may receive more than one unit of service for obtaining competitive employment during a 12-month period only if the individual has been in competitive paid employment for a minimum of 30 consecutive days between units of service.

(4) A unit of service is one job placement. A maximum of three units of service for obtaining employment is available per 12-month period.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.41(8).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

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

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

(1) Dressing.

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

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

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

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

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

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

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions 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, guardian, or attorney in fact under a durable power of attorney for health care 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, guardian, or attorney in fact under a durable power of attorney for health care 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, parent, guardian, or attorney in fact under a durable power of attorney for health care and the 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 or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact 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.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)*"d."*

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS MR waiver supported community living service.

78.41(12) *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. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a consumer eligible for the HCBS MR waiver for paid or unpaid employment, but are not job-task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the consumer through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the consumer through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Community skills training services are those activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are those activities which assist a consumer to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a person to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) Transportation services are those activities and expenditures designed to assist the consumer to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or day programs.

(6) Treatment services are those activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the consumer and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to consumers living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

(3) Intermittent service shall be provided as defined in rule 441—83.81(249A).

**c.* Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of three consumers may reside in a living unit, except when the provider meets the requirements set forth in 441—paragraph 77.39(13)"*e.*"

*Effective date of December 15, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

(1) Consumers may live in the home of their family or legal representative or in other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

*(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living in the home of their family, legal representative, or foster families shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age appropriateness and individual attention span.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. 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 consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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.

*Effective date of December 15, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

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

(1) Dressing.

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

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

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

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

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

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

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding of performing the essential job functions are not included in consumer-directed attendant care services.

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

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

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

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

(1) Tube feedings of consumers unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

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

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care 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, guardian, or attorney in fact under a durable power of attorney for health care 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, parent, guardian, or attorney in fact under a durable power of attorney for health care and the 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 or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact 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.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care 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, guardian, or attorney in fact under a durable power of attorney for health care 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 on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the 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 or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact 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.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.46(2) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.
(11) Special door and window locks.
(12) Specialized doorknobs and handles.
(13) Plexiglas replacement for glass windows.
(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
(15) Motion detectors.
(16) Low-pile carpeting or slip-resistant flooring.
(17) Telecommunications device for the deaf.
(18) Exterior hard-surface pathways.
(19) New door opening.
(20) Pocket doors.
(21) Installation or relocation of controls, outlets, switches.
(22) Air conditioning and air filtering if medically necessary.
(23) Heightening of existing garage door opening to accommodate modified van.
(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,000 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $500 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The service shall be identified in the consumer's service plan. A unit is a one-time installation fee or one month of service. Maximum units per state fiscal year are the initial installation and 12 months of service. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days a week.

d. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each consumer.

78.46(4) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a physical disability which provide for the health and safety of the consumer that are not covered by Medicaid, are not funded by vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial costs.

a. Consumers may receive specialized medical equipment once a month until a maximum yearly usage of $6000 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and shall be identified in the consumer's service plan.

78.46(5) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

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

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*December 15, 2002, effective date of 78.41(1)"*c*"(3), 78.41(1)"*d*," 78.43(2)"*c*," 78.43(2)"*c*"(3) and 78.43(2)"*d*" delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

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: Activities to obtain a job	Fee schedule	$500 per unit not to exceed $1,500 per calendar year
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $32.64 per hour for all activities other than personal care and services in an enclave setting. Maximum of $18.49 per hour for personal care. Maximum of $5.78 per hour for services in an enclave setting. Total not to exceed $2,772 per month. Maximum of 40 units per week.
6. Transportation	Fee schedule	State per mile rate for individual providers; rate set by area agency on aging for all others.
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 not to exceed the daily rate of $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour not to exceed the daily rate of $71.90 per day
9. Home and vehicle modification	Fee schedule	$6,000 per year
10. Specialized medical equipment	Fee schedule	$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
Home health agency (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
Child care home or center	Contractual rate. See 441—subrule 170.4(7)	$12.24 per hour
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	$32.64 per hour, not to exceed the maximum ICF/MR rate per day
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
3. Supported employment:		
Activities to obtain a job	Fee schedule	$500 per unit not to exceed $1,500 per calendar year
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $32.64 per hour for all activities other than personal care and services in an enclave setting. Maximum of $18.49 per hour for personal care. Maximum of $5.78 per hour for services in an enclave setting. Total not to exceed $2,772 per month. Maximum of 40 units per week.
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 not to exceed the daily rate of $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour not to exceed the daily rate of $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
Home health agency (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

Provider category	Basis of reimbursement	Upper limit
Child care home or 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
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	$32.64 per hour, not to exceed the maximum ICF/MR rate per day
10. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15).	The maximum daily per diem for ICF/MR
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the state per mile rate (for individual providers), or rate set by area agency on aging
12. Adult day care	Fee schedule	County contract rate or, in the absence of a contract rate, $27.50 per half day, $55 per full day, or $70 per extended day
13. Prevocational services	Fee schedule	County contract rate or, in the absence of a contract rate, $45 per day
14. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, $12.33 per hour, $30 per half-day, or $60 per day
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 not to exceed the daily rate of $106.82 per day
Individual provider	Fee agreed upon by consumer and provider	$12.33 per hour not to exceed the daily rate of $71.90 per day
2. Home and vehicle modification	Fee schedule	$6,000 per year
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	$6,000 per year

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82.5(12) *Termination or change of owner.*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of the property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next semiannual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities which have changed or will change ownership shall continue at the rate allowed the previous owner.

82.5(13) *Assessed fee.* The fee assessed pursuant to 441—Chapter 36 shall be an allowable cost for cost reporting and audit purposes.

a. For the purpose of implementing the assessment for facilities operated by the state, Medicaid reimbursement rates shall be recalculated effective October 1, 2003, as provided in paragraph *"b."*

b. For purposes of determining rates paid for services rendered after October 1, 2003, each state-operated facility's annual costs for periods before implementation of the assessment shall be increased by an amount equal to 6 percent of the facility's annual revenue for the preceding fiscal year.

82.5(14) *Payment to new facility.* A facility receiving Medicaid ICF/MR certification on or after July 1, 1992, shall be subject to the provisions of this subrule.

a. A facility receiving initial Medicaid certification for ICF/MR level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility shall be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate shall be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/MR with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year. The state hospital schools shall not be included in the compilation of facility costs. The beginning rates for a new facility shall be effective with the date of Medicaid certification.

b. Following six months of operation as a Medicaid-certified ICF/MR, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted to 100 percent occupancy plus the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average. Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards.

Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period.

1. Allowable organization costs. Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

(16) Administrative office supplies and equipment, including depreciation, rent, repairs, and maintenance as documented by a supplemental schedule which identifies the portion of repairs and maintenance, depreciation, and rent which applies to office supplies and equipment.

(17) Data processing and bank charges.

(18) Advertising.

(19) Travel, entertainment and vehicle expenses not directly involving residents.

f. Facility rates shall be rebased using the cost report for the year covering state fiscal year 1996 and shall subsequently be rebased each four years. The department shall consider allowing special rate adjustments between rebasing cycles if:

(1) An increase in the minimum wage occurs.

(2) A change in federal regulations occurs which necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes which necessitate the addition of staff or other resources.

(3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).

(4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Total patient days for purposes of the computation shall be inpatient days as determined in subrule 82.5(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate shall be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase which shall not exceed the percentage change in the Consumer Price Index for all urban consumers, U.S. City Average.

h. State-owned ICFs/MR shall submit semiannual cost reports and shall receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index, All Urban Consumers, U.S. City Average.

i. The projected reimbursement for the first annual period will be determined by taking the per diem rate calculated for the base period and then multiplying it by the Consumer Price Index and adding it to the base rate. The projected reimbursement for each period thereafter (until rebasing) will be calculated by taking the lower of the prior year's actual or the projected reimbursement per diem times the Consumer Price Index and adding it to the lower of the two. If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, it shall receive in the following period the maximum allowable base as calculated as reimbursement.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.

441—82.6(249A) Eligibility for services.

82.6(1) *Interdisciplinary team.* The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified mental retardation professional.

82.6(2) *Evaluation.* The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

a. Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

b. An evaluation of the resources available in the home, family, and community.

c. An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate care facility for the mentally retarded services are required by an individual whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

d. An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

e. Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

82.6(3) *Certification statement.* Eligible individuals may be admitted to an intermediate care facility for the mentally retarded upon the certification of a physician that there is a necessity for care at the facility. Eligibility shall continue as long as a valid need for the care exists.

82.6(4) Rescinded IAB 4/9/97, effective 6/1/97.

This rule is intended to implement Iowa Code section 249A.12.

441—82.7(249A) Initial approval for ICF/MR care.

82.7(1) *Referral through targeted case management.* Persons seeking ICF/MR placement shall be referred through targeted case management. The case management program shall identify any appropriate alternatives to the placement and shall inform the person of the alternatives. A referral shall be made by targeted case management to the central point of coordination having financial responsibility for the person. The department is the central point of coordination for persons with state case status.

82.7(2) *Approval of ICF/MR placement by central point of coordination.* The central point of coordination shall approve ICF/MR placement, offer a home- or community-based alternative, or refer the person back to the targeted case management program for further consideration of service needs within 30 days of receipt of a referral. Initial placement must be approved by the central point of coordination with responsibility for the person. Once approved, the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice.

82.7(3) *Approval by Iowa Foundation for Medical Care.* Medicaid payment shall be made for intermediate care facility for the mentally retarded care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the Iowa Foundation for Medical Care which is designated as the professional standards review organization for the state.

The Iowa Foundation for Medical Care shall review ICF/MR admissions and transfers only when documentation is provided which verifies a referral from targeted case management which includes an approval by the central point of coordination.

82.7(4) *Appeal rights.* Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7. The applicant or consumer 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 consumer may file an appeal with the department.

The applicant or consumer for whom the county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to 441—paragraph 25.13(2)*"j."* If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department.

This rule is intended to implement Iowa Code section 249A.12.

441—82.8(249A) Determination of need for continued stay. Certification of need for continued stay shall be made according to procedures established by the Iowa Foundation for Medical Care.

This rule is intended to implement Iowa Code section 249A.12.

82.17(2) *Auditing of proper billing and handling of patient funds.*

a. Field auditors of the department of inspections and appeals or representatives of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. Field auditors of the department of inspections and appeals or representatives of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.9(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph *"d"* the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

441—82.18(249A) Out-of-state facilities. Payment will be made for care in out-of-state intermediate care facilities for the mentally retarded. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

82.18(1) Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

82.18(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

82.18(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds shall be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

441—82.19(249A) ICF/MR development. Rescinded IAB 2/5/03, effective 2/1/03.

These rules are intended to implement Iowa Code sections 249A.4, 249A.12, and 249A.16.

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◊ Two ARCs

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 one billable unit of service under the waiver per calendar quarter.

83.2(2) *Need for services.*

a. The consumer shall have a service plan approved by the department which is developed by the service worker identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The service 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 consumer's condition. The service worker shall have a face-to-face visit with the consumer at least annually.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The service worker shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the consumer's service needs through nonwaiver Medicaid services.

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

If more than $500 is paid for home and vehicle modification services, the service worker shall encumber up to $500 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

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 consumers to be served as set forth in the federally approved HCBS ill and handicapped waiver. The number of consumers to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of consumers specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall contact the bureau of long-term care for all applicants for the waiver to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau by the end of the fifth working day after receipt of a completed Form 470-2927, Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid recipients, the county department office shall contact the bureau by the end of the fifth working day after receipt of either Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, with the choice of HCBS waiver indicated by signature of the consumer or a written request signed and dated by the consumer.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the bureau of long-term care shall enter persons on a waiting list according to the following:

(1) Consumers not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927, Health Services Application, is date-stamped in the county department office or upon the county department office's receipt of disability determination, whichever is later.

(2) Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)*"a"*(2) is date-stamped in the county department office.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots 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. The bureau of long-term care shall contact the county department office when a slot becomes available.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. A consumer must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The income maintenance or service worker shall have the consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care complete and sign Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, indicating the consumer'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.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations and the service plan are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations and the service plan are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations and the service plan are completed, but shall not be earlier than the first of the month following the date of application.

83.43(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—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual 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.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services 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—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling services, home health aide services, homemaker services, nursing care services, respite care services, home-delivered meals, adult day care services, and consumer-directed attendant care services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition. In addition, the service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services.

441—83.48(249A) Adverse service actions.

83.48(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. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.42(2)*"b"* or cannot be met by the services provided under the waiver.

d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.49(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, an appeal may be filed with the department.

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

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.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"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.

"Counseling" means face-to-face mental health services provided to the consumer and caregiver by a qualified mental retardation professional (QMRP) to facilitate home management of the consumer and prevent institutionalization.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"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.

*"Guardian"*means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intermediate care facility for the mentally retarded (ICF/MR)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons who are mentally retarded or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

"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 institution" means a 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.

"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.

"Person with a related condition" means an individual who has a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a mentally retarded person and requires treatment or services similar to those required for a mentally retarded person.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.

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) to (3) Rescinded IAB 3/7/01, effective 5/1/01.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For supported employment services:

(1) Be at least age 16.

(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. Choose HCBS MR waiver services rather than ICF MR services.

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.

j. Be assigned an HCBS MR payment slot pursuant to subrule 83.61(4).

k. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

1. Social history;
2. Case history that includes previous placements and service programs;
3. Medical history that includes major illnesses and current medications;
4. Current psychological evaluations and consultations;
5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;
6. Any current court orders in effect regarding the child;
7. Any legal history;
8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;
9. Whether the proposed placement would be safe for the child and for other children living in that setting; and
10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/MR;
2. Be at risk of ICF/MR placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)*"a"*; or
3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

l. For day habilitation, be 16 years of age or older.

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.

c. Be ineligible for the HCBS MR waiver.

d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.

e. Be eligible for Medicaid under 441—Chapter 75.

f. Be aged 18 years to 64 years.

g. Rescinded IAB 2/7/01, effective 2/1/01.

h. Be in need of skilled nursing or intermediate care facility level of care. Initial decisions on level of care shall be made for the department by the Iowa Foundation for Medical Care (IFMC) within two working days of receipt of medical information. After notice of an adverse decision by IFMC, the Medicaid applicant or recipient or the applicant's or recipient's representative may request reconsideration by IFMC pursuant to subrule 83.109(2). On initial and reconsideration decisions, IFMC determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2). Adverse decisions by IFMC on reconsiderations may be appealed to the department pursuant to 441—Chapter 7 and rule 441—83.109(249A).

i. Choose HCBS.

j. Use a minimum of one unit of service per calendar quarter under this program.

83.102(2) *Need for services.*

a. The consumer shall have a service plan which is developed by the consumer and a department service worker. This must be completed and approved prior to service provision and at least annually thereafter.

The service worker shall identify the need for service based on the needs of the consumer as well as the availability and appropriateness of services.

b. The total cost of physical disability waiver services shall not exceed $621 per month.

If more than $500 is paid for home and vehicle modification services, the service worker shall encumber up to $500 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

83.102(3) *Slots.* The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) *County payment slots for persons requiring the ICF/MR level of care.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) *Securing a slot.*

a. The county department office shall contact the bureau of long-term care for all cases to determine if a slot is available for all new applications for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau by the end of the second working day after receipt of a completed Form 470-2927, Health Services Application, submitted on or after April 1, 1999.

(2) For current Medicaid recipients, the county department office shall contact the bureau by the end of the second working day after receipt of Form 470-3501, Physical Disability Waiver Assessment Tool, with the choice of HCBS waiver indicated by the signature of the consumer or a written request signed and dated by the consumer.

b. On the third day after the receipt of the completed Form 470-2927, Health Services Application, if no slot is available, the bureau of long-term care shall enter consumers on the HCBS physical disabilities waiver waiting list according to the following:

(1) Consumers not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927, Health Services Application, is submitted on or after April 1, 1999, and date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added on the basis of the date the consumer requests HCBS physical disability program services as documented by the date of the consumer's signature on Form 470-2927. In the event that more than one application is received on the same day, consumers shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots 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.

83.102(6) *Securing a county payment slot.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application. The discharge planner shall complete Form 470-3502, Physical Disability Waiver Assessment Tool, and submit it to the Iowa Foundation for Medical Care (IFMC) review coordinator. After completing the determination of the level of care needed by the applicant, the IFMC review coordinator shall inform the income maintenance worker and the discharge planner of IFMC's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community. The applicant, the applicant's parent, the applicant's legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall complete Form 470-3502, Physical Disability Waiver Assessment Tool, and submit it to the Iowa Foundation for Medical Care (IFMC) review coordinator. After completing the determination of the level of care needed by the applicant, the IFMC review coordinator shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

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TITLE XIII
SERVICE ADMINISTRATION

CHAPTER 130
GENERAL PROVISIONS

[Prior to 7/1/83, Social Services[770] Ch 130]
[Prior to 2/11/87, Human Services[498]]

441—130.1(234) Definitions.

"Family" includes the following members:

1. Legal spouses (including common law) who reside in the same household.
2. Natural, adoptive, or step mother or father, and children who reside in the same household.
3. An individual or a child who lives alone or who resides with a person, or persons, not legally responsible for the child's support.

"Rehabilitative treatment service" means treatment services designed to address the treatment needs of a child in one of the following programs:

1. Family-centered.
2. Family preservation.
3. Family foster care.
4. Group care.

"Review organization" means the entity designated by the department to make rehabilitative treatment service authorization determination.

This rule is intended to implement Iowa Code section 234.6.

441—130.2(234) Application.

130.2(1) Application for social services shall be made at any county office of the department of human services on forms available at the county office.

Application for services shall be made on Form 470-0615, Application for All Social Services.

130.2(2) The application may be filed by the applicant, the applicant's authorized representative, or where the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.

130.2(3) The date of application is the date a signed application form is received in the county office.

130.2(4) The application shall be approved or denied within 30 days from the date of application and the applicant notified of the decision. The decision shall be mailed or given to the applicant on the date the determination is made except that for services ordered by the court, the court order provided by the court and the case permanency plan provided by the department shall serve as notification. When individual case management services are being provided under 441—Chapter 24 for persons with mental retardation, a developmental disability, or chronic mental illness, the application shall be approved or denied no later than the date that the department service manager, who is part of the interdisciplinary team, signs the individual program plan.

130.2(5) Eligibility shall be redetermined in the same manner as an application at least every 6 months for family-centered services. For all other services, eligibility shall be redetermined in the same manner as an application at least every 12 months.

130.2(6) Rescinded IAB 6/9/04, effective 7/1/04.

130.2(7) Rescinded IAB 6/9/04, effective 7/1/04.

130.2(8) For rehabilitative treatment services, the worker shall make a referral of the child or family to the review organization as directed in rule 441—185.3(234).

This rule is intended to implement Iowa Code section 234.6.

441—130.3(234) Eligibility.

130.3(1) Eligibility factors for services available through the department are individual need for a service and family income except when services are provided without regard to income or when services are directed in a court order.

a. Individual need is established when the service to be provided is directed at and will facilitate an individual in reaching or maintaining one of the goals and objectives in 130.7(1). Except when the court establishes need, the department shall do so in accordance with individual service chapters. The department shall determine the number of units to be provided.

b. The block grant service to be provided shall be contained in the pre-expenditure report and listed for the specific district and county. Service available through the department and funded by resources other than the social service block grant is identified in rules for that specific service.

c. Service shall be provided only when funds are available for service delivery.

d. Persons are financially eligible for services when they are in one of the following categories:

(1) Income maintenance status. They are recipients of the family investment program, or those whose income was taken into account in determining the needs of family investment program recipients, or recipients of supplemental security income or state supplementary assistance, or those in the 300 percent group as defined in 441—subrule 75.1(7).

(2) Income eligible status. The monthly gross income according to family size is no more than the following amounts:

Monthly Gross Income Limits

Family Size	
1 Member	$ 583
2 Members	762
3 Members	942
4 Members	1,121
5 Members	1,299
6 Members	1,478
7 Members	1,510
8 Members	1,546
9 Members	1,581
10 Members	1,612
11 Members	1,645
12 Members	1,678
13 Members	1,711
14 Members	1,744
15 Members	1,777
16 Members	1,810
17 Members	1,843
18 Members	1,876
19 Members	1,909
20 Members	1,942

(3) to (5) Rescinded IAB 6/9/04, effective 7/1/04.

e. Certain services are provided without regard to income which means family income is not considered in determining eligibility. The services provided without regard to income are information and referral, child abuse investigation, child abuse treatment, child abuse prevention services, including protective child care services, family-centered services, dependent adult abuse evaluation, dependent adult abuse treatment, dependent adult abuse prevention services, and purchased adoption services to individuals and families referred by the department.

f. In certain cases the department will provide services directed in a court order.

130.3(2) To be eligible for services the person must be living in the state of Iowa. Living in the state shall include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

130.3(3) In determining gross income, all income received by an individual from sources identified by the U.S. Census Bureau in computing median income is considered and includes money wages or salary, net income from nonfarm self-employment, net income from farm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, worker's compensation, alimony, child support; and veterans pensions. Excluded from the computation of monthly gross income are the following:

a. Per capita payments to or funds held in trust for any individual in satisfaction of a judgment of the Indian claims commission or the court of claims.

b. Payments made pursuant to the Alaska Claims Settlement Act to the extent such payments are exempt from taxation under section 21(a) of the Act.

c. Money received from the sale of property, unless the person was engaged in the business of selling such property.

d. Withdrawals of bank deposits.

e. Money borrowed.

f. Tax refunds.

g. Gifts.

h. Lump sum inheritances or insurance payments or settlements.

i. Capital gains.

j. The value of the coupon allotment under the Food Stamp Act of 1964, as amended, in excess of the amount paid for the coupons.

k. The value of USDA donated foods.

l. The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program for children under the National School Lunch Act, as amended.

m. Earnings of a child 14 years of age or under.

n. Loans and grants obtained and used under conditions that preclude their use for current living expenses.

o. Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act.

p. Home produce utilized for household consumption.

q. Earnings received by any youth under Title III, Part C—Youth Employment Demonstration Program of the Comprehensive Employment and Training Act of 1973.

r. Stipends received by persons for participating in the foster grandparent program.

s. The first $65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

t. Payments from the low-income home energy assistance program.

u. In determining eligibility for purchase of local services, one-third of the income of a disabled survivor who is a recipient of child's insurance benefits under the federal old-age, survivors, and disability insurance program established under Title II of the Federal Social Security Act.

v. In determining eligibility for purchase of local services, one-third of the income of a person who receives social security permanent disability benefits.

w. Agent Orange settlement payments.

x. Rescinded IAB 6/9/04, effective 7/1/04.

y. Rescinded IAB 6/9/04, effective 7/1/04.

z. Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

aa. Rescinded IAB 6/9/04, effective 7/1/04.

ab. Rescinded IAB 6/9/04, effective 7/1/04.

130.3(4) Rescinded IAB 8/9/89, effective 10/1/89.

130.3(5) Temporary absence. The composition of the family group does not change when one, or more, of the group members is temporarily absent from the household.

"Temporary absence" means:

a. A medical absence anticipated to be less than three months.

b. An absence for the purpose of education or employment.

c. When a family member is absent and intends to return home within three months.

130.3(6) Rescinded IAB 6/9/04, effective 7/1/04.

This rule is intended to implement Iowa Code section 234.6.

441—130.4(234) Fees. The department may set fees to be charged to clients for services received. The fees will be charged to those clients eligible under rule 130.3(234), but not those receiving services without regard to income due to a protective service situation or for rehabilitative treatment services. Nothing in these rules shall preclude a client from voluntarily contributing toward the costs of service.

130.4(1) *Collection.* The provider shall collect fees from clients. The provider shall maintain records of fees collected, and such records shall be available for audit by the department or its representative. When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. Reasonable effort to collect means an original billing and two follow-up notices of nonpayment.

130.4(2) *Monthly income.* Rescinded IAB 1/8/92, effective 3/1/92.

130.4(3) *Child care services.* Rescinded IAB 6/9/04, effective 7/1/04.

130.4(4) Rescinded, effective 7/1/81.

This rule is intended to implement Iowa Code section 234.6.

441—130.5(234) Adverse service actions.

130.5(1) *Denial.* Services shall be denied when it is determined by the department that:

a. The client is not in need of service, or

b. The client is not financially eligible, or

c. The service to be provided is not in the Social Services Block Grant Pre-Expenditure Report, or

d. There is another community resource available to provide the service or a similar service free of charge to the client that will meet the client's needs, or

e. In cases other than protective service investigation, the client, parent, or representative refuses to sign the application form, or

f. The service for which the client is eligible is currently not available; a list of these services will be posted in each local office, or

g. Funding is not available to provide the service. A list of services not available due to lack of funding shall be posted in each local office.

h. Rescinded IAB 8/9/89, effective 10/1/89.

i. Rescinded IAB 6/9/04, effective 7/1/04.

130.5(2) *Termination.* A particular service may be terminated when the department determines that:

a. The specific need to attain the goals and objectives to which the service was directed has been achieved, or

b. After repeated assessment, it is evident that the family or individual is unable to achieve or maintain the goals set forth in the individual client service plan, or

c. After repeated efforts, it is evident that the family or individual is unwilling to accept further service, or

d. The client's income or resources exceed the financial guidelines, or

e. The service is no longer available in the Social Services Block Grant Pre-Expenditure Report, or

f. No payment or partial payment of client fees has been received within 30 days following the issuance of the last billing, or

g. Another community resource is available to provide the service or a similar service free of charge to the client that will meet the client's needs, or

h. The client refuses to allow documentation of eligibility as to need, income, and resources, or

i. Funding is not available to provide the service. A list of services not available due to lack of funding shall be posted in each local office.

j. The fee for case management services has not been paid within 30 days of the date on the second invoice sent by the department case management unit to the client. The second invoice shall be sent 30 days after the date of the first invoice if full payment of the fee has not been received.

130.5(3) *Reduction.* A particular service may be reduced when the department determines that:

a. Continued provision of service at its current level is not necessary. The department shall determine the level to which the service may be reduced without jeopardizing the client's continued progress toward achieving or maintaining the goal. The client shall be notified of the decision.

b. Another community resource is available to provide the same or similar service to the client at no financial cost to the client, that will meet the client's needs.

c. Funding is not available to continue the service at the current level. The client shall be reassessed to determine the level of service to be provided.

d. Rescinded IAB 6/9/04, effective 7/1/04.

130.5(4) Rescinded, effective 6/1/84.

130.5(5) *Pending changes.* Workers shall endeavor to make clients aware of pending changes in services to be provided by social services block grant from one program year to the next, particularly for those services that will no longer be available. This requirement also applies to time-limited services.

130.5(6) *Inability of eligible cases to pay fees.* After billing or notification of termination and when the client reports in writing the inability to pay the fee due to the existence of one or more of the conditions set forth in the paragraphs below, and the worker assesses and verifies the condition, service shall be continued without fee until the condition no longer exists and the client is able to participate in the current fee for service. The worker shall assess all inability to pay cases to determine whether any case can be charged a reduced fee. The reduced fee shall then be charged until full participation in fees is possible.

a. Extensive medical bills for which there is neither payment through the medical assistance program, Title XVIII of the Social Security Act, nor other insurance coverage.

b. Shelter costs in excess of 30 percent of the household income.

c. Utility costs not including the cost of a telephone, in excess of 15 percent of the household income.

d. Rescinded 10/30/91, effective 11/1/91.

e. Additional expenses for food resulting from diets prescribed by a physician.

This rule is intended to implement Iowa Code section 234.6.

441—130.6(234) Social casework. For each active service case, when service is provided directly, purchased, or by a combination of methods, a department social worker shall:

130.6(1) Determine eligibility. For rehabilitative treatment services, eligibility shall be determined by the review organization as directed in 441—subrule 185.2(2).

130.6(2) Ensure that there is a department case plan for each individual or family based on assessment of strengths and needs. Furnish appropriate sections of the initial plan and of all updated department case plans to the provider agency when services are purchased for an individual. When individual case management services are being provided under 441—Chapter 24 for persons with mental retardation, a developmental disability, or chronic mental illness, the individual case management services provider shall distribute the case plans.

130.6(3) Refer the client to other workers or agencies through proper channels, and coordinate all workers involved in the case.

When individual case management services are being provided under 441—Chapter 24 for persons with mental retardation, a developmental disability, or chronic mental illness, the individual case management services provider shall be responsible for making referrals and coordinating workers as specified in the individual program plan.

130.6(4) Enter information to the service reporting system.

130.6(5) Monitor the case to ensure that eligibility continues, services are received, plans are adjusted as needed, services reporting system reporting is correct, and the case is canceled when appropriate, according to these rules.

130.6(6) Ensure that services are unavailable elsewhere without cost to the client.

This rule is intended to implement Iowa Code section 234.6.

441—130.7(234) Case plan. The department worker shall develop a case plan with or on behalf of persons approved to receive services. However, a case plan is not required (1) for child or adult protective investigation, (2) for family planning, (3) for foster care cases in which the department does not have custody, guardianship or a voluntary placement agreement, or (4) when child care is the only service. A case plan shall be developed with or on behalf of every other person approved to receive services unless the person has a case manager as specified in 441—Chapter 24. When department services are provided before an individual program plan in compliance with 441—Chapter 24 is approved, a department case plan must be developed according to the requirements of this rule.

When individual case management services are being provided under 441—Chapter 24 for persons with mental retardation, a developmental disability, or chronic mental illness, the rules in 441—Chapter 24 on time limits, plan format and on who develops the plan shall apply for adults and for children whose services are not under court jurisdiction. The department worker shall determine eligibility for those services provided by the department; however, a separate department case plan need not be developed. If the individual program plan does not include sufficient information to meet department service requirements or the requirements in this chapter, the person providing department social casework shall complete either a case plan or addendum and coordinate distribution to the persons who receive the individual program plan with the case manager.

The case plan shall become part of the client's case record. The client shall participate in the development of this plan to the extent possible. The case plan shall be consistent with other service or program plans. A copy of the case plan shall be provided to the client or, when indicated, to the parent or representative of the client. For adult services the case plan shall be recorded using Form 470-0583, Individual Client Case Plan. For children's services the case plan shall be known as the case permanency plan and shall be prepared using Form 470-3453, Case Plan.

130.7(1) Services shall be directed toward the social services block grant goals of:

a. Achieving or maintaining self-support to prevent, reduce or eliminate dependency.

b. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency.

c. Preventing or remedying neglect, abuse or exploitation of children or adults unable to protect their own interest, or preserving, rehabilitating or reuniting families.

d. Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care.

e. Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

130.7(2) The recorded case plan shall contain, but not be limited to, the following:

a. The goal and objective to which the plan is directed, stated in a clear manner indicating the specific services required to achieve or maintain the goals to meet the needs of the particular client.

b. Activities of clients, workers, and others involved in the plan related to specific services. These shall be measurable and have time frames for completion.

c. A summary of all pertinent information relating to the client and the client's situation relative to need, and containing, but not limited to, the following:

(1) Emotional behavior.

(2) Social aspects.

(3) Historical perspective.

(4) Reasons for success or lack of success.

d. Information on case entries that will substantiate the client's eligibility for service.

e. A target date for reevaluation of the case plan based on assessment of need, which shall not exceed six months.

f. A review of financial eligibility in accordance with 130.2(5).

g. The reason for termination or reduction of any or all services.

h. Rescinded IAB 8/9/89, effective 10/1/89.

130.7(3) The case plan shall be developed and filed in the case record before services begin unless:

a. The department receives judicial notice that services have been court-ordered. The case plan shall be filed within 45 days from the date the notice is received or within 60 days from the date the child entered foster care, whichever is the earlier date.

b. An unanticipated provision of service is provided for the protection and well-being of a client. Assessment shall begin immediately. The case plan shall be filed within 45 days from the date services are initiated or within 60 days from the date the child entered foster care, whichever is the earlier date.

130.7(4) The reevaluation of the case plan shall include all components listed under 130.7(2) and shall be filed at least every six months, or more often when there are significant changes, when required by the court, or when required according to the rules of the service.

130.7(5) The case plan may be amended between evaluation periods. Participants in the plan shall receive a copy of the amendment.

This rule is intended to implement Iowa Code section 234.6 and 1984 Iowa Acts, chapter 1310, section 3.

441—130.8 Monitoring and evaluation. Rescinded IAB 12/13/89, effective 2/1/90.

441—130.9(234) Entitlement. Except as provided for rehabilitative treatment services, there is no automatic right to ongoing service in any service category from one fiscal year to the next.

This rule is intended to implement Iowa Code section 234.6.

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TITLE XV
INDIVIDUAL AND FAMILY SUPPORT AND PROTECTIVE SERVICES

CHAPTER 170
CHILD CARE SERVICES

[Prior to 7/1/83, Social Services[770] Ch 132]
[Previously appeared as Ch 132—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to establish requirements for the payment of child care services. Child care services are for children of low-income parents who are in academic or vocational training; or employed or looking for employment; or for a limited period of time, unable to care for children due to physical or mental illness; or needing protective services to prevent or alleviate child abuse or neglect. Services may be provided in a licensed child care center, a registered child development home, the home of a relative, the child's own home, a nonregistered family child care home, or in a facility exempt from licensing or registration.

441—170.1(237A) Definitions.

"Child care" means a service that provides child care in the absence of parents for a portion of the day, but less than 24 hours. Child care supplements parental care by providing care and protection for children who need care in or outside their homes for part of the day. Child care provides experiences for each child's social, emotional, intellectual, and physical development. Child care may involve comprehensive child development care or it may include special services for a child with special needs. Components of this service shall include supervision, food services, program and activities, and may include transportation.

"Child with protective needs" means a child who has a case plan that identifies protective child care as a required service and who is a member of a family with one of the following:

1. A confirmed case of child abuse.
2. Episodes of family or domestic violence or substance abuse which place the child at risk of abuse or neglect and have resulted in a service referral to family preservation or family-centered services.

"Child with special needs" means a child with one or more of the following conditions:

1. The child has been diagnosed by a physician or by a person endorsed for service as a school psychologist by the Iowa department of education to have a developmental disability which substantially limits one or more major life activities, and the child requires professional treatment, assistance in self-care, or the purchase of special adaptive equipment.
2. The child has been determined by a qualified mental retardation professional to have a condition which impairs the child's intellectual and social functioning.
3. The child has been diagnosed by a mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially from behavior appropriate to the child's age, or which significantly interferes with the child's intellectual, social, or personal adjustment.

"Client" means a current or former recipient of the child care assistance program.

"Client error" means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances which affect eligibility or the amount of assistance received;
2. Failure to timely report changes in income, resources, or other circumstances which affect eligibility or the amount of assistance received;
3. Failure to timely report the receipt of child care units in excess of the number approved by the department;

4. Failure to comply with the need for service requirements.

"Department" means the Iowa department of human services.

"Food services" means the preparation and serving of nutritionally balanced meals and snacks.

"Fraudulent means" means knowingly making or causing to be made a false statement or a misrepresentation of a material fact, knowingly failing to disclose a material fact, or committing a fraudulent practice.

"In-home" means care which is provided within the child's own home.

"Migrant seasonal farm worker" means a person to whom all of the following conditions apply:

1. The person performs seasonal agricultural work which requires travel so that the person is unable to return to the person's permanent residence within the same day.

2. Most of the person's income is derived from seasonal agricultural work performed during the months of July through October. Most shall mean the simple majority of the income.

3. The person generally performs seasonal agricultural work in Iowa during the months of July through October.

"Overpayment" means any benefit or payment received in an amount greater than the amount the client or provider is entitled to receive.

"Parent" means the parent or the person who serves in the capacity of the parent of the child receiving child care assistance services.

"Program and activities" means the daily schedule of experiences in a child care setting.

"Provider" means a licensed child care center, a registered child development home, a relative who provides care in the relative's own home solely for a related child, a caretaker who provides care for a child in the child's home, a nonregistered child care home, or a child care facility which is exempt from licensing or registration.

"Provider error" means and may result from:

1. Presentation for payment of any false or fraudulent claim for services or merchandise;

2. Submittal of false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;

3. Failure to report the receipt of a child care assistance payment in excess of that approved by the department;

4. Charging the department an amount for services rendered over and above what is charged private pay clients for the same services.

"Recoupment" means the repayment of an overpayment by a payment from the client or provider or both.

"Relative" means an adult aged 18 or older who is a grandparent, aunt or uncle to the child being provided child care.

"Supervision" means the care, protection, and guidance of a child.

"Transportation" means the movement of children in a four or more wheeled vehicle designed to carry passengers, such as a car, van, or bus, between home and facility.

"Unit of service" means a half day which shall be up to 5 hours of service per 24-hour period.

"Vocational training" means a training plan which includes a specific goal, that is, high school completion, improved English skills, development of specific academic or vocational skills.

1. Training may be approved for high school completion activities, adult basic education, GED, English as a second language, and a postsecondary education, up to and including a baccalaureate degree program.

2. Training may be approved for college programs which lead to an associate of arts degree.

3. Training shall be on a full-time basis. The training facility shall define what is considered as full time. Part-time plans may be approved only if the number of credit hours to complete training is less than full-time status, the required prerequisite credits or remedial course work is less than full-time status, or training is not offered on a full-time basis.

441—170.2(237A,239B) Eligibility requirements. A person deemed eligible for benefits under this chapter is subject to all other state child care assistance requirements including, but not limited to, provider requirements under Iowa Code chapter 237A and provider reimbursement methodology. The department shall determine the number of units of service to be approved.

170.2(1) *Financial eligibility.* Financial eligibility for child care assistance shall be based on federal poverty levels as determined by the Office of Management and Budget and on Iowa's median family income as determined by the U.S. Census Bureau. Poverty guidelines and median family income amounts are updated annually. Changes shall go into effect for the child care assistance program on July 1 of each year.

a. Income limits. For initial and ongoing eligibility, a family's nonexempt gross monthly income as established in paragraph 170.2(1)*"c"* cannot exceed:

(1) 140 percent of the federal poverty level applicable to the family size for children needing basic care, or

(2) 175 percent of the federal poverty level applicable to the family size for children needing special needs care, or

(3) 85 percent of Iowa's median family income, if that figure is lower than the standard in subparagraph (1) or (2).

b. Exceptions to income limits.

(1) A person who is participating in activities approved under the PROMISE JOBS program is eligible for child care assistance without regard to income if there is a need for child care services.

(2) A person who is part of the family investment program or whose earned income was taken into account in determining the needs of a family investment program recipient is eligible for child care assistance without regard to income if there is a need for child care services.

(3) Protective child care services are provided without regard to income.

(4) In certain cases, the department will provide child care services directed in a court order.

c. Determining gross income. In determining a family's gross monthly income, the department shall consider all income received by a family member from sources identified by the U.S. Census Bureau in computing median income, unless excluded under paragraph 170.2(1)*"d."*

(1) Income considered shall include wages or salary, net income from farm or nonfarm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, workers' compensation, alimony, child support, and veterans pensions.

(2) For migrant seasonal farm workers, the monthly gross income shall be determined by calculating the total amount of income earned in a 12-month period preceding the date of application and dividing the total amount by 12.

d. Income exclusions. The following sources are excluded from the computation of monthly gross income:

(1) Per capita payments from or funds held in trust in satisfaction of a judgment of the Indian Claims Commission or the court of claims.

(2) Payments made pursuant to the Alaska Claims Settlement Act, to the extent the payments are exempt from taxation under Section 21(a) of the Act.

(3) Money received from the sale of property, unless the person was engaged in the business of selling property.

(4) Withdrawals of bank deposits.

(5) Money borrowed.

(6) Tax refunds.

(7) Gifts.

(8) Lump-sum inheritances or insurance payments or settlements.

(9) Capital gains.

(10) The value of the food assistance allotment under the Food Stamp Act of 1964.

(11) The value of USDA donated foods.

(12) The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program for children under the National School Lunch Act.

(13) Earnings of a child 14 years of age or younger.

(14) Loans and grants obtained and used under conditions that preclude their use for current living expenses.

(15) Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act.

(16) Home produce used for household consumption.

(17) Earnings received by any youth under Title III, Part C—Youth Employment Demonstration Program of the Comprehensive Employment and Training Act of 1973.

(18) Stipends received for participating in the foster grandparent program.

(19) The first $65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

(20) Payments from the Low-Income Home Energy Assistance Program.

(21) Agent Orange settlement payments.

(22) The income of the parents with whom a teen parent resides.

(23) For children with special needs, income spent on any regular ongoing cost that is specific to that child's disability.

(24) Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

(25) Income received by a Supplemental Security Income recipient if the recipient's earned income was considered in determining the needs of a family investment program recipient.

(26) The income of a child who would be in the family investment program eligible group except for the receipt of Supplemental Security Income.

(27) Any adoption subsidy payments received from the department.

e. Family size. The following people shall be included in the family size for the determination of eligibility:

(1) Legal spouses (including common law) who reside in the same household.

(2) Natural mother or father, adoptive mother or father, or stepmother or stepfather, and children who reside in the same household.

(3) A child or children who live with a person or persons not legally responsible for the child's support.

f. Effect of temporary absence. The composition of the family does not change when a family member is temporarily absent from the household. "Temporary absence" means:

(1) An absence for the purpose of education or employment.

(2) An absence due to medical reasons that is anticipated to last less than three months.

(3) Any absence when the person intends to return home within three months.

170.2(2) *General eligibility requirements.* In addition to meeting financial requirements, the child needing services must meet age and residency requirements and each parent in the household must have at least one need for service.

a. Age. Child care shall be provided only to children up to age 13, unless they are children with special needs in which case child care shall be provided up to age 19. Children who are part of the family investment program who are 13 years of age and older may be eligible for child care assistance benefits if there are special circumstances surrounding the child in need of child care. The child's parent or guardian shall submit a request for an exception to the supervisor of the county department office.

b. Need for service. Each parent in the household shall meet one or more of the following requirements:

(1) The parent is in academic or vocational training. Child care provided while the parent participates in postsecondary education leading up to and including a baccalaureate degree program or vocational training shall be limited to a 24-month lifetime limit. A month is defined as a fiscal month or part thereof and shall generally have starting and ending dates that fall within two calendar months but shall only count as one month. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the 24-month limit.

Payment shall not be approved for the following:

1. When labor market statistics for a local area indicate low employment potential. Exceptions may be made when the client has a job offer prior to entering the training or if a client is willing to relocate after training to an area where there is employment potential. Clients willing to relocate must provide documentation from the department of workforce development, private employment agencies, or employers that jobs paying at least minimum wage for which training is being requested are available in the locale specified by the client.
2. Jobs paying less than minimum wage.
3. College coursework for a client who possesses a baccalaureate degree unless the coursework is to obtain a teaching certificate or complete continuing education units.
4. The course or training is one that the client has previously completed.
5. When the client was previously unable to maintain the cumulative grade point average required by the training or academic facility in the same training for which application is now being made. This does not apply to parents under the age of 18 who are enrolled in high school completion activities.

PROMISE JOBS child care allowances provided while the parent is a recipient of the family investment program and participating in PROMISE JOBS components in postsecondary education or training shall count toward the 24-month lifetime limit.

(2) The parent is employed 28 or more hours per week, or an average of 28 or more hours per week during the month. Child care services may be provided for the hours of employment of a single parent or the coinciding hours of employment of both parents in a two-parent home, and for actual travel time between home, child care facility, and place of employment.

(3) The parent needs child care as part of a protective service plan to prevent or alleviate child abuse or neglect.

(4) The person who normally cares for the child is absent from the home due to inpatient hospitalization or outpatient treatment because of physical or mental illness, or is present but is unable to care for the child, as verified by a physician. Care under this paragraph is limited to a maximum of one month, unless extenuating circumstances are justified and approved after case review by the service area manager or designee.

(5) The parent is looking for employment. Child care for job search shall be limited to only those hours the parent is actually looking for employment including travel time. A job search plan shall be approved by the department and limited to a maximum of 30 working days in a 12-month period. Child care in two-parent families may be provided only during the coinciding hours of both parents' looking for employment, or during one parent's employment and one parent's looking for employment. Documentation of job search contacts shall be furnished to the department. The department may enter into a nonfinancial coordination agreement for information exchange concerning job search documentation.

EXCEPTION: Additional hours may be paid for job search for PROMISE JOBS recipients if approved by the PROMISE JOBS worker.

(6) The person is participating in activities approved under the PROMISE JOBS program and there is a need for child care services.

(7) The family is part of the family investment program and there is a need for child care.

If a parent in a family investment program household remains in the home, child care assistance can be paid if that parent receives Supplemental Security Income.

c. Residency. To be eligible for child care services, the person must be living in the state of Iowa. "Living in the state" shall include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

170.2(3) *Priority for assistance.* Child care services shall be provided only when funds are available. Funds available for child care assistance shall first be used to continue assistance to families currently receiving child care assistance and to families with protective child care needs. When funds are insufficient, families applying for services must meet the specific requirements in this subrule.

a. Priority groups. As funds are determined available, families shall be served on a statewide basis from a service-area-wide waiting list as specified in subrule 170.3(4) based on the following schedule in descending order of prioritization.

(1) Families with an income at or below 100 percent of the federal poverty level whose members are employed at least 28 hours per week, and parents with a family income at or below 100 percent of the federal poverty level who are under the age of 21 and are participating in an educational program leading to a high school diploma or equivalent.

(2) Parents under the age of 21 with a family income at or below 100 percent of the federal poverty guidelines who are participating, at a satisfactory level, in an approved training program or in an education program.

(3) Families with an income of more than 100 percent but not more than 140 percent of the federal poverty guidelines whose members are employed at least 28 hours per week.

(4) Families with an income at or below 175 percent of the federal poverty guidelines whose members are employed at least 28 hours per week with a special needs child as a member of the family.

b. Exceptions to priority groups. The following are eligible for child care assistance notwithstanding waiting lists for child care services:

(1) Families with protective child care needs.

(2) Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

(3) Families that receive a state adoption subsidy for a child.

c. Effect on need for service. Families approved under a priority group are not required to meet the requirements in paragraph 170.2(2)*"b"* except at review or redetermination.

170.2(4) *Reporting changes.* The parent must report any changes in circumstances affecting these eligibility requirements and changes in the choice of provider to the county office worker or the department's designee within ten calendar days of the change.

441—170.3(237A,239B) Application and determination of eligibility.

170.3(1) *Application process.*

a. Application for child care assistance may be made at any county office of the department on Form 470-3624, Child Care Assistance Application.

b. The application may be filed by the applicant, by the applicant's authorized representative or, when the applicant is incompetent or incapacitated, by a responsible person acting on behalf of the applicant.

c. The date of application is the date a signed application form is received in the county office.

170.3(2) *Exceptions to application requirement.* Applications are not required for:

a. A person who is participating in activities approved under the PROMISE JOBS program.

b. Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

c. Families with protective service needs.

d. Child care services provided under a court order.

170.3(3) *Application processing.* The department shall approve or deny an application as soon as possible, but no later than 30 days following the date the application was received.

The department shall issue a written notice of decision to the applicant by the next working day following a determination of eligibility. EXCEPTION: When the court orders services, the court order provided by the court and the case plan provided by the department shall serve as written notification.

170.3(4) *Waiting lists for child care services.* When the department has determined that there may be insufficient funding, applications for child care assistance shall be taken only for the priority groups for which funds have been determined available according to subrule 170.2(3).

a. The department shall maintain a log of families applying for child care services that meet the requirements within the priority groups for which funds may be available.

(1) Each family shall be entered on the logs according to their eligibility priority group and in sequence of their date of application.

(2) If more than one application is received on the same day for the same priority group, families shall be entered on the log based on the day of the month of the birthday of the oldest eligible child. The lowest numbered day shall be first on the log. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

b. When the department determines that there is adequate funding, the department shall notify the public regarding the availability of funds.

170.3(5) *Review and redetermination.* Eligibility for child care assistance shall be redetermined at least every six months in the same manner as at application. EXCEPTION: Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients shall be deemed eligible notwithstanding eligibility redetermination requirements.

a. If the department has suspended family investment program benefits, the family will continue to receive child care assistance on the basis of family investment program eligibility until family investment program eligibility has been canceled.

b. If family investment program eligibility ends, the department shall redetermine child care assistance eligibility according to the requirements in rule 441—170.2(237A,239B). The redetermination of eligibility shall be completed within 30 days.

441—170.4(237A) Elements of service provision.

170.4(1) *Case plan.* The case plan shall be developed by the department service worker and contain information described in 441—subrule 130.7(2), when the child meets the need for service under 170.2(2)*"b"*(3).

170.4(2) *Fees.* Fees for services received shall be charged to clients according to the schedule in this subrule, except that fees shall not be charged to clients receiving services without regard to income. Nothing in these rules shall preclude a client from voluntarily contributing toward the costs of service.

a. Fee schedule. The fee schedule for child care services is shown in the following table:

Monthly Income Increment Levels According to Family Size

Income Increment Levels	1	2	3	4	5	6	7	8	9	10	Half-Day Fee
A	$ 737	$ 989	$1241	$1492	$1744	$1996	$2248	$2499	$2751	$3003	$0.00
B	776	1041	1306	1571	1836	2101	2366	2631	2896	3161	$0.50
C	819	1099	1379	1659	1939	2219	2498	2778	3058	3338	$1.00
D	865	1161	1456	1752	2047	2343	2638	2934	3229	3525	$1.50
E	914	1226	1538	1850	2162	2474	2786	3098	3410	3722	$2.00
F	965	1295	1624	1954	2283	2613	2942	3272	3601	3931	$2.50
G	1019	1367	1715	2063	2411	2759	3107	3455	3803	4151	$3.00
H	1076	1444	1811	2179	2546	2913	3281	3648	4016	4383	$3.50
I	1136	1524	1912	2301	2689	3077	3465	3853	4241	4629	$4.00
J	1200	1610	2020	2429	2839	3249	3659	4068	4478	4888	$4.50
K	1267	1700	2133	2565	2998	3431	3864	4296	4729	5162	$5.00
L	1338	1795	2252	2709	3166	3623	4080	4537	4994	5451	$5.50
M	1413	1896	2378	2861	3343	3826	4308	4791	5274	5756	$6.00

The following instructions apply to the use of the sliding fee schedule:

(1) Find the family size that was used in determining income eligibility for service. Move across the monthly income table to the column headed by that number.

(2) Move down the column for the applicable family size to the highest figure that is equal to or less than the family's gross monthly income. Income at or above that amount (but less than the amount in the next row) corresponds to the fee in the last column of that row. EXAMPLES: A family with income above the Level A amount but less than the Level B amount pays the Level A fee ($0.00). A family with income at or above the Level B amount but less than the Level C amount pays the Level B fee ($0.50).

(3) The fee applies to each unit of service used by the family. The unit of service is a half-day, defined as up to 5 hours of service per 24-hour period.

(4) When a family has more than 10 members, determine the income levels by multiplying the figures in the 4-member column by 0.03. Round the number to the nearest dollar and multiply by the number in the family in excess of 10. Add the results to the amounts in the 10-member column.

(5) When more than one child in a family is receiving child care assistance, there is no additional fee. The fee shall be based on the child who receives the most care.

b. Collection. The provider shall collect fees from clients.

(1) The provider shall maintain records of fees collected. These records shall be available for audit by the department or its representative.

(2) When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. "Reasonable effort to collect" means an original billing and two follow-up notices of nonpayment.

c. Inability of client to pay fees. Child care assistance may be continued without a fee, or with a reduced fee, when a client reports in writing the inability to pay the assessed fee due to the existence of one or more of the conditions set forth below. Before reducing the fee, the worker shall assess the case to verify that the condition exists and to determine whether a reduced fee can be charged. The reduced fee shall then be charged until the condition justifying the reduced fee no longer exists. Reduced fees may be justified by:

(1) Extensive medical bills for which there is no payment through insurance coverage or other assistance.

(2) Shelter costs that exceed 30 percent of the household income.

(3) Utility costs not including the cost of a telephone that exceed 15 percent of the household income.

(4) Additional expenses for food resulting from diets prescribed by a physician.

170.4(3) *Method of provision.* Parents shall be allowed to exercise their choice for in-home care, except when the parent meets the need for service under subparagraph 170.2(2)*"b"*(3), as long as the conditions in paragraph 170.4(7)*"d"* are met. When the child meets the need for service under 170.2(2)*"b"*(3), parents shall be allowed to exercise their choice of licensed, registered, or nonregistered child care provider except when the department service worker determines it is not in the best interest of the child.

The provider must meet one of the applicable requirements set forth below.

a. Licensed child care center. A child care center shall be licensed by the department to meet the requirements set forth in 441—Chapter 109 and shall have a current Certificate of License, Form 470-0618.

b. Registered child development home. A child development home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form 470-3498.

c. Registered family child care home. Rescinded IAB 1/7/04, effective 3/1/04.

d. Relative care. Rescinded IAB 2/6/02, effective 4/1/02.

e. In-home care. The adult caretaker selected by the parent to provide care in the child's own home shall be sent the pamphlet Comm. 95, Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890, Payment Application for Nonregistered Providers.

Form 470-2890 shall be signed by the provider and returned to the department before payment may be made. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

(1) Minimum health and safety requirements;

(2) Limits on the number of children for whom care may be provided;

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and

(4) Conditions that warrant nonpayment.

f. Nonregistered family child care home. The adult caretaker selected by the parent to provide care in a nonregistered family child care home shall be sent the pamphlet Comm. 95, Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890, Payment Application for Nonregistered Providers.

Form 470-2890 shall be signed by the provider and returned to the department before payment may be made. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

(1) Minimum health and safety requirements;

(2) Limits on the number of children for whom care may be provided;

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and

(4) Conditions that warrant nonpayment.

g. Exempt facilities. Child care facilities operated by or under contract to a public or nonpublic school accredited by the department of education that are exempt from licensing or registration may receive payment for child care services when selected by a parent.

h. Record checks for nonregistered family child care homes. If a nonregistered child care provider wishes to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete Form 470-0643, Request for Child Abuse Information, and Form 595-1489, Non-Law Enforcement Record Check Request, Form A, for the provider, for anyone having access to a child when the child is alone, and for anyone 14 years of age or older living in the home. The county office worker or the PROMISE JOBS worker shall provide the necessary forms. The provider shall return the forms to the county office or PROMISE JOBS worker.

If any of these individuals has a record of founded child abuse, a criminal conviction, or placement on the sex offender registry, the department shall perform an evaluation following the process defined at 441—subrule 110.7(3) or rule 441—110.31(237A). If any of the individuals would be prohibited from registration, employment, or residence, the person shall not provide child care and is not eligible to receive public funds to do so. The department's designee shall notify the applicant, and shall forward a copy of that notification to the county attorney, the county office, and the PROMISE JOBS worker, if applicable. A person who continues to provide child care in violation of this law is subject to penalty and injunction under Iowa Code chapter 237A.

170.4(4) *Components of service program.* Every child eligible for child care services shall receive supervision, food services, and program and activities, and may receive transportation.

170.4(5) *Levels of service according to age.* Rescinded IAB 9/30/92, effective 10/1/92.

170.4(6) *Provider's individual program plan.* An individual program plan shall be developed by the child care provider for each child within 30 days after placement when the need for service was established under 170.2(3)*"d."* The program plan shall be supportive of the service worker's case plan. The program plan shall contain goals, objectives, services to be provided, and time frames for review.

170.4(7) *Payment.* The department shall make payment for child care provided to eligible families when the provider has a completed Form 470-3871, Child Care Assistance Provider Agreement, on file with the department. Both the child care provider and the county office worker or PROMISE JOBS worker shall sign this form.

The county office worker or PROMISE JOBS worker shall determine the number of units of service authorized for each eligible family and inform the family and the family's provider through the notice of decision required in subrule 170.3(3).

The department shall issue payment when the provider submits correctly completed documentation of attendance and charges. Providers shall submit either Form 470-0020, Purchase of Services Provider Invoice, accompanied by Form 470-3872, Child Care Assistance Attendance Sheet, signed by the parent, or Form 470-3896, PROMISE JOBS Child Care Attendance and Invoice.

a. Rate of payment. The rate of payment for child care services, except for in-home care which shall be paid in accordance with 170.4(7)*"d,"* shall be the actual rate charged by the provider for a private individual, not to exceed the maximum rates shown below. When a provider does not have a half-day rate in effect, a rate is established by dividing the provider's declared full-day rate by 2. When a provider has neither a half-day nor a full-day rate, a rate is established by multiplying the provider's declared hourly rate by 4.5. Payment shall not exceed the rate applicable to the provider and age group in Table I, except for special needs care which shall not exceed the rate applicable to the provider and age group in Table II. To be eligible for the special needs rate, the provider must submit documentation to the child's service worker that the child needing services has been assessed by a qualified professional and meets the definition for "child with special needs," and a description of the child's special needs, including, but not limited to, adaptive equipment, more careful supervision, or special staff training.

Table I Half-Day Rate Ceilings for Basic Care				
Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	$12.45	$10.00	$9.00	$8.19
Preschool	$10.50	$ 9.00	$8.55	$7.19
School Age	$ 9.00	$ 9.00	$8.33	$7.36

Table II Half-Day Rate Ceilings for Special Needs Care				
Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	$48.00	$15.75	$12.38	$10.24
Preschool	$28.13	$14.63	$12.38	$ 8.99
School Age	$28.04	$13.50	$11.25	$ 9.20

The following definitions apply in the use of the rate tables:

(1) "Child care center" shall mean those providers as defined in 170.4(3)*"a"* and *"g."* "Registered child development home" shall mean those providers as defined in 170.4(3)*"b."* " Nonregistered family child care home" shall mean those providers as defined in 170.4(3)*"d"* and *"f."*

(2) Under age group, "infant and toddler" shall mean age two weeks to two years; "preschool" shall mean two years to school age; "school age" shall mean a child in attendance in full-day or half-day classes.

b. Payment for days of absence. Payment may be made to a child care provider defined in subrule 170.4(3) for an individual child not in attendance at a child care facility not to exceed four days per calendar month providing that the child is regularly scheduled on those days and the provider also charges a private individual for days of absence.

c. Payment for multiple children in a family. When a provider reduces the charges for the second and any subsequent children in a family with multiple children whose care is unsubsidized, the rate of payment made by the department for a family with multiple children shall be similarly reduced.

d. Payment for in-home care. Payment may be made for in-home care when there are three or more children in a family who require child care services. The rate of payment for in-home care shall be the minimum wage amount.

e. Limitations on payment. Payment shall not be made for therapeutic services that are provided in the care setting and include, but are not limited to, services such as speech, hearing, physical and other therapies, individual or group counseling, therapeutic recreation, and crisis intervention.

f. Review of the calculation of the rate of payment. Maximum rate ceilings are not appealable. A provider who is in disagreement with the calculation of the half-day rate as set forth in 170.4(7)*"a"* may request a review. The procedure for review is as follows:

(1) Within 15 calendar days of notification of the rate in question, the provider shall send a written request for review to the human services area administrator. The request shall identify the specific rate in question and the methodology used to calculate the rate. A written response from the human services area administrator shall be provided within 15 calendar days of receipt of the request for review.

(2) When dissatisfied with the response, the provider may, within 15 calendar days of the response, request a review by the chief of the bureau of individual and family support services. The provider shall submit the original request, the response received, and any additional information desired to the bureau chief. The bureau chief shall render a decision in writing within 15 calendar days of receipt of the request.

(3) The provider may appeal the decision to the director of the department or the director's designee within 15 calendar days of the decision. The director or director's designee shall issue the final department decision within 15 calendar days of receipt of the request.

441—170.5(237A) Adverse actions.

170.5(1) *Provider agreement.* The department may refuse to enter into or may revoke the Child Care Assistance Provider Agreement, Form 470-3871, if:

a. The department finds a hazard to the safety and well-being of a child, and the provider cannot or refuses to correct the hazards; or

b. The provider has submitted claims for payment for which the provider is not entitled.

170.5(2) *Denial.* Child care assistance shall be denied when the department determines that:

a. The client is not in need of service; or

b. The client is not financially eligible; or

c. There is another community resource available to provide the service or a similar service free of charge; or

d. An application is required and the client or representative refuses to sign the application form; or

e. Funding is not available.

170.5(3) *Termination.* Child care assistance may be terminated when the department determines that:

a. The client no longer meets the eligibility criteria in subrule 170.2(2); or

b. The client's income exceeds the financial guidelines; or

c. The client refuses to allow documentation of eligibility as to need and income; or

d. No payment or only partial payment of client fees has been received within 30 days following the issuance of the last billing; or

e. Another community resource is available to provide the service or a similar service free of charge; or

f. Funding is not available.

170.5(4) *Reduction.* Authorized units of service may be reduced when the department determines that:

a. Continued provision of service at the current level is not necessary to meet the client's service needs; or

b. Another community resource is available to provide the same or similar service free of charge that will meet the client's needs; or

c. Funding is not available to continue the service at the current level. When funding is not available, the department may limit on a statewide basis the number of units of child care services for which payment will be made.

441—170.6(237A) Appeals. Notice of adverse actions and the right of appeal shall be given in accordance with 441—Chapter 7.

441—170.7(237A) Provider fraud.

170.7(1) *Fraud.* The department shall consider a child care provider to have committed fraud when:

a. The department of inspections and appeals, in an administrative or judicial proceeding, has found the provider to have obtained by fraudulent means child care assistance payment in an amount in excess of $1,000; or

b. The provider has agreed to entry of a civil judgment or judgment by confession that includes a conclusion of law that the provider has obtained by fraudulent means child care assistance payment in an amount in excess of $1,000.

170.9(7) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the amount of the overpayment is less than $35. Recoupment will be waived on nonfraud overpayments of less than $35 which have been held in suspense for three years.

These rules are intended to implement Iowa Code sections 237A.13 and 237A.29.

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SHELTERED WORK/WORK ACTIVITY SERVICES
Rescinded IAB 3/6/02, effective 5/1/02

65.17(10) *Methods to reduce soil loss and potential surface water pollution.* The manure management plan shall include an identification of the methods, structures or practices that will be used to prevent or diminish soil loss and potential surface water pollution during the application of manure. Until a phosphorus index is required in accordance with 65.17(1)*"d,"* the current manure management plan shall maintain a summary or copy of the conservation plan for the cropland where manure from the animal feeding operation will be applied if the manure will be applied on highly erodible cropland. The conservation plan shall be the conservation plan approved by the local soil and water conservation district or its equivalent. The summary of the conservation plan shall identify the methods, structures or practices that are contained in the conservation plan. When a phosphorus index is required in accordance with 65.17(1)*"d,"* the manure management plan shall indicate for each field in the plan the crop rotation, tillage practices and supporting practices used to calculate sheet and rill erosion for the phosphorus index. A copy of the NRCS RUSLE2 profile erosion calculation record shall satisfy the requirement to indicate the crop rotation, tillage practices and supporting practices to calculate sheet and rill erosion. The plan shall also identify the highly erodible cropland where manure will be applied. The manure management plan may include additional information such as whether the manure will be injected or incorporated or the type of manure storage structure.

65.17(11) *Spray irrigation.* Requirements contained in subrules 65.3(2) and 65.3(3) regarding the use of spray irrigation equipment to apply manure shall be followed. A plan which has identified spray irrigation equipment as the method of manure application shall identify any additional methods or practices to reduce potential odor, if any other methods or practices will be utilized.

65.17(12) *Current manure management plan.* The owner of a confinement feeding operation who is required to submit a manure management plan shall maintain a current manure management plan at the site of the confinement feeding operation or at a residence or office of the owner or operator of the operation within 30 miles of the site. The plan shall include completed manure sales forms for a confinement feeding operation from which manure is sold. If manure management practices change, a person required to submit a manure management plan shall make appropriate changes consistent with this rule. If values other than the standard table values are used for manure management plan calculations, the source of the values used shall be identified.

65.17(13) *Record keeping.* Records shall be maintained by the owner of a confinement feeding operation who is required to submit a manure management plan. This recorded information shall be maintained for three years following the year of application or for the length of the crop rotation, whichever is greater. Effective August 25, 2006, records shall be maintained for five years following the year of application or for the length of the crop rotation, whichever is greater. Records shall be maintained at the site of the confinement feeding operation or at a residence or office of the owner or operator of the facility within 30 miles of the site. Records to demonstrate compliance with the manure management plan shall include the following:

a. Factors used to calculate the manure application rate:

(1) Optimum yield for the planned crop.

(2) Types of nitrogen credits and amounts.

(3) Remaining crop nitrogen needed.

(4) Nitrogen content and first-year nitrogen availability of the manure.

(5) Phosphorus content of the manure if required in accordance with 65.17(3)*"i."* If an actual sample is used, documentation shall be provided.

b. If phosphorus-based application rates are used, the following shall be included:

(1) Crop rotation.

(2) Phosphorus removed by crop harvest of that crop rotation.

c. Maximum allowable manure application rate.

d. Actual manure application information:

(1) Methods of application when manure from the confinement feeding operation was applied.

(2) Date(s) when the manure from the confinement feeding operation was applied.

(3) Location of the field where the manure from the confinement feeding operation was applied, including the number of acres.

(4) The manure application rate.

**e.* Effective August 25, 2005, date(s) and application rate of commercial nitrogen and phosphorus on fields that received manure.

f. When a phosphorus index is required in accordance with 65.17(1)"*d,*" a copy of the current soil test lab results for each field in the manure management plan.

g. For sales of manure under 65.17(2)"*b,*" record-keeping requirements of 65.17(2)"*b*"(8) shall be followed.

65.17(14) *Record inspection.* The department may inspect a confinement feeding operation at any time during normal working hours and may inspect the manure management plan and any records required to be maintained. As required in Iowa Code section 459.312(12), Iowa Code chapter 22 shall not apply to the records which shall be kept confidential by the department and its agents and employees. The contents of the records are not subject to disclosure except as follows:

a. Upon waiver by the owner of the confinement feeding operation.

b. In an action or administrative proceeding commenced under this chapter. Any hearing related to the action or proceeding shall be closed.

c. When required by subpoena or court order.

65.17(15) *Enforcement action.* An owner required to provide the department a manure management plan pursuant to this rule who fails to provide the department a plan or who is found in violation of the terms and conditions of the plan shall not be subject to an enforcement action other than assessment of a civil penalty pursuant to Iowa Code section 455B.191.

65.17(16) *Soil sampling requirements for fields where the phosphorus index must be used.* Soil samples shall be obtained from each field in the manure management plan at least once every four years. Each soil sample shall be analyzed for phosphorus and pH. The soil sampling protocol shall meet all of the following requirements:

a. Acceptable soil sampling strategies include, but are not limited to, grid sampling, management zone sampling, and soil type sampling. Procedural details can be taken from Iowa State University extension publication PM 287, "Take a Good Soil Sample to Help Make Good Decisions," NCR-13 Report 348, "Soil Sampling for Variable-Rate Fertilizer and Lime Application," or other credible soil sampling publications.

b. Each soil sample must be a composite of at least ten soil cores from the sampling area, with each core containing soil from the top six inches of the soil profile.

c. Each soil sample shall represent no more than ten acres. For fields less than or equal to 15 acres, only one soil sample is necessary.

d. Soil analysis must be performed by a lab enrolled in the IDALS soil testing certification program.

e. The soil phosphorus test method must be an appropriate method for use with the phosphorus index. If soil pH is greater than or equal to 7.4, soil phosphorus data from the Bray-1 extraction method is not acceptable for use with the phosphorus index.

*August 25, 2004, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held August 11, 2004.

567—65.21(455B) Transfer of legal responsibilities or title. If title or legal responsibility for a permitted animal feeding operation and its animal feeding operation storage structure is transferred, the person to whom title or legal responsibility is transferred shall be subject to all terms and conditions of the permit and these rules. The person to whom the permit was issued and the person to whom title or legal responsibility is transferred shall notify the department of the transfer of legal responsibility or title of the operation within 30 days of the transfer. Within 30 days of receiving a written request from the department, the person to whom legal responsibility is transferred shall submit to the department all information needed to modify the permit to reflect the transfer of legal responsibility. A person who has been classified as a habitual violator under Iowa Code section 455B.191 shall not acquire legal responsibility or a controlling interest to any additional permitted confinement feeding operations for the period that the person is classified as a habitual violator. A person who has an interest in a confinement feeding operation that is the subject of a pending enforcement action shall not acquire legal responsibility or an interest to any additional permitted confinement feeding operations for the period that the enforcement action is pending.

567—65.22(455B) Validity of rules. If any part of these rules is declared unconstitutional or invalid for any reason, the remainder of said rules shall not be affected thereby and shall remain in full force and effect, and to that end, these rules are declared to be severable.

These rules are intended to implement Iowa Code sections 455B.104, 455B.134(3)*"e,"* 455B.171 to 455B.188, and 455B.191; Iowa Code chapter 459; and 1998 Iowa Acts, chapter 1209, sections 41 and 44 to 47.

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571—20.5(462A) Procedure—dealer.

20.5(1) Upon sale of a vessel the dealer shall complete the first assignment information required on the reverse of the certificate of origin.

20.5(2) The dealer shall deliver the certificate of origin to the purchaser along with a bill of sale or receipt (DNR Form 542-0471) showing that the person has purchased the vessel for consumer use.

571—20.6(462A) Procedure—purchaser.

20.6(1) The purchaser shall utilize the information contained on the certificate of origin to complete the information required on the application for vessel title.

20.6(2) The purchaser shall surrender the certificate of origin to the county recorder upon applying for a vessel title.

571—20.7(462A) Procedure—county recorder.

20.7(1) The county recorder shall verify that the information contained in the application and the certificate of origin correspond and shall utilize that information so far as possible in issuing the vessel title.

20.7(2) The county recorder shall retain the certificate of origin as a part of the permanent record of that vessel's title transactions.

571—20.8(462A) Vessel titling. A person shall not title a vessel after December 31, 1987, without furnishing to the county recorder a manufacturer's certificate of origin.

These rules are intended to implement Iowa Code sections 462A.3, 462A.77 and 462A.79.

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CHAPTER 38
BOAT REGISTRATION AND NUMBERING
[Prior to 12/31/86, Conservation Commission[290] Ch 28]

571—38.1(462A) Emblem placed. The current registration emblem shall be placed four inches toward the stern of the registration number on each side of the bow of the vessel. On the port side the emblem will be four inches behind the registration number, and on the starboard side four inches in front of the registration number.

On sailboats, when the registration number is placed on the mast as permitted by 571—paragraph 38.19(1)"*a*," the registration emblem shall be placed four inches below the registration number on each side of the mast.

All newly registered boats or boats with renewed registrations will receive emblems with the registration certificate.

This rule shall apply to all registered vessels, including those being used by dealers in accordance with Iowa Code chapter 462A.

The requirements of this chapter pertaining to the display of registration decals, registration numbers and passenger capacity numbers do not apply to vessels that are exempt pursuant to Iowa Code section 462A.6A.

This rule is intended to implement Iowa Code sections 462A.5 and 462A.6A.

571—38.2 to **38.5** Reserved.

571—38.6(462A) Procedure for application for boat registration number—content.

38.6(1) *Application.* The following information shall be submitted on DNR Forms 542-8067 and 542-2000:

a. Name and address of owner.

b. Present number (if any).

c. Hull material (wood, steel, aluminum, plastic, other).

d. Type of propulsion (outboard, inboard, other).

e. Length and width of boat.

f. Make and model year. For home-built vessels, the year that construction is started shall serve as the model year.

g. Statement as to use.

h. Signature.

i. From whom purchased (name and address).

38.6(2) *Vessels not previously registered.* If a person is making application for a boat registration number for a used vessel that has never before been registered or titled and the person does not have any satisfactory proof of ownership, the county recorder may issue a certificate of number for the used vessel if the applicant has provided the recorder with a signed and notarized affidavit, on DNR Form 542-8074, stating that the person making the application is the lawful owner of the vessel.

571—38.7 to **38.9** Reserved.

571—38.10(462A) Information on certificate. The certificate of number (DNR Form 542-0540) shall show the following:

1. Name and address of boat owner.
2. Number issued.
3. Expiration date.
4. Make, or model, or type of boat.
5. Hull material (wood, steel, aluminum, plastic, other).
6. Length and width of vessel.
7. Propulsion (inboard, outboard, other).
8. Maximum capacity rating (number of persons).
9. Decal audit number.
10. If vessel is required to be bonded, date of bonding.

571—38.11(462A) Registration applied for card.

38.11(1) *Procedure for registration applied for card—content.* The following information shall be furnished, required and stated on the registration applied for card (DNR Form 542-0538):

a. Name and address of dealer.
b. Make and model of vessel.
c. Hull identification (or serial) number of vessel.
d. Present registration number (if any).
e. Date of purchase.
f. Name and address of purchaser.

The above information shall be legibly printed on the card by the dealer selling the vessel.

38.11(2) *Use.* The registration applied for card may be used only after an application for registration has been made to the county recorder. Placing a completed application for registration and required fee in the mail to the recorder shall constitute making an application.

38.11(3) *Placement on vessel.* The registration applied for card shall be placed on the forward half of the vessel in a position so as to be clearly visible at all times and shall be maintained in a legible manner.

38.11(4) *Proof of purchase.* The operator of any vessel displaying a registration applied for card shall carry and display upon request of any peace officer a valid bill of sale for said vessel.

This rule is intended to implement Iowa Code section 462A.49.

571—38.12(462A) Vessels in storage. If the owner of a currently registered vessel places the vessel in storage, the owner shall return the registration certificate to the county recorder with an affidavit on DNR Form 542-8048. The county recorder shall notify the department of each registered vessel placed in storage. When the owner of a stored vessel desires to renew the vessel's registration, the owner shall apply to the county recorder and pay the applicable fees.

571—38.13 and **38.14** Reserved.

571—38.15(462A) Numbering pattern to be used.

38.15(1) *Identification number.* The identification numbers awarded under the Iowa system shall consist of three parts. The first part shall consist of the letters "IA" indicating this state. The second part shall consist of not more than four Arabic numerals. The third part shall consist of not more than two letters.

38.15(2) *Example.* The parts shall be separated by a hyphen or an equivalent space. As example: IA-2500-C IA-9875-EA IA 7560 ZZ

38.15(3) *Unusable letters.* Since the letters "I," "O," and "Q" may be mistaken for Arabic numerals, they shall not be used in the suffix.

571—38.16 to **38.18** Reserved.

571—38.19(462A) Display of number on vessel, as to size, block type and contrasting color.

38.19(1) *Application of number.* The identification number awarded to any vessel under the Iowa numbering system shall be displayed thereon by being:

a. Painted on, or attached to, each side of the bow (i.e., the forward half) of the vessel; read from left to right, and in such position as to provide maximum visibility.

b. In block characters of good proportion not less than three inches in height.

c. Of a color which will contrast with the color of the background (i.e., dark numbers on a light background, or light numbers on a dark background) and so maintained as to be clearly visible and legible.

d. On vessels propelled by sail only, the numbers may be placed in such a position as to provide maximum visibility, on each side of the bow or deck or on each side of the boom or mast. In all cases except placement on the mast, the numbers shall read from left to right and comply with *"b"* and *"c"* of this subrule. In placement on the mast the number shall read from top to bottom and comply with *"b"* and *"c"* of this subrule.

38.19(2) *Restriction.* No other number shall be carried on the bow of the vessel.

38.19(3) *Purchase of number.* Purchase and attachment of these letters and number is the responsibility of the boat owner.

This rule is intended to implement Iowa Code section 462A.5.

571—38.20(462A) Special certificates for boat dealers or manufacturers. A manufacturer or dealer may operate an unregistered vessel for purposes of transporting, testing, demonstrating, or selling the vessel after first obtaining a special certificate from the department. An application for a special certificate shall be submitted on DNR Form 542-0488. A manufacturer or dealer operating a vessel pursuant to the issuance of a special certificate shall file an annual report on DNR Form 542-8062.

571—38.21(462A) Boat dealer's annual report of vessels with expired registrations. Each boat dealer shall file, before May 5 of each year, an annual report on DNR Form 542-8063 listing all used vessels held by the dealer for sale or trade and for which the registration fee for the current year has not been paid.

571—38.22 to **38.24** Reserved.

571—38.25(462A) Number designating passenger capacity. The passenger capacity of boats as assigned by the commission shall be painted or attached to the starboard side (the right side while in boat and facing the bow) of boat within nine inches of transom in three-inch or larger block numbers in a color contrasting to the boat color so that the numbers ride above the water line when boat is fully loaded.

571—38.26(462A) Monthly reports by county recorders. Each county recorder shall submit a monthly report to the department on DNR Form 542-0418 listing all boats registered in that county in the previous month. The applicable fees shall accompany the monthly report.

571—38.27 to **38.29** Reserved.

571—38.30(462A) Boats for hire. Each commercial boat operator will be required to number the boat or boats used to operate for hire with block characters of good proportion not less than three inches in height, in the following manner.

Upon making application for a number for commercially operated vessels the following type number will be assigned:

Example IA-1555-E

To identify this vessel as a commercial vessel it will be required that the commercial operator affix an X as the final letter of the suffix:

Example IA-1555-EX

When a commercial operator transfers a vessel to another individual, unless it be to another commercial operator, it will be the operator's responsibility to remove the second letter from the suffix. (The letter X).

Transferred to

Commercial	*Private Individual*
IA-1555-XX	IA-1555-X
IA-1555-EX	IA-1555-E

Transferred to

Private	*Commercial Operator*
IA-1555-A	IA-1555-AX
IA-1555-D	IA-1555-DX

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CHAPTER 39
BOATING PASSENGER CAPACITY

[Prior to 12/31/86, Conservation Commission[290] Ch 29]

571—39.1(462A) U.S. Coast Guard capacity rating. In the registration of vessels for which a U.S. Coast Guard capacity rating in whole persons has been assigned as evidenced by a U.S. Coast Guard capacity plate affixed to the vessel, that capacity shall be recognized as the registration capacity.

571—39.2(462A) Vessels assigned a capacity rating by the manufacturer. In the registration of vessels for which a U.S. Coast Guard capacity rating in whole persons has not been assigned but a plate has been affixed to the vessel containing capacity information, in whole persons, furnished by the boating industry association, national marine manufacturer association or any similar organization, that capacity shall be recognized as the registration capacity.

571—39.3(462A) Vessels not containing capacity rating information. In the registration of vessels for which no passenger capacity information has been provided by the U.S. Coast Guard or the manufacturer, the passenger capacity designated on the registration shall be O.R., "Operators Responsibility." The responsibility for determining passenger capacity of a vessel so designated shall rest with the operator of the vessel. Such operation must comply with the provisions of Iowa Code section 462A.12(1).

571—39.4(462A) Incorrect registration. When information contained on the registration certificate of a vessel is found to be incorrect regarding vessel length, vessel width, or passenger capacity, officers appointed by the department of natural resources may, upon inspection of the vessel, or the county recorder, upon presentation of adequate documentation including, but not limited to, an affidavit by the owner, may change the information on the certificate.

The officer shall within four days notify the department of natural resources and the county recorder of the county in which the vessel is registered of the changes on DNR Form 542-8094.

These rules are intended to implement Iowa Code sections 462A.20 and 462A.24.

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CHAPTER 40
BOATING SPEED AND DISTANCE ZONING
[Prior to 12/31/86, Conservation Commission[290] Ch 30]

571—40.1(462A) Restricted areas. All vessels, except authorized emergency vessels, shall be operated in compliance with, and all persons engaged in water recreation activities, shall obey restrictions with posted areas marked with a uniform waterway buoy or official signs adopted by the natural resource commission.

571—40.2(462A) Uniform buoy system. All buoys placed shall be those of the uniform waterway marking system adopted by the natural resource commission and shall be constructed, placed, and maintained in accordance with Iowa Code chapter 462A and Iowa Administrative Code 571—Chapters 40 and 41.

571—40.3(462A) Commission approval. The placement of buoys or official signs that restrict speed and distance or involve special zoning restrictions shall be approved by the natural resource commission.

571—40.4(462A) Right for aggrieved party to appeal. Any finding or establishment of areas involving special speed and distance or zoning restrictions by the natural resource commission may be appealed by aggrieved party upon written notice. A hearing thereon shall be held by the natural resource commission within 30 days thereafter.

571—40.5(462A) Rathbun Lake, Appanoose County—zoned areas.

40.5(1) Areas may be specifically designated for swimming and wading.

40.5(2) Areas may be designated restricted speed areas.

571—40.6(462A) Red Rock Lake, Marion County—zoned areas.

40.6(1) Areas may be specifically designated for swimming and wading.

40.6(2) Areas may be designated restricted speed areas.

40.6(3) Areas may be designated as "no anchoring" areas.

571—40.7(462A) Coralville Lake, Johnson County—zoned areas.

40.7(1) Areas may be specifically designated for swimming and wading.

40.7(2) Areas may be designated restricted speed areas.

571—40.8(462A) Saylorville Lake, Polk County—zoned areas.

40.8(1) Areas may be specifically designated for swimming and wading.

40.8(2) Areas may be designated restricted speed areas.

571—40.9(462A) Lake Odessa in Louisa County.

40.9(1) Areas may be designated restricted speed areas.

40.9(2) All motorboats, except authorized emergency vessels, shall be operated at no-wake speed year around, on that portion of Lake Odessa known as the Sand Run Chute, lying south of the main lake to a point 100 yards south of the Sand Run Chute boat ramp.

571—40.10(462A) Mississippi River lock and dam safety zone. A safety zone is hereby established in Iowa waters above and below all navigation lock and dam structures on the Mississippi River between the Iowa-Minnesota border and the Iowa-Missouri border. The established zone shall be 600 feet upstream and 150 feet downstream from the roller gate or tainter gate section of the structure.

40.10(1) The safety zone does not include the area directly above and below the navigation lock structure.

40.10(2) The safety zone does not include the area directly above and below the solid fill portion of the dam and structure.

40.10(3) The safety zone shall be recognized by the state of Iowa only when plainly marked as follows:

a. Upstream signs worded—Restricted area keep 600 feet from dam.

b. Downstream signs worded—Restricted area keep 150 feet from dam.

c. Flashing red lights will be used to make the outer limits of the restricted areas.

40.10(4) No boat or vessel of any type, except authorized vessels, shall enter the established safety zones recognized by the state of Iowa as described in this rule.

571—40.11(462A) Joyce Slough Area. The Joyce Slough Area, a portion of the Mississippi River within the city of Clinton, Iowa, is hereby zoned to be a harbor area and vessels traveling therein shall not travel at speeds in excess of five miles per hour.

571—40.12(462A) Swan Slough, Camanche, Iowa. A restricted speed zone is hereby established in all or part of the main channel of Swan Slough (Mississippi River mile 510.2 to 511.3), Camanche, Iowa, as designated by buoys.

571—40.13(462A) Massey Slough. Operation of vessels in Massey Slough of the Mississippi River at Massey Station, Dubuque County, Iowa, extending from a northerly to southerly direction from the upper end to the lower end of the slough, encompassing the water in Section 14, Township 88N, Range 3E of the 5th P.M., tract number NFIA-26M.

40.13(1) All boats underway must maintain a speed of less than five miles per hour in said waters.

40.13(2) Reserved.

571—40.14(462A) Black Hawk County waters. Operation of vessels in Black Hawk County on the Cedar River and any connected backwaters shall be governed by this departmental rule as well as all applicable state laws and regulations.

40.14(1) No vessel, except authorized emergency vessels, shall be operated in marked areas at a speed greater than the limit designated by buoys, signs, or other approved uniform waterway marking devices marking the area.

40.14(2) All vessels, except authorized emergency vessels, shall be operated at a no-wake speed when within 600 feet of the Franklin Street bridge. This 600-foot zone shall be designated by buoys, signs, or other approved uniform waterway marking devices.

40.14(3) No vessel shall tow skiers, surfboard riders, or other towable devices within the zone established by 40.14(2).

571—40.46(462A) Zoning of Carter Lake, Pottawattamie County.

40.46(1) All vessels operated in a designated zone known as Shoal Pointe Canal shall be operated at a no-wake speed.

40.46(2) The city of Carter Lake shall designate and maintain the no-wake zone with marker buoys approved by the natural resource commission.

571—40.47(462A) Zoning of the Mississippi River, McGregor, Clayton County.

40.47(1) All vessels, except commercial barge traffic, shall be operated at a no-wake speed within the area of river mile markers 634 and 633.4 and designated by buoys or other approved uniform waterway markers.

40.47(2) The city of McGregor will designate the no-wake zone with buoys approved by the natural resource commission.

571—40.48(462A) Zoning of the Mississippi River, Marquette, Clayton County.

40.48(1) All vessels, except commercial barge traffic, shall be operated at a no-wake speed within the area of river mile markers 634.5 and 634.9 and designated by buoys or other approved uniform waterway markers.

40.48(2) The city of Marquette will designate and maintain the no-wake zone with buoys approved by the natural resource commission.

571—40.49(462A) Zoning of Green Island, Jackson County. All motorboats except authorized emergency vessels shall operate at no-wake speed year around on boat channels adjacent to the interior channel 4 levee at the Green Island State Wildlife area. Both channels begin at the Green Island county road parking lot and proceed north 7920 feet along each side of the channel 4 levee to an intersection with the Snag Slough complex.

571—40.50(462A) Mooring of vessels on riparian property of the state of Iowa. Where the state of Iowa owns riparian property adjacent to sovereign land or water, mooring of vessels is prohibited between sunset and sunrise on those riparian or sovereign lands or waters where posted by either official buoys or official signs of the department of natural resources.

These rules are intended to implement the provisions of Iowa Code sections 462A.17, 462A.26, and 462A.31.

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CHAPTER 46
ALL-TERRAIN VEHICLE AND SNOWMOBILE BONDING

571—46.1(321G) Bond required before issuance of title or registration. If the county recorder or the department is not satisfied as to the ownership of the snowmobile or all-terrain vehicle or that there are no undisclosed security interests in the snowmobile or all-terrain vehicle, the recorder or the department shall require completion of the following procedure prior to issuing title and registration:

46.1(1) *Identification.* The applicant shall contact the department and provide the department with identifying information in regard to the all-terrain vehicle or snowmobile. The required identifying information shall include the vehicle or snowmobile identification number and such additional information as may be requested by the department. If no vehicle or snowmobile identification number is currently affixed, the applicant shall complete the department's procedure for obtaining such number, and the assigned number shall be affixed before the applicant may proceed with the application process set forth in this chapter.

46.1(2) *Records search.* Upon receipt of sufficient identifying information from an applicant, the department shall:

a. Search the state files to determine if there is an owner of record for the all-terrain vehicle or snowmobile and if the all-terrain vehicle or snowmobile has been reported stolen; and

b. Notify the applicant, orally or in writing, in regard to whether a record of prior ownership has been located and, if so, provide the name and last-known address of the owner of record.

46.1(3) *Examination.* At any time after being contacted by the applicant and before approval of an application, the department may examine the all-terrain vehicle or snowmobile.

46.1(4) *Notice to owner of record.* If the department finds a record of prior ownership in the state files, the applicant shall notify the owner of record at the owner's last-known address by certified mail, return receipt requested. The notice shall state that the owner of record may assert the owner's right to claim the all-terrain vehicle or snowmobile. If neither the applicant nor the department receives a response from the owner of record within ten days after receipt of notice or the post office returns the notice to the applicant as undeliverable or unclaimed, the department will continue processing the bond application.

46.1(5) *Submission of application.* The applicant shall submit an application on DNR Form 542-8065 or 542-8067. The application shall include a statement obtained from an Iowa-registered dealer for all-terrain vehicles or snowmobiles indicating the current value of the all-terrain vehicle or snowmobile. The following documents shall be submitted with the application form:

a. Photographs of the all-terrain vehicle or snowmobile which show the front, rear, and one side of the all-terrain vehicle or snowmobile.

b. The written ownership document received at the time that the all-terrain vehicle or snowmobile was acquired.

c. Satisfactory proof of the all-terrain vehicle or snowmobile identification number.

d. The undeliverable or unclaimed certified letter and envelope addressed to the previous owner or the signed certified mail receipt, if a record of prior ownership was located by the department.

e. A surety bond on DNR Form 542-8092 in an amount equal to one and one-half times the current value of the all-terrain vehicle or snowmobile.

46.1(6) *Approval.* If the department determines that the applicant has complied with this rule, that there is sufficient evidence to indicate that the applicant is the rightful owner, and that there is no known unsatisfied security interest, the department shall forward the original application to the county recorder and notify the applicant that the all-terrain vehicle or snowmobile may be registered and titled in Iowa.

46.1(7) *Disapproval.* If the department determines that the applicant has not complied with this rule, that there is sufficient evidence to indicate that the applicant may not be the rightful owner, that there is an unsatisfied security interest, or that the owner of record asserts a claim for the all-terrain vehicle or snowmobile, the department shall not authorize issuance of a certificate of title or registration receipt and shall notify the applicant in writing of the reason(s).

This rule is intended to implement Iowa Code section 321G.29.

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CHAPTER 47
VESSEL BONDING

571—47.1(462A) Bond required before issuance of title or registration. If the county recorder or the department is not satisfied as to the ownership of a vessel or that there are no undisclosed security interests in the vessel, the recorder or the department shall require completion of the following procedure prior to issuing title or registration:

47.1(1) *Identification.* The applicant shall contact the department and provide the department with identifying information in regard to the vessel. The required identifying information shall include the hull identification number, if applicable, and such additional information as may be requested by the department. If no hull identification number is currently affixed on a vessel otherwise required by law to have a hull identification number, the applicant shall complete the department's procedure for obtaining such number, and the assigned number shall be affixed before the applicant may proceed with the application process set forth in this chapter.

47.1(2) *Records search.* Upon receipt of sufficient identifying information from an applicant, the department shall:

a. Search the state files to determine if there is an owner of record for the vessel and if the vessel has been reported stolen; and

b. Notify the applicant, orally or in writing, in regard to whether a record of prior ownership has been located and, if so, provide the name and last-known address of the owner of record.

47.1(3) *Examination.* At any time after being contacted by the applicant and before approval of an application, the department may examine the vessel.

47.1(4) *Notice to owner of record.* If the department finds a record of prior ownership in the state files, the applicant shall notify the owner of record at the owner's last-known address by certified mail, return receipt requested. The notice shall state that the owner of record may assert the owner's right to claim the vessel. If neither the applicant nor the department receives a response from the owner of record within ten days after receipt of notice or the post office returns the notice to the applicant as undeliverable or unclaimed, the department will continue processing the bond application.

47.1(5) *Submission of application.* The applicant shall submit an application on DNR Form 542-8067. The form shall include a statement obtained from an Iowa-registered dealer for vessels indicating the current value of the vessel. The following documents shall be submitted with the application form:

a. Photographs of the vessel which show the front, rear, and one side of the vessel.

b. The written ownership document received at the time that the vessel was acquired.

c. Satisfactory proof of the hull identification number or DNR Form 542-2000.

d. The undeliverable or unclaimed certified letter and envelope addressed to the previous owner or the signed certified mail receipt, if a record of prior ownership was located by the department.

e. A surety bond on DNR Form 542-8092 in an amount equal to one and one-half times the current value of the vessel.

47.1(6) *Approval.* If the department determines that the applicant has complied with this rule, that there is sufficient evidence to indicate that the applicant is the rightful owner, and that there is no known unsatisfied security interest, the department shall forward the original application to the county recorder and notify the applicant that the vessel may be registered in Iowa.

47.1(7) *Disapproval.* If the department determines that the applicant has not complied with this rule, that there is sufficient evidence to indicate that the applicant may not be the rightful owner, that there is an unsatisfied security interest, or that the owner of record asserts a claim for the vessel, the department shall not authorize issuance of a certificate of title or registration receipt and shall notify the applicant in writing of the reason(s).

This rule is intended to implement Iowa Code sections 462A.5 and 462A.5A.

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CHAPTER 48
Reserved

CHAPTER 50
ALL-TERRAIN VEHICLE AND SNOWMOBILE ACCIDENT REPORTS, TITLING, REGISTRATION AND NUMBERING

[Prior to 12/31/86, Conservation Commission[290] Ch 50]

571—50.1(321G) Accident report. Whenever any all-terrain vehicle or snowmobile is involved in an accident resulting in injury or death to anyone or property damage amounting to $200 or more, the operator shall file a report of the accident with the department of natural resources within 48 hours. The report shall be on DNR Form 542-8093, completed and submitted in duplicate, including the following information:

1. Registration numbers of all-terrain vehicles or snowmobiles involved.
2. The locality where the accident occurred.
3. Date and time of accident.
4. Weather and visibility conditions.
5. Operator's name, address, age and years of experience in operating all-terrain vehicles or snowmobiles.
6. Name(s) and address(es) of owner(s) of all-terrain vehicle(s) or snowmobile(s) involved, and any other witness(es).
7. Name(s) and address(es) of operator(s) of other vehicle(s) involved.
8. Safety equipment being worn by operator and passenger(s).
9. Name(s) and address(es) of any person(s) injured or killed.
10. The nature and extent of injury to any person(s).
11. Description of damage to any property (including all-terrain vehicles or snowmobiles) and estimated cost of repair.
12. Description of the accident.
13. Horsepower, make and year of each all-terrain vehicle or snowmobile involved.
14. Estimated speed of vehicles involved.
15. Whether alcohol or drugs were contributing factors.
16. Whether all-terrain vehicle or snowmobile was rented or privately owned.

571—50.2(321G) Registration and titling—required forms. All applications, affidavits, liens and certificates shall be completed in full on DNR Forms 542-0540, 542-0974, 542-0976, 542-0978, 542-0979, 542-8050, 542-8065, 542-8067, 542-8092, and 542-8095 as provided by the department.

571—50.3(321G) All-terrain vehicle and snowmobile safety-education classes. For the purposes of this rule, all-terrain vehicle and snowmobile safety-education classes shall be considered special events. Unregistered all-terrain vehicles and snowmobiles may be used in safety-education classes under the supervision of a certified instructor if successful completion of the course will qualify the student for an Iowa DNR safety certificate.

571—50.4 Reserved.

571—50.5(321G) Registration applied for card and proof of purchase.

50.5(1) *Registration certificate.* The current registration certificate of an all-terrain vehicle or snowmobile shall be the permit required by Iowa Code section 462A.33 for operation on the surface of the ice.

50.5(2) *Procedure for registration applied for card—content.* The following information shall be furnished, required and stated on the registration applied for card (DNR Form 542-0499):

a. Name and address of dealer.

b. Make and model of all-terrain vehicle or snowmobile.

c. Serial number of all-terrain vehicle or snowmobile.

d. Present registration number (if any).

e. Date of purchase.

f. Name and address of purchaser.

The above required information shall be legibly printed on the card by the dealer selling the all-terrain vehicle or snowmobile. The card shall be completed in duplicate and one copy returned forthwith to the department of natural resources.

50.5(3) *Use.* The registration applied for card may be used only after an application for registration has been made to the county recorder. Placing a completed application for registration and required fee in the mail to the recorder shall constitute making an application.

50.5(4) *Placement on machine.* The registration applied for card shall be placed on the forward portion of the machine in a position so as to be clearly visible at all times and shall be maintained in a legible manner.

50.5(5) *Proof of purchase.* The operator of any all-terrain vehicle or snowmobile displaying a registration applied for card shall carry and display upon request of any peace officer a valid bill of sale for the all-terrain vehicle or snowmobile.

571—50.6(321G) Placement in storage. If the owner of a currently registered all-terrain vehicle or snowmobile places it in storage, the owner shall return the registration certificate to the county recorder with an affidavit on DNR Form 542-8048. The county recorder shall notify the department of each registered all-terrain vehicle or snowmobile placed in storage. When the owner of a stored all-terrain vehicle or snowmobile desires to renew the registration, the owner shall apply to the county recorder and pay the applicable fees.

571—50.7(321G) Application for and placement of new or replacement vehicle identification number (VIN).

50.7(1) The owner of a home-built or rebuilt all-terrain vehicle or snowmobile for which there is no legible vehicle identification number may make application on DNR Form 542-8065 or 542-8067 for the issuance of a new VIN. The application process shall include an inspection of the all-terrain vehicle or snowmobile by a department designee. If the application is approved, the VIN shall be affixed to the vehicle in the presence of the department designee. The completed application shall then be surrendered to the county recorder.

50.7(2) Placement of department-issued vehicle identification number.

a. Snowmobile. The VIN shall be affixed in a conspicuous location on the outside of the tunnel.

b. All-terrain vehicle. The VIN shall be affixed to the frame under the seat.

c. Two-wheeled off-road motorcycle registered as an all-terrain vehicle. The VIN shall be affixed to the steering yoke.

571—50.8(321G) Identification number. The audit number on the snowmobile or all-terrain vehicle registration decal shall serve as the identification number required to be displayed as prescribed by Iowa Code section 321G.5.

571—50.9(321G) Procedure for placement of registration decal.

50.9(1) *Snowmobile.* The decal with audit number shall be affixed to each side of the front half of the snowmobile so that the decal is clearly visible.

50.9(2) *All-terrain vehicle.* The decal with audit number shall be affixed to the rear so that the decal is clearly visible.

50.9(3) *Two-wheeled off-road motorcycle registered as an all-terrain vehicle.* The decal with audit number shall be affixed to the steering yoke in such a manner that the decal does not cover up the vehicle identification number and is clearly visible.

571—50.10(321G) Special certificates for dealers or manufacturers. A manufacturer or dealer may operate an unregistered all-terrain vehicle or snowmobile for purposes of transporting, testing, demonstrating, or selling the all-terrain vehicle or snowmobile after first obtaining a special certificate from the department. An application for a special certificate shall be submitted on DNR Form 542-0845. A manufacturer or dealer operating an all-terrain vehicle or snowmobile pursuant to the issuance of a special certificate shall file an annual report on DNR Form 542-8053.

571—50.11(321G) Dealer's annual report of expired registrations. Each dealer shall file, before January 10 of each year, an annual report on DNR Form 542-8054 listing all used all-terrain vehicles and snowmobiles held by the dealer for sale or trade and for which the registration fee for the current year has not been paid.

571—50.12(321G) Monthly all-terrain vehicle reports by county recorders. Each county recorder shall submit a monthly report to the department on DNR Form 542-0896 listing all all-terrain vehicles registered in that county in the previous month. The applicable fees shall accompany the monthly report.

571—50.13(321G) Monthly snowmobile vehicle reports by county recorders. Each county recorder shall submit a monthly report to the department on DNR Form 542-1524 listing all snowmobiles registered in that county in the previous month. The applicable fees shall accompany the monthly report.

These rules are intended to implement Iowa Code chapter 321G.

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Hawkeye Wildlife Area ..... Johnson
Muskrat Slough ..... Jones
Colyn Area ..... Lucas
Red Rock Area ..... Marion, Polk, Warren
Badger Lake ..... Monona
Tieville/Decatur Bend ..... Monona
Five Island Lake ..... Palo Alto
Big Creek-Saylorville Complex ..... Polk
Chichaqua Area ..... Polk
Cottonwood Area ..... Polk
I-35 Area ..... Polk
Smith Area ..... Pottawattamie
Lake View Area ..... Sac
McCausland ..... Scott
Princeton Area ..... Scott
Prairie Rose Lake ..... Shelby
Otter Creek Marsh ..... Tama
Green Valley Lake ..... Union
Three Mile Lake ..... Union
Lake Sugema ..... Van Buren
Rice Lake Area ..... Winnebago
Snyder Lake ..... Woodbury
Elk Creek Marsh ..... Worth
Lake Cornelia ..... Wright

b. It shall be unlawful to trespass in any manner on the following areas, where posted, anytime year around, except that department personnel and law enforcement officials may enter the area at any time in performance of their duties, and hunters under the supervision of department staff may enter when specifically authorized by the department of natural resources.

Area	County
Middle River Wildlife Area (formerly Banner Pits)	Warren
Black Hawk Bottoms Wildlife Area	Des Moines

52.1(3) *Open water refuges.* Rescinded 6/17/98, effective 7/22/98.

This rule is intended to implement Iowa Code sections 481A.5, 481A.6, 481A.8 and 481A.39.

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CHAPTER 91
WATERFOWL AND COOT HUNTING SEASONS
[Prior to 12/31/86, Conservation Commission[290] Ch 107]

571—91.1(481A) Ducks (split seasons). The north duck hunting zone is that part of Iowa north of a line beginning on the Nebraska-Iowa border at State Highway 175, east to State Highway 37, southeast to U.S. Highway 59, south to I-80 and along I-80 to the Iowa-Illinois border. The south duck hunting zone is the remainder of the state. Open season for hunting ducks shall be September 18 to September 22, 2004, and October 16 to December 9, 2004, in the north zone; September 25 and 26, 2004, and October 16 to December 12, 2004, in the south zone. Shooting hours are one-half hour before sunrise to sunset each day. The season for canvasbacks will be October 23 to November 21, 2004, in the north zone, and October 23 to November 21, 2004, in the south zone. The season for pintails will be from September 18 to September 22, 2004, and October 16 to November 9, 2004, in the north zone; September 25 and 26, 2004, and October 16 to November 12, 2004, in the south zone.

91.1(1) *Bag limit.* The daily bag limit of ducks is 6, and may include no more than 4 mallards (no more than 2 of which may be females), 1 black duck, 2 wood ducks, 1 pintail, 3 scaup, 3 mottled ducks, 1 canvasback, and 2 redheads. The daily bag limit of mergansers is 5, only 1 of which may be a hooded merganser.

91.1(2) *Possession limit.* Possession limit is twice the daily bag limit.

571—91.2(481A) Coots (split season). Same as duck season dates and shooting hours.

91.2(1) *Bag and possession limits.* Daily bag limit is 15 and possession limit is 30.

91.2(2) Reserved.

571—91.3(481A) Geese. The north goose hunting zone is that part of Iowa north of U.S. Highway 20. The south goose hunting zone is the remainder of the state. The open season for hunting Canada geese and brant is September 25 to October 3, 2004, and October 16 to December 5, 2004, in the north goose hunting zone and October 2 to October 10, 2004, and October 30 to December 19, 2004, in the south goose hunting zone. The open season for hunting white-fronted geese is September 25 to December 19, 2004, in the north goose hunting zone and October 2 to December 26, 2004, in the south goose hunting zone. The open season for hunting white and blue-phase snow geese and Ross' geese, collectively referred to as light geese, is September 25, 2004, to January 9, 2005, statewide. Light geese may also be taken under the conservation order from the U.S. Fish and Wildlife Service from January 10, 2005, through April 15, 2005. Shooting hours are one-half hour before sunrise to sunset, except that during the conservation order shooting hours will be extended to one-half hour after sunset each day. The open season for hunting Canada geese only shall be September 11 and September 12, 2004, in the north goose hunting zone. The open season for hunting Canada geese only shall be September 1 to September 15, 2004, in two specific areas described as follows:

91.3(1) *Cedar Rapids/Iowa City goose hunting zone.* The Cedar Rapids/Iowa City goose hunting zone includes portions of Linn and Johnson Counties bounded as follows: Beginning at the intersection of the west border of Linn County and Linn County Road E2W; thence south and east along County Road E2W to Highway 920; thence north along Highway 920 to County Road E16; thence east along County Road E16 to County Road W58; thence south along County Road W58 to County Road E34; thence east along County Road E34 to Highway 13; thence south along Highway 13 to Highway 30; thence east along Highway 30 to Highway 1; thence south along Highway 1 to Morse Road in Johnson County; thence east along Morse Road to Wapsi Avenue; thence south along Wapsi Avenue to Lower West Branch Road; thence west along Lower West Branch Road to Taft Avenue; thence south along Taft Avenue to County Road F62; thence west along County Road F62 to Kansas Avenue; thence north along Kansas Avenue to Black Diamond Road; thence west on Black Diamond Road to Jasper Avenue; thence north along Jasper Avenue to Rohert Road; thence west along Rohert Road to Ivy Avenue; thence north along Ivy Avenue to 340th Street; thence west along 340th Street to Half Moon Avenue; thence north along Half Moon Avenue to Highway 6; thence west along Highway 6 to Echo Avenue; thence north along Echo Avenue to 250th Street; thence east on 250th Street to Green Castle Avenue; thence north along Green Castle Avenue to County Road F12; thence west along County Road F12 to County Road W30; thence north along County Road W30 to Highway 151; thence north along the Linn-Benton County line to the point of beginning.

91.3(2) *Des Moines goose hunting zone.* The Des Moines goose hunting zone includes those portions of Polk, Warren, Madison and Dallas Counties bounded as follows: Beginning at the intersection of Northwest 158th Avenue and County Road R38 in Polk County; thence south along County Road R38 to Northwest 142nd Avenue; thence east along Northwest 142nd Avenue to Northeast 126th Avenue; thence east along Northeast 126th Avenue to Northeast 46th Street; thence south along Northeast 46th Street to Highway 931; thence east along Highway 931 to Northeast 80th Street; thence south along Northeast 80th Street to Southeast 6th Avenue; thence west along Southeast 6th Avenue to Highway 65; thence south and west along Highway 65 to Highway 69 in Warren County; thence south along Highway 69 to County Road G24; thence west along County Road G24 to Highway 28; thence southwest along Highway 28 to 43rd Avenue; thence north along 43rd Avenue to Ford Street; thence west along Ford Street to Filmore Street; thence west along Filmore Street to 10th Avenue; thence south along 10th Avenue to 155th Street in Madison County; thence west along 155th Street to Cumming Road; thence north along Cumming Road to Badger Creek Avenue; thence north along Badger Creek Avenue to County Road F90 in Dallas County; thence east along County Road F90 to County Road R22; thence north along County Road R22 to Highway 44; thence east along Highway 44 to County Road R30; thence north along County Road R30 to County Road F31; thence east along County Road F31 to Highway 17; thence north along Highway 17 to Highway 415 in Polk County; thence east along Highway 415 to Northwest 158th Avenue; thence east along Northwest 158th Avenue to the point of beginning.

91.3(3) *Bag limit.* Daily bag limit is 2 Canada geese, 2 white-fronted geese, 2 brant, and 20 light geese, except from September 1 to September 15 in the Cedar Rapids/Iowa City goose hunting zone and the Des Moines goose hunting zone when the daily bag limit is 3 Canada geese.

91.3(4) *Possession limit.* Possession limit is twice the daily bag limit and no possession limit on light geese.

j. *Area ten.* Rescinded IAB 9/5/01, effective 8/17/01.

k. *Area eleven.* Starting at the junction of the navigation channel of the Mississippi River and the mouth of the Maquoketa River in Jackson County, proceeding southwesterly along the high-water line on the west side of the Maquoketa River to U.S. Highway 52; thence southeast along U.S. Highway 52 (including the right-of-way) to 607th Avenue; thence east along 607th Avenue (including the right-of-way) to the Sioux Line Railroad; thence north and west along the Sioux Line Railroad to the Green Island levee; thence northeast along a line following the Green Island levee to the center of the navigational channel of the Mississippi River; thence northwest along the center of the navigational channel to the point of beginning.

l. *Area twelve.* Portions of Polk, Warren, Jasper, and Marion Counties bounded as follows: Beginning at the junction of County Road G40 and Iowa Highway 14 in Marion County; thence north along Highway 14 to Iowa Highway 163 in Jasper County; thence north and west along Highway 163 to State Highway 316; thence south and east along Highway 316 (including the right-of-way) to Iowa Highway 5; thence south and east along Highway 5 to County Road G40 in Marion County; thence east along County Road G40 to the point of beginning.

m. *Area thirteen.* Portions of Van Buren and Davis Counties bounded as follows: Beginning at the junction of State Highway 16 and State Highway 98 in Van Buren County; thence east and south along State Highway 16 (including the right-of-way) to State Highway 1 in Van Buren County; thence south along State Highway 1 (including the right-of-way) to State Highway 2; thence west along State Highway 2 (including the right-of-way) to County Road V42 in Davis County; thence north along County Road V42 (including the right-of-way) to County Road J40 in Davis County; thence east and south along County Road J40 (including the right-of-way) to County Road V64 in Van Buren County; thence north along County Road V64 (including the right-of-way) to State Highway 98 in Van Buren County; thence north along State Highway 98 (including the right-of-way) to the point of beginning.

n. *Area fourteen.* Portions of Bremer County bounded as follows: Beginning at the intersection of County Road V56 and 140th Street (also named State Highway 93); thence south along County Road V56 (including the right-of-way) to State Highway 3; thence west along State Highway 3 (including the right-of-way) to County Road V43; thence north along County Road V43 (including the right-of-way) to County Road C33; thence west along County Road C33 (including the right-of-way) to Navaho Avenue; thence north along Navaho Avenue (including the right-of-way) to State Highway 93; thence west along State Highway 93 (including the right-of-way) to U.S. Highway 63; thence north 7 miles along U.S. Highway 63 (including the right-of-way) to the Bremer-Chickasaw County line; thence east 3 miles along the Bremer-Chickasaw County line road (including the right-of-way) to Oakland Avenue; thence south along Oakland Avenue (including the right-of-way) to 120th Street; thence east along 120th Street (including the right-of-way) to Piedmont Avenue; thence south along Piedmont Avenue (including the right-of-way) to 140th Street; thence east along 140th Street, which becomes State Highway 93, to the point of beginning.

o. Area fifteen. Portions of Butler County bounded as follows: Beginning at the junction of County Road T16 and 230th Street; thence south 5 miles on County Road T16 (including the right-of-way) to 280th Street; thence east 3 miles along 280th Street (including the right-of-way) to Grand Avenue; thence south on Grand Avenue (including the right-of-way) to County Road C55 (also named 290th Street); thence east 3 miles on County Road C55 (including the right-of-way) to Jay Avenue; thence north along Jay Avenue (including the right-of-way) to 280th Street; thence east 3 miles on 280th Street (including the right-of-way) to State Highway 14; thence north 6 miles on State Highway 14 (including the right-of-way) to 230th Street; thence west on 230th Street (including the right-of-way) to Jackson Avenue; thence north on Jackson Avenue (including the right-of-way) to 220th Street; thence west on 220th Street (including the right-of-way) to County Road T25 (also named Hickory Avenue); thence south 0.5 mile on County Road T25 (including the right-of-way) to 225th Street; thence west on 225th Street (including the right-of-way) to Fir Avenue; thence south 0.5 miles on Fir Avenue (including the right-of-way) to 230th Street; thence west on 230th Street (including the right-of-way) to the point of beginning.

p. Area sixteen. A portion of Union County bounded as follows: Beginning at the intersection of U.S. Highway 169 and Three Mile Creek Drive near Afton; thence west along U.S. Highway 34 (including the right-of-way) approximately 2.5 miles to Union County Road P43 (also named Twelve Mile Lake Road); thence north along Union County Road P43 (including the right-of-way) approximately 5 miles to Union County Road H17; thence east along Union County Road H17 (including the right-of-way) approximately 6 miles to Quail Avenue; thence south along Quail Avenue (including the right-of-way) to Three Mile Creek Drive; thence south along Three Mile Creek Drive to the point of beginning.

q. Area seventeen. Rescinded IAB 9/1/04, effective 8/13/04.

91.4(3) *Forney Lake.* The entire Forney Lake area, in Fremont County, north of the east-west county road, shall be closed to waterfowl hunting prior to the opening date for taking geese on the area each year.

571—91.5(481A) Canada goose hunting within closed areas.

91.5(1) *Ruthven, Kettleson-Hogsback, Ingham Lake and Rice Lake closed areas.*

a. Purpose. The hunting of Canada geese in closed areas is being undertaken to allow landowners or tenants who farm in these closed areas to hunt Canada geese on land they own or farm in the closed area.

b. Criteria.

(1) Landowners and tenants who own or farm land in the closed areas will be permitted to hunt Canada geese in the closed areas for three years. This experimental hunting opportunity will be evaluated by the landowners and the DNR following each season, at which time changes may be made.

(2) Landowners and those individuals named on the permit according to the criteria specified in paragraph (9) of this subrule will be permitted to hunt in the closed area. Tenants may obtain a permit instead of the landowner if the landowner transfers this privilege to the tenant. Landowners may choose, at their discretion, to include the tenant and those individuals of the tenant's family specified in paragraph (9) of this subrule on their permit. Landowners may assign the permit for their land to any landowner or tenant who owns or farms at least eight acres inside the closed area. Assigned permits must be signed by both the permittee and the landowner assigning the permit.

(3) Landowners must hold title to, or tenants must farm by a rent/share/lease arrangement, at least eight acres inside the closed area to qualify for a permit.

(4) No more than one permit will be issued to corporations, estates, or other legal associations that jointly own land in the closed area. No individual may obtain more than two permits nor may an individual be named as a participant on more than two permits.

(5) Persons holding a permit can hunt with those individuals named on their permit as specified in paragraph (9) of this subrule on any property they own (or rent/share/lease in the case of tenants) in the closed area provided their activity complies with all other regulations governing hunting. Nothing herein shall permit the hunting of Canada geese on public property within the closed area.

(6) Persons hunting under this permit must adhere to all municipal, county, state and federal regulations that are applicable to hunting and specifically applicable to Canada goose hunting including, but not limited to: daily limits, possession limits, shooting hours, methods of take, and transportation. Hunting as authorized by this rule shall not be used to stir or rally waterfowl.

(7) Hunting within the closed area will be allowed through October 15.

(8) Permit holders will be allowed to take eight Canada geese per year in the closed area.

(9) Permits will be issued only to individual landowners or tenants; however, permit holders must specify, when requesting a permit, the names of all other individuals qualified to hunt on the permit. Individuals qualified to hunt on the permit shall include the landowners or tenants and their spouses, children, children's spouses, grandchildren, siblings and siblings' spouses only.

c. Procedures.

(1) Permits can be obtained from the local conservation officer at the wildlife unit headquarters within the closed area at announced times, but no later than 48 hours before the first Canada goose season opens. The permit will be issued to an individual landowner or tenant and must list the names of all individuals that may hunt with the permittee. The permit will also contain a description of the property covered by the permit. The permit must be carried by a member of the hunting party whose name is listed on the permit. Conservation officers will keep a record of permittees and locations of properties that are covered by permits.

(2) Eight consecutively numbered tags will be issued with each permit. Geese will be tagged around the leg immediately upon being reduced to possession and will remain tagged until delivered to the person's abode. Within one week of the close of hunting within the closed area during at least the first three years the hunt is permitted, unused tags must be turned in at the wildlife unit headquarters within the closed area or the permittee must report the number of geese killed. Failure to turn in unused tags or report the number of geese killed within the specified time period may result in the permittee's forfeiting the opportunity to hunt within the closed area the following year.

(3) No one may attempt to take Canada geese under this permit unless the person possesses an unused tag for the current year.

(4) No landowner or tenant shall be responsible or liable for violations committed by other individuals listed on the permit issued to the landowner or tenant.

91.5(2) Reserved.

571—91.6(481A) Youth waterfowl hunt. A special youth waterfowl hunt will be held on October 2 and 3, 2004, in the north duck hunting zone and October 9 and 10, 2004, in the south duck hunting zone. Youth hunters must be 15 years old or younger. Each youth hunter must be accompanied by an adult 18 years old or older. The youth hunter does not need to have a hunting license or stamps. The adult must have a valid hunting license and habitat stamp if normally required to have them to hunt and a state waterfowl stamp. Only the youth hunter may shoot ducks and coots. The adult may hunt for any other game birds for which the season is open. The daily bag and possession limits are the same as for the regular waterfowl season, as defined in subrule 91.1(1). All other hunting regulations in effect for the regular waterfowl season apply to the youth hunt.

These rules are intended to implement Iowa Code sections 481A.38, 481A.39, and 481A.48.

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CHAPTER 105
DEER POPULATION MANAGEMENT AREAS

571—105.1(481A) Purpose. The purpose of this chapter is to establish special deer population management areas on selected properties managed by the department and county conservation boards or located in specific cities or in other government jurisdictions to ensure the harvest of a specific number of deer to reduce economic and biological damage caused by high deer populations.

571—105.2(481A) Definitions.

"Area" means recreation areas as designated in 571—61.2(461A).

"Department" means the department of natural resources.

"Special deer management zone" means defined units of public and private land.

"Urban" means areas mostly within incorporated city limits including county and state land.

571—105.3(481A) Designated areas.

105.3(1) State park and recreation areas.

105.3(2) Urban deer management units.

105.3(3) Iowa Army Ammunition Plant Deer Management Unit.

105.3(4) County park deer management units.

105.3(5) Special deer management zones.

571—105.4(481A) Conditions. The hunting of deer shall be permitted subject to the following conditions, limitations and procedures.

105.4(1) *State parks and recreation areas.*

a. Deer hunting on the area may occur only when approved by the natural resource commission and on dates established by the commission. Before presenting its recommendations to the commission, the department shall hold a public meeting in the vicinity of any state park or recreation area for the purpose of assessing the need for and interest in holding a deer population control hunt in that park or recreation area. A summary of public comments received at the meeting shall be included with other recommendations related to hunting the state park or recreation area.

b. Every hunter must have in possession a paid special antlerless-deer-only hunting license valid only for the specific state park or recreation area.

c. If the commission approves a hunting season, the commission shall establish the number of special antlerless-deer-only licenses valid only for each state park or recreation area which shall be valid only for the season specified.

d. The special licenses will be issued on a first-come, first-served basis at the specified locations on dates announced by the commission.

e. Special antlerless-deer-only licenses shall normally be limited to one per person, shall be issued to Iowa residents only and shall cost $25. The commission may establish procedures for issuing more than one license per person if quotas for any hunt do not fill. If more than one antlerless license is allowed, all antlerless licenses issued after the first license shall cost $10.

f. Only 10-, 12-, 16- or 20-gauge shotguns, shooting single slugs only, and flintlock and percussion cap lock muzzleloaded rifles or muskets of not less than .44 caliber nor larger than .775 caliber, shooting single projectiles only, or recurve, compound or longbows shooting broadhead arrows will be permitted.

g. All licensees shall attend a special meeting prior to hunting in a state park or recreation area to become familiar with boundaries, location of private lands, safety areas around buildings, access points, objectives of the hunt and other aspects of hunting on a special deer population management area.

h. All licensees who are successful during the hunt must check their deer at the designated headquarters prior to leaving the area.

i. For special youth educational hunts at state parks or recreation areas, licensing requirements for accompanying adults are the same as for youth deer hunts as established by 571—subrule 106.10(1).

105.4(2) *Urban deer management units.*

a. Special urban deer management units will be defined and seasons and method of take established upon request from the city or special deer task force and approved by the natural resource commission.

b. Deer hunting in the unit may occur only when approved by the natural resource commission according the number, type of license, and dates established by the commission.

c. Every hunter must have in possession a current paid special deer license for the city specified.

d. Special urban deer licenses shall cost $25 and shall be issued to Iowa residents only. The commission may establish procedures for issuing more than one license per person if quotas for any hunt do not fill. If more than one antlerless license is allowed, all antlerless licenses issued after the first license shall cost $10.

e. Cities, deer task forces, or other public entities may require hunters to do one or more of the following: pass a hunter safety and education course, pass a weapons proficiency test, or be approved by the appropriate police department or conservation officer.

f. Hunting in urban deer management units shall be limited to areas specified by the natural resource commission and city ordinance.

g. Other methods of deer removal in urban areas may be approved by the natural resource commission in cooperation with the city government.

105.4(3) *Iowa Army Ammunition Plant (IAAP) deer management unit.*

a. The deer management unit is defined as all federal land administered by the IAAP.

b. A maximum of 500 antlerless deer licenses shall be issued by the IAAP on a first-come, first-served basis.

c. Every hunter must have in possession a current paid special antlerless deer license for the IAAP only.

d. Special antlerless deer licenses will be valid for the IAAP only and must comply with all applicable regulations provided in 571—Chapter 106.

e. Special antlerless-only deer licenses for the IAAP deer management unit shall cost $25 and shall be issued to Iowa residents only. The commission may establish procedures for issuing more than one license per person if quotas for any hunt do not fill. If more than one antlerless license is allowed, all antlerless licenses issued after the first license shall cost $10.

f. All hunters must comply with IAAP requirements.

105.4(4) *County park deer management units.*

a. Deer hunting in the unit may occur only when approved by the natural resource commission according to the number, type of license, and dates established by the commission.

b. Every hunter must have in possession a paid special deer license valid only for the specified county park.

c. Special deer licenses valid only for specified county parks shall be issued for specified deer seasons and shall be valid only for the specified dates.

d. The special licenses issued for each season will be issued on a first-come, first-served basis at the location and dates announced by the natural resource commission.

e. The special deer licenses for each deer management area shall cost $25 and shall be issued to Iowa residents only. The commission may establish procedures for issuing more than one license per person if quotas for any hunt do not fill. If more than one antlerless license is allowed, all antlerless licenses issued after the first license shall cost $10.

f. Only 10-, 12-, 16- or 20-gauge shotguns, shooting single slugs only, and flintlock and percussion cap lock muzzleloaded rifles or muskets of not less than .44 caliber nor larger than .775 caliber, shooting single projectiles only, or archery equipment will be permitted.

g. County park managers may require licensees to pass a shooting proficiency test and attend a special meeting prior to hunting to become familiar with boundaries, location of private lands, safety areas around buildings, access points, objectives of the hunt and other aspects of hunting on a special deer population management area.

h. All licensees who are successful during the hunt must check their deer at the designated headquarters prior to leaving the area.

105.4(5) *Special deer management zones.*

a. Special deer management zones may be established as defined and approved by the natural resource commission.

b. The commission shall establish seasons, method of take and manner of issuing special antlerless-deer-only licenses valid only for each special deer management zone.

c. Every hunter must have in possession a current paid special antlerless-only deer license for the specified deer management zone.

d. The special deer zone licenses will be valid only for a specific deer management zone and hunters must comply with all applicable regulations provided in 571—Chapter 106.

e. Local authorities may implement additional requirements.

These rules are intended to implement Iowa Code sections 481A.38, 481A.39 and 481A.48.

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CHAPTER 281
CONTINUING EDUCATION FOR SOCIAL WORKERS

645—280.8(154C) Licensure by reciprocal agreement. The board may enter into a reciprocal agreement with the District of Columbia, any state, territory, province or foreign country with equal or similar requirements for licensure of social workers.

645—280.9(154C) License renewal.

280.9(1) The biennial license renewal period for a license to practice social work shall begin on January 1 of odd-numbered years and end on December 31 of the next even-numbered year. All licensees shall renew on a biennial basis.

280.9(2) At least 60 days prior to expiration of the license, the licensee shall be notified by mail that an on-line renewal application is available at the board's Internet address. Renewal applications are also available by mail upon request.

a. The required materials and the renewal fee are to be submitted to the board office 30 days before license expiration.

b. Individuals who were issued their initial licenses within six months of the license renewal date will not be required to renew their licenses until the next renewal two years later.

c. 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 27 hours of continuing education per biennium for each subsequent license renewal.

d. Persons licensed to practice social work shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.

e. Failure to receive the notice of renewal shall not relieve the licensee of the responsibility for submitting the required materials and the renewal fee to the board office 30 days before license expiration.

280.9(3) Mandatory reporting of child abuse and dependent adult abuse.

a. A licensee who regularly examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"f."*

b. A licensee who regularly examines, attends, counsels or treats dependent adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"f."*

c. A licensee who regularly examines, attends, counsels or treats both dependent adults and children in Iowa shall indicate on the renewal application completion of training in abuse identification and reporting in dependent adults and children or condition(s) for waiver of this requirement as identified in paragraph *"f."*

d. Training may be completed through separate courses as identified in paragraphs *"a"* and *"b"* or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse.

e. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs *"a"* to *"c,"* including program date(s), content, duration, and proof of participation.

f. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including waiver of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 281.

g. The board may select licensees for audit of compliance with the requirements in paragraphs *"a"* to *"e."*

280.9(4) Late renewal. If the renewal fee, continuing education report and renewal application are received within 30 days after the license expiration date, the late fee for failure to renew before expiration is charged.

280.9(5) When all requirements for license renewal are met, the licensee shall be sent a license renewal card by regular mail.

645—280.10(272C) Exemptions for inactive practitioners.

280.10(1) A licensee who is not engaged in practice in the state of Iowa may be granted a waiver of compliance and obtain a certificate of exemption upon written application to the board. For an LMSW or an LISW, the application shall contain a statement that the applicant will not engage in practice in the state of Iowa without first complying with all regulations governing reinstatement after exemption. For an LBSW, the application shall contain a statement that the applicant shall not hold the applicant out to be a licensed social worker. The application for a certificate of exemption shall be submitted upon the form provided by the board. A licensee must hold a current license to apply for exempt status. The licensee may apply for inactive status prior to the license expiration date.

280.10(2) Reinstatement of exempted, inactive practitioners. Inactive practitioners who have requested and been granted a waiver of compliance with the renewal requirements and who have obtained a certificate of exemption shall, prior to engaging in the practice of the profession in Iowa, satisfy the requirements for reinstatement as outlined in 645—281.10(154C,272C).

280.10(3) Licensees shall renew at the next scheduled renewal cycle. Licensees who were issued their reinstated licenses within six months prior to the renewal shall not be required to renew their licenses until the renewal date two years later.

280.10(4) Verifications of license(s) are required from any state in which the licensee has practiced since the Iowa license became inactive.

280.10(5) A new licensee who is on inactive status during the initial license renewal time period and reinstates before the first license expiration date will not be required to complete continuing education only for that first license renewal time period. Twenty-seven hours of continuing education will be required for every renewal thereafter.

280.10(6) Reinstatement of inactive license after exemption. The following chart illustrates the requirements for reinstatement based on the length of time a license has been inactive.

An applicant shall satisfy the following requirements:	First renewal	2 renewals
Submit written application for reinstatement to the board	Required	Required
Pay the current renewal fee	$60-LBSW $100-LMSW $120-LISW	$60-LBSW $100-LMSW $120-LISW
Pay the reinstatement fee	$50	$50
Successfully complete continuing education which includes three hours of social work ethics each biennium OR Successfully complete board-approved examination as deemed necessary by the board within one year prior to application	27 hours Board-approved examination	54 hours Board-approved examination
Total fees and continuing education hours required for reinstatement:	27 hours and $110-LBSW $150-LMSW $170-LISW	54 hours and $110-LBSW $150-LMSW $170-LISW

645—280.11(272C) Lapsed licenses.

280.11(1) If the renewal fee and continuing education report are received more than 30 days after the license expiration date, the license shall be lapsed. An application for reinstatement must be filed with the board accompanied by the reinstatement fee, the renewal fee(s) for each biennium the license is lapsed and the late fee for failure to renew before expiration. The licensee may be subject to an audit of the licensee's continuing education report.

280.11(2) Licensees who have not fulfilled the requirements for license renewal or for an exemption in the required time frame will have a lapsed license and shall not engage in the practice of social work. Practicing without a license may be cause for disciplinary action.

280.11(3) In order to reinstate a lapsed license, licensees shall comply with all requirements for reinstatement of a lapsed license as outlined in 645—281.6(154C).

280.11(4) After the reinstatement of the lapsed license, the licensee shall renew at the next scheduled renewal cycle and complete the continuing education required for the biennium.

280.11(5) Verifications of license(s) are required from any state in which the licensee has practiced since the Iowa license lapsed.

280.11(6) Reinstatement of a lapsed license. The following chart illustrates the requirements for reinstatement based on the length of time a license has lapsed.

An applicant shall satisfy the following requirements:	30 days after expiration date up to 1 renewal	2 renewals	3 renewals	4 renewals
Submit written application for reinstatement	Required	Required	Required	Required
Pay renewal fee(s)	$60-LBSW $100-LMSW $120-LISW	$120-LBSW $200-LMSW $240-LISW	$180-LBSW $300-LMSW $360-LISW	$240-LBSW $400-LMSW $480-LISW
Pay late fee	$50	$50	$50	$50
Pay the reinstatement fee	$50	$50	$50	$50
Satisfactorily complete continuing education requirements during the period since the license lapsed	27 hours	54 hours	81 hours	108 hours
Successfully pass the board-approved licensure examination	NA	NA	Required	Required
Total fees and continuing education hours required for reinstatement:	27 hours and $160-LBSW $200-LMSW $220-LISW	54 hours and $220-LBSW $300-LMSW $340-LISW	81 hours and $280-LBSW $400-LMSW $460-LISW	108 hours and $340-LBSW $500-LMSW $580-LISW

645—280.12(272C) Duplicate certificate or wallet card.

280.12(1) A duplicate wallet card or duplicate certificate shall be required if the current wallet card or certificate is lost, stolen or destroyed. A duplicate wallet card or duplicate certificate shall only be issued for such circumstances.

280.12(2) A duplicate wallet card or duplicate certificate shall be issued upon receipt of the completed application and receipt of the fee as specified in rule 645—284.1(147,154C).

280.12(3) If the board receives the completed application, stating that the wallet card or certificate was not received within 60 days after being mailed by the board, no fee shall be required to issue a duplicate wallet card or duplicate certificate.

645—280.13(17A,147,272C) License denial.

280.13(1) An applicant who has been denied licensure by the board may appeal the denial and request a hearing on the issues related to the licensure denial by serving a notice of appeal and request for hearing upon the board not more than 30 days following the date of mailing of the notification of licensure denial to the applicant. The request for hearing as outlined in these rules shall specifically describe the facts to be contested and determined at the hearing.

280.13(2) If an applicant who has been denied licensure by the board appeals the licensure denial and requests a hearing pursuant to this rule, the hearing and subsequent procedures shall be held pursuant to the process outlined in Iowa Code chapters 17A and 272C.

These rules are intended to implement Iowa Code chapters 17A, 147, 154C and 272C.

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281.4(3) *Review of programs.* Continuing education programs/activities shall be reported every year at the designated time as assigned by the board. The board may at any time reevaluate an approved sponsor. 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).

281.4(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. Course outline;
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.

281.4(5) *Voluntary relinquishment.* The approved sponsor may voluntarily relinquish sponsorship by notifying the board office in writing.

645—281.5(154C) Audit of continuing education report. After each educational biennium, the board may audit licensees to review compliance with continuing education requirements.

281.5(1) The board may audit a percentage of its licensees and may determine to audit a licensee at the discretion of the board. Licensees whose license renewal applications are submitted late (after the end of the compliance period) may be submitted for a continuing education audit.

281.5(2) The licensee shall make available to the board for auditing purposes the following information:

a. Date and location of course, course title, course description/detailed outline, course schedule, names and qualifications of instructors/speakers and method of presentation; or a program brochure which shows that the course content relates to the profession;

b. Number of contact hours for program attended; and

c. Certificate of completion or evidence of successful completion of the course from the course sponsor.

281.5(3) For auditing purposes, all licensees must retain the above information for two years after the biennium has ended.

281.5(4) Information identified in subrule 281.5(2) must be submitted within one month after the date of notification of the audit. An extension of time may be granted on an individual basis.

281.5(5) The licensee shall be notified if the submitted materials are incomplete or unsatisfactory. The licensees shall be given the opportunity to submit make-up credit to cover the deficit found through the audit if the board determines that the deficiency resulted despite the good-faith conduct on the part of the licensee. The deadline for receipt of the documentation for this make-up credit is within 90 days from the date of mailing to the licensee's last address on file at the board office.

281.5(6) Failure to complete the audit satisfactorily or falsification of information may result in board action as described in 645—Chapter 283.

281.5(7) Failure to notify the board of a current mailing address will not absolve the licensee from the audit requirement, and an audit must be completed before license renewal.

645—281.6(154C) 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 a 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 the late fee which has been assessed by the board for failure to renew;
4. Pays the reinstatement fee; and
5. Provides evidence of satisfactory completion of Iowa 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 27 (which includes three hours of social work ethics) by the number of bienniums since the license lapsed.
6. If the license has lapsed for more than two bienniums, the applicant shall successfully pass the board-approved licensure examination.

645—281.7(154C,272C) Continuing education waiver for active practitioners. A social worker licensed to practice social work 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 social worker.

645—281.8(154C,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 practice in Iowa without first complying with all regulations governing reinstatement after exemption. The application for an 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—281.9(154C,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—281.10(154C,272C) Reinstatement of inactive practitioners. Inactive practitioners who have been granted a waiver of compliance with these rules and obtained a certificate of exemption shall, prior to engaging in the practice of social work in the state of Iowa, satisfy the following requirements for reinstatement.

281.10(1) Submit written application for reinstatement to the board upon forms provided by the board;

281.10(2) Pay the reinstatement fee;

281.10(3) Pay the current renewal fee; and

281.10(4) Furnish in the application evidence of one of the following:

a. Completion of a total number of hours of approved continuing education computed by multiplying 27 (which includes three hours of social work ethics) by the number of bienniums a certificate of exemption shall be in effect for such applicant to a maximum of two bienniums; or

b. Successful completion of any or all parts of the board-approved licensure examination as deemed necessary by the board, successfully completed within one year immediately prior to the submission of such application for reinstatement.

645—281.11(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 and chapter 154C.

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TITLE VI
PROFESSIONAL REGULATION

CHAPTER 30
DISCIPLINE
[Prior to 5/18/88, Dental Examiners, Board of[320]]

650—30.1(153) General. The board has authority to impose discipline for any violation of Iowa Code title IV, chapter 272C, or the rules promulgated thereunder.

650—30.2(153) Methods of discipline. The board has authority to impose one or more of the following disciplinary sanctions:

1. Revocation of license or registration.
2. Suspension of license or registration until further order of the board or for a specified period.
3. Nonrenewal of license or registration.
4. Prohibit permanently, until further order of the board or for a specified period, the engaging in specified procedures, methods or acts.
5. Probation.
6. Require additional education or training.
7. Require clinical or written examination.
8. Order a physical, mental, or clinical evaluation.
9. Impose civil penalties not to exceed $10,000 where specifically provided by rules.
10. Issue citation and warning.
11. Such other sanctions allowed by law as may be appropriate.

650—30.3(153) Discretion of board. The following factors may be considered by the board in determining the nature and severity of the disciplinary sanction to be imposed:

1. The relative seriousness of the violation as it relates to assuring the citizens of this state a high standard of professional care.
2. The facts of the particular violation.
3. Any extenuating circumstances or other countervailing considerations.
4. Number of prior violations or complaints.
5. Seriousness of prior violations or complaints.
6. Whether remedial action has been taken.
7. Such other factors as may reflect upon the competency, ethical standards and professional conduct of the licensee or registrant.

650—30.4(147,153,272C) Grounds for discipline. The following shall constitute grounds for the imposition by the board of one or more of the disciplinary sanctions set forth in rule 650—30.2(153) specifically including the imposition of civil penalties not to exceed $10,000. This rule is not subject to waiver pursuant to 650—Chapter 7 or any other provision of law.

1. Fraud or deceit in procuring a resident dentist license, faculty permit, or license to practice dentistry or dental hygiene, or registration as a dental assistant, whether by examination or credentials. Fraud or deceit shall mean any false or misleading statement of a material fact or omission of information required to be disclosed.
2. Fraud or deceit in renewing a resident dentist license, faculty permit, or other license to practice dentistry or dental hygiene, or registration as a dental assistant, including but not limited to false or misleading statements concerning continuing education required for renewal.

3. Fraud in representation as to skill or ability whether by words or conduct, false or misleading allegations, or concealment of that which should have been disclosed, including but not limited to false or misleading statements contained in advertising allowed by these rules.

4. Conviction of a felony crime or conviction of a misdemeanor crime if the misdemeanor conviction relates to the practice of the profession.

5. Habitual use of drugs or intoxicants rendering unfit for practice.

6. Practicing dentistry, dental hygiene, or dental assisting while in a state of advanced physical or mental disability where such disability renders the licensee or registrant incapable of performing professional services or impairs functions of judgment necessary to the practice.

7. Improper sexual contact with, or making suggestive, lewd, lascivious or improper remarks or advances to a patient or a coworker.

8. Willful and gross malpractice.

9. Willful and gross neglect.

10. Obtaining any fee by fraud or misrepresentation.

11. Receiving or paying any fees for referral of patients.

12. Failure to pay fees required by these rules.

13. Unprofessional conduct including, but not limited to, those acts defined by Iowa Code section 153.32 or any violation of 650—Chapter 27.

14. Using or attempting to use any patient recall list, records, reprints or copies thereof, or any information gathered from patients served by a dental hygienist in the office of a prior employer unless such names appear on a recall list of the new employer through the legitimate practice of dentistry.

*15. Engaging in the practice of dentistry, dental hygiene, or dental assisting in Iowa after failing to renew a license or registration to practice in Iowa within 60 days of expiration of the license or registration.

16. Failure to maintain a satisfactory standard of competency.

17. Failure to maintain adequate safety and sanitary conditions for a dental office.

18. Indiscriminately or promiscuously prescribing or dispensing any drug or prescribing or dispensing any drug for other than lawful purposes.

19. Encouraging, assisting or enabling the unauthorized practice of dentistry, dental hygiene, or dental assisting in any manner.

20. Associating with a dental laboratory or technician where the dentist delegates or permits the assumption by the dental laboratory or dental laboratory technician of any service constituting the practice of dentistry or where the laboratory or technician holds itself out to the public in any way as selling, supplying, furnishing, constructing, repairing or altering prosthetic dentures, bridges, ortho dontic or other appliances or devices to be used as substitutes for or as part of natural teeth or associated structures, or for correction of malocclusions or deformities.

21. Failure to prominently display the names of all persons who are practicing dentistry, dental hygiene, or dental assisting within an office.

22. Employment of or permitting an unlicensed or unregistered person to practice dentistry, dental hygiene, or dental assisting.

23. Failure to comply with the decision of the board imposing discipline.

*24. Failure to report any of the following:

Any acts or omissions which could result in discipline of a licensee or registrant when committed by a person licensed or registered to practice dentistry, dental hygiene, or dental assisting.

Every adverse judgment in a professional malpractice action to which the licensee or registrant was a party.

Every settlement of a claim against the licensee or registrant alleging malpractice.

Every conviction or violation of law or statute of this or another state as set forth in paragraph 30.4"4."

*August 25, 2004, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held August 11, 2004.

25. Rescinded IAB 2/6/02, effective 3/13/02.

26. Knowingly providing false information to the board or an agent of the board during the course of an inspection or investigation or interfering with an inspection or investigation.

*27. In a case that has been referred by the Iowa practitioner review committee (IPRC) to the board, violating the terms of an initial agreement with the IPRC or a recovery contract entered into with the IPRC.

28. Violating any provision of Iowa law, or being a party to or assisting in any violation of any provision of Iowa law.

29. Any willful or repeated violations of Iowa law, or being a party to or assisting in any violation of any provision of Iowa law.

30. Knowingly submitting a false continuing education reporting form or failure to meet the continuing education requirements for renewal of an active license or registration.

31. Failure to notify the board of change of address within 60 days.

32. Failure to report a license or registration revocation, suspension or other disciplinary action taken by a licensing authority of another state, territory or country within 30 days of the final action by the licensing authority. A stay by an appellate court shall not negate this requirement; however, if the disciplinary action is overturned or reversed by a court of last resort, the report shall be expunged from the records of the board when the board is so notified.

33. Failure to comply with a subpoena issued by the board.

34. Engaging in the practice of dentistry, dental hygiene, or dental assisting with an expired or inactive renewal.

*35. Failure to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as required or recommended for dentistry by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

36. Failure to comply with the recommendations of the expert review panel established pursuant to Iowa Code subsection 139C.2(3) and applicable hospital protocols established pursuant to subsection 139C.2(1).

37. Failure to comply with the infection control standards which are consistent with the standards set forth in 875—Chapters 10 and 26.

38. Failure to fully and promptly comply with office inspections conducted at the request of the board to determine compliance with sanitation and infection control standards.

39. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the licensee's or registrant's profession or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

40. Habitual intoxication or addiction to the use of drugs.

41. Noncompliance with a support order or with a written agreement for payment of support as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 252J. Disciplinary proceedings initiated under this subrule shall follow the procedures set forth in Iowa Code chapter 252J and Iowa Administrative Code 650—Chapter 33.

42. Receipt of a certificate of noncompliance issued by the college student aid commission pursuant to Iowa Code sections 261.121 to 261.127. Disciplinary proceedings initiated under this subrule shall follow the procedures set forth in Iowa Code sections 261.121 to 261.127 and Iowa Administrative Code 650—Chapter 34.

43. Practicing beyond training.

44. Delegating any acts to any licensee or registrant that are beyond the training or education of the licensee or registrant, or that are otherwise prohibited by rule.

*August 25, 2004, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held August 11, 2004.

650—30.5(153) Impaired practitioner review committee. Transferred IAB 2/6/02, effective 3/13/02. See 650—Chapter 35.

These rules are intended to implement Iowa Code sections 261.121 to 261.127 and Iowa Code chapters 147, 153, 252J, 272C, and 598.

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31.7(2) The dental hygiene committee shall determine which peer review committee will review a case involving a dental hygienist and what complaints or other matters shall be referred to a peer review committee for investigation, review, and report to the dental hygiene committee. The dental hygiene committee may use the peer review system organized under the ethics committee of the Iowa dental hygienists' association or a specifically constituted peer review committee designated by the dental hygiene committee for matters involving dental hygienists.

31.7(3) The Iowa dental association, the Iowa dental hygienists' association and the Iowa dental assistants association shall register yearly and keep current their peer review systems with the board. Peer review committee members shall be registered with the board when appointed.

31.7(4) Members of the peer review committees shall not be liable for acts, omissions or decisions made in connection with service on the peer review committee. However, immunity from civil liability shall not apply if the act is done with malice.

650—31.8(272C) Duties of peer review committees.

31.8(1) The peer review committees shall observe the requirements of confidentiality imposed by Iowa Code section 272C.6.

31.8(2) The board may provide investigative and related services to peer review committees.

31.8(3) A peer review committee shall thoroughly investigate a complaint as assigned and provide a written report to the board in accordance with the board's direction.

31.8(4) The peer review report shall contain a statement of facts and a recommendation as to whether a violation of the standard of care occurred. The peer review committee should consider relevant statutes, board rules, ethical standards and standards of care in making its recommendations.

31.8(5) The peer review report shall be signed by the members of the peer review committee concurring in the report.

31.8(6) Upon completion, the peer review report and all investigative information shall be submitted to the board.

650—31.9(272C) Board review. The board shall review all investigative reports and proceed pursuant to 650—Chapter 51.

650—31.10(272C) Confidentiality of investigative files. Complaint files, investigation files, all other investigation reports, and other investigative information in the possession of the board or peer review committee acting under the authority of the board or its employees or agents which relate to licensee or registrant discipline shall be privileged and confidential, and shall not be subject to discovery, subpoena, or other means of legal compulsion for their release to any person other than the licensee or registrant and the board, its employees and agents involved in licensee or registrant discipline, or be admissible in evidence in any judicial or administrative proceeding other than the proceeding involving licensee or registrant discipline. However, a final written decision and finding of fact of the board in a disciplinary proceeding shall be public record.

650—31.11(272C) Reporting of judgments or settlements. Each licensee or registrant shall report to the board every adverse judgment in a malpractice action to which the licensee or registrant is a party and every settlement of a claim against the licensee or registrant alleging malpractice. The report together with a copy of the judgment or settlement must be filed with the board within 30 days from the date of said judgment or settlement.

650—31.12(272C) Investigation of reports of judgments and settlements. Reports received by the board from the commissioner of insurance, insurance carriers and licensees or registrants involving adverse judgments in a professional malpractice action, and settlement of claims alleging malpractice, shall be reviewed and investigated by the board in the same manner as is prescribed in these rules for the review and investigation of complaints.

650—31.13(272C) Mandatory reporting.

31.13(1) *Definitions.* For the purposes of this rule, the following definitions apply:

"Knowledge" means any information or evidence acquired from personal observation, from a reliable or authoritative source, or under circumstances that cause the licensee or registrant to believe that there exists a substantial likelihood that an act or omission may have occurred.

"Reportable act or omission" means any conduct that may constitute a basis for disciplinary action under the rules or statutory provisions governing the practice of dentistry, dental hygiene, or dental assisting in Iowa.

31.13(2) *Reporting requirement.* A report shall be filed with the board when a licensee or registrant has knowledge that another person licensed or registered by the board may have committed a reportable act or omission.

a. The report shall be filed with the board within seven days from the date the licensee or registrant acquires knowledge of the reportable act or omission.

b. The report shall contain the name and the address of the licensee or registrant who may have committed the reportable act or omission, the date, time, place and circumstances in which the reportable act or omission may have occurred, and a statement indicating how the knowledge was acquired.

c. The requirement to report takes effect when a licensee or registrant has knowledge that another licensee or registrant may have committed a reportable act or omission. The final determination of whether or not such act or omission has occurred is the responsibility of the board.

31.13(3) *Failure to report.* Failure to report knowledge of a reportable act or omission within the required seven-day period shall constitute a basis for the initiation of a board disciplinary action against the licensee or registrant who failed to report.

***650—31.14(272C) Failure to report licensee or registrant.** Upon obtaining information that a licensee or registrant failed to file a report required by rule 31.13(272C) within seven days from the date the licensee or registrant acquired the information, the board may initiate a disciplinary proceeding against the licensee or registrant who failed to make the required report.

*August 25, 2004, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held August 11, 2004.

650—31.15(272C) Immunities. A person shall not be civilly liable as a result of filing a report or complaint with the board, or for the disclosure to the board or its agents or employees, whether or not pursuant to a subpoena of records, documents, testimony or other forms of information which constitute privileged matter concerning a recipient of health care services or some other person, in connection with proceedings of a peer review committee, or in connection with duties of the board. However, immunity from civil liability shall not apply if the act is done with malice.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and Iowa Code sections 153.33, 272C.3, and 272C.4.

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40.14(422) Contract sales
40.15(422) Reporting of incomes by married taxpayers who file a joint federal return but elect to file separately for Iowa income tax purposes
40.16(422) Income of nonresidents
40.17(422) Income of part-year residents
40.18(422) Net operating loss carrybacks and carryovers
40.19(422) Casualty losses
40.20(422) Adjustments to prior years
40.21(422) Additional deduction for wages paid or accrued for work done in Iowa by certain individuals
40.22(422) Disability income exclusion
40.23(422) Social security benefits
40.24(99E) Lottery prizes
40.25(422) Certain unemployment benefits received in 1979
40.26(422) Contributions to the judicial retirement system
40.27(422) Incomes from distressed sales of qualifying taxpayers
40.28 Reserved
40.29(422) Intangible drilling costs
40.30(422) Percentage depletion
40.31(422) Away-from-home expenses of state legislators
40.32(422) Interest and dividends from regulated investment companies which are exempt from federal income tax
40.33(422) Partial exclusion of pensions and annuities for retired and disabled public employees
40.34(422) Exemption of restitution payments for persons of Japanese ancestry
40.35(422) Exemption of Agent Orange settlement proceeds received by disabled veterans or beneficiaries of disabled veterans
40.36(422) Exemption of interest earned on bonds issued to finance beginning farmer loan program
40.37(422) Exemption of interest from bonds issued by the Iowa comprehensive petroleum underground storage tank fund board
40.38(422) Capital gains deduction or exclusion for certain types of net capital gains
40.39(422) Exemption of interest from bonds or notes issued to fund the E911 emergency telephone system
40.40(422) Exemption of active-duty military pay of national guard personnel and armed forces reserve personnel received for services related to operation desert shield
40.41(422) Disallowance of private club expenses
40.42(422) Depreciation of speculative shell buildings
40.43(422) Retroactive exemption for payments received for providing unskilled in-home health care services to a relative
40.44(422,541A) Individual development accounts
40.45(422) Exemption for distributions from pensions, annuities, individual retirement accounts, and deferred compensation plans received by nonresidents of Iowa
40.46(422) Taxation of compensation of nonresident members of professional athletic teams
40.47(422) Partial exclusion of pensions and other retirement benefits for disabled individuals, individuals who are 55 years of age or older, surviving spouses, and survivors
40.48(422) Health insurance premiums deduction
40.49(422) Employer social security credit for tips
40.50(422) Computing state taxable amounts of pension benefits from state pension plans
40.51(422) Exemption of active-duty military pay of national guard personnel and armed forces military reserve personnel for overseas services pursuant to military orders for peacekeeping in the Bosnia-Herzegovina area
40.52(422) Mutual funds

701—39.3(422) Form for filing.

39.3(1) *Use of and completeness of prescribed forms.* Returns shall, in all cases, be made by residents and nonresidents on forms supplied by the department of revenue and finance. Taxpayers not supplied with the proper forms shall make application for the forms to the department, in ample time to have their returns made, verified and filed on or before the due date. Each taxpayer shall carefully prepare a return so as to fully and clearly set forth the data required. For lack of a prescribed form, a statement made by a taxpayer disclosing gross income and the deductions from gross income may be accepted as a tentative return, and if verified and filed within the prescribed time, will relieve the taxpayer from liability to penalties, provided that without unnecessary delay a tentative return is replaced by a return made on the proper form. Each question shall be answered and each direction complied with in the same manner as if the forms and instructions were embodied in these regulations. Individual resident taxpayers shall enter the name of the school district of residence on the return. If the school district is not supplied, the return shall be deemed incomplete.

A return not signed by the taxpayer or the taxpayer's agent or guardian, shall not be deemed completely executed and filed as required by law.

Failure to receive the proper form does not relieve the taxpayer from the obligation of making any return required by statute.

39.3(2) *Optional method of filing.* The front and back page of the Iowa individual income tax return, if properly completed, may be filed as an optional return, if a complete facsimile or photocopy of the federal return and supporting schedules are attached.

39.3(3) *Copy of federal income tax return to be filed by nonresident.* A nonresident taxpayer must file a copy of their federal income tax return for the current tax year with their Iowa income tax return. The copy shall include full and complete copies of all farm, business, capital gains and other schedules that were filed with the federal return.

39.3(4) *Amended returns.* If it becomes known to the taxpayer that the amount of income reported to be federal net income or Iowa taxable income was erroneously stated on the Iowa return, or changed by an Internal Revenue Service audit, or otherwise, the taxpayer shall file an amended Iowa return along with supporting schedules, to include the amended federal return if applicable. A copy of the federal revenue agent's report and notification of final federal adjustments provided by the taxpayer will be acceptable in lieu of an amended return. The assessment or refund of tax shall be dependent on the statute of limitations as set forth in 701—subrule 38.2(1) and rule 701—43.3(422).

39.3(5) *Voter's registration forms in income tax booklets and income tax return instructions.* Effective for tax years beginning on or after January 1, 1989, income tax return booklets and income tax return instructions shall include two voter registration forms. The voter registration forms to be inserted into the income tax return instruction forms and booklets are to be designed by the voter registration commission. However, effective July 1, 1992, the voter registration forms are to be inserted in the income tax return booklets and income tax return instructions only for odd-numbered tax years. Thus, the voter registration forms will not be included in the income tax return booklets for the 1992 tax year but are to be included in the booklets for 1993.

Effective July 1, 2004, the requirement that voter registration forms be included in the income tax booklets and income tax instructions has been eliminated. The official Web site of the department includes the official electronic state of Iowa voter registration form and a link to the Iowa secretary of state's official Web site.

This rule is intended to implement Iowa Code sections 422.13, 422.21 and 422.22 and Iowa Code sections 48A.24 and 421.17 as amended by 2004 Iowa Acts, Senate File 2296.

701—39.4(422) Filing status.

39.4(1) *Single taxpayers.* The term "single person" includes, for income tax purposes, an unmarried person, a person legally separated under a decree of divorce or separate maintenance or any other person not properly classified under subrules 39.4(2) through 39.4(8).

39.4(2) *Married taxpayers.* A taxpayer is considered married for the entire year if on the last day of the tax year the taxpayer is *(a)* married and living together with the taxpayer's spouse, *(b)* married and living apart from the spouse, but not legally separated under a decree of divorce or separate maintenance, *(c)* living together with the spouse in a common law marriage that is recognized by the state where the common law marriage exists or *(d)* widowed but the spouse died during the year.

39.4(3) *Common law marriage.* A common law marriage is a social relationship between a man and a woman that meets all the necessary requisites of a marriage except that it was not solemnized, performed or witnessed by an official authorized by law to perform marriages. The necessary elements of a common law marriage are: *(a)* a present intent of both parties freely given to become married, *(b)* a public declaration by the parties or a holding out to the public that they are husband and wife, *(c)* continuous cohabitation together as husband and wife (this means consummation of the marriage), and *(d)* both parties must be capable of entering into the marriage relationship. No special time limit is necessary to establish a common law marriage. Iowa recognizes, for income tax purposes, all valid common law marriages.

39.4(4) *Married filing jointly.* Married taxpayers who file a joint return with the Internal Revenue Service may file a joint return with the Iowa department of revenue and finance.

39.4(5) *Married filing separately on the same form.* Married taxpayers may file separately on the same form. This return is also known as the combined return. If a married taxpayer files a combined return with his or her spouse, any refund will be issued in both names.

39.4(6) *Married filing separately.* Married taxpayers, each having income in his or her own right, may file separate returns if they do not wish to file separately on the same form.

39.4(7) *Head of household.* The term *"head of household"* denotes a single individual and shall have the same meaning as defined in the Internal Revenue Code as defined in the Iowa Code. An individual who is claiming "surviving spouse" status for federal income tax purposes may not claim "head of household" on the Iowa individual income tax return.

39.4(8) *Surviving spouse.* The term "surviving spouse" shall have the same meaning as defined in the Internal Revenue Code. Individuals who qualify and file as a qualifying widow(er) with a dependent child on the federal return may file using the same filing status on the Iowa return.

This rule is intended to implement Iowa Code section 422.12.

701—39.5(422) Payment of tax.

39.5(1) *Payment of tax for wage earners.* Withholding of tax on wage earners is required under Iowa Code section 422.16. See 701—Chapter 46.

39.5(2) *Payment of tax on income not subject to withholding.* Those taxpayers with income not subject to withholding which will produce a tax liability of $50 or more, shall file and pay a declaration of estimated tax. See 701—Chapter 47 of the rules.

39.5(3) *Full estimated payment on original due date.* When an extension is requested as provided by Iowa Code section 422.21, the total amount of estimated tax must be paid on or before the due date for filing the return.

39.5(4) *Balance of tax due.* If the computation on the tax return shows additional tax due, it shall be paid in full with the filing of the return.

39.5(5) *Payment of tax by uncertified checks.* The department will accept uncertified checks in payment of income taxes, provided the checks are collectible for their full amount without any deduction for exchange or other charges. The date on which the department receives the check will be considered the date of payment, so far as the taxpayer is concerned, unless the check is returned dishonored. If one check is remitted to cover two or more individuals' taxes, the remittance must be accompanied by a letter of transmittal stating: *(a)* the name of the drawer of the check; *(b)* the amount of the check; *(c)* the amount of any cash, money order or other instrument included in the same remittance; *(d)* the name of each individual whose tax is to be paid by the remittance; and *(e)* the amount of payment on account of each individual.

When a state income tax return or claim for refund is filed for forgiveness of tax for an individual who was killed in military or terrorist action, a notation should be entered at the top of the return "Forgiveness of Tax—Killed in Military Action" or "Forgiveness of Tax—Killed in Terrorist Action" depending on how the individual was killed. In addition, a copy of the death certificate, or other evidence of the person's death or evidence establishing that the individual is missing in action and presumed dead, should be attached to the claim for refund or the tax return. A refund claim for forgiveness of tax will be honored only if the claim is made within the statute of limitations for refund provided in Iowa Code subsection 422.73(2).

This rule is intended to implement Iowa Code sections 422.5 and 422.73.

701—39.12(422) Tax benefits for persons in the armed forces serving in a combat zone or a qualified hazardous duty area or deployed outside the United States in a contingency operation. For tax years ending after August 2, 1990, a number of state tax benefits are authorized for persons in the armed forces who serve in an area designated by the President and the Congress as a combat zone. Similar state tax benefits are also authorized for persons who serve in an area designated by the President and the Congress as a qualified hazardous duty area for tax years beginning on or after January 1, 1999. In addition, uniform state tax benefits are authorized for persons in the armed forces of the United States who were deployed outside the United States in an operation designated by the Secretary of Defense as a contingency operation as defined in 10 U.S.C. § 101(a)(13), or which became a contingency operation by the operation of law. Persons who were deployed in a contingency operation who ceased to participate in such operation on or after May 21, 2003, are considered to be eligible individuals for purposes of being granted additional time to perform certain acts with the department to the extent the period for performing an act did not expire prior to May 21, 2003, or a later date if the person ceased to participate in the contingency operation on a date after May 21, 2003. Those persons who were serving in support of the armed forces personnel in a combat zone or those persons who were serving in support of armed forces personnel in a qualified hazardous duty area are also eligible for the state tax benefits. The eligible individuals are given the same additional time period to file state income tax returns and perform other acts related to the department of revenue as would constitute timely filing of returns or timely performance of other acts as described in Section 7508(a) of the Internal Revenue Code. "Other acts related to the department" includes filing claims for refund for any type of tax administered by the department, making tax payments other than withholding payments, filing appeals on tax matters, filing returns for taxes other than income tax, and performing other acts such as making timely contributions to individual retirement accounts. The additional time period for filing returns and performing other acts applies to the spouse of the person who was in the combat zone or the qualified hazardous duty area or the spouse of a person who was serving in support of persons in the combat zone or the hazardous duty area to the extent the spouse files jointly or separately on the combined return with the person who was in the combat zone or the hazardous duty area, or when the spouse is a party with the person who was serving in support of persons in the combat zone or hazardous duty area to any tax matter with the department for which the additional time period is allowed. The additional time period for filing state returns and performing other acts is 180 days after the person leaves the combat zone or hazardous duty area or ceases to participate in the contingency operation which is the same time period as allowed in federal income tax law. However, a person who was hospitalized because of illness or injury in the combat zone or the hazardous duty area has up to five years to file returns or perform certain acts with this department after leaving the combat zone or hazardous duty area.

For tax years beginning on or after January 1, 1995, certain persons performing peacekeeping duties in a location designated by Congress as a qualified hazardous duty area or other individuals performing military duties overseas in support of the persons in the hazardous duty area are eligible for the tax benefits described above. See rule 39.14(422) for additional information on the Bosnia-Herzegovina hazardous duty area.

This rule is intended to implement Iowa Code sections 422.3 and 422.21 as amended by 2003 Iowa Acts, House File 674.

701—39.13(422) Electronic filing of Iowa individual income tax returns. Electronic filing allows individuals who meet qualifications set out by the department to file their Iowa income tax returns electronically. All information is electronically transmitted. Nothing is submitted on paper, unless specifically requested by the department. A taxpayer's electronic Iowa return will include the same information as if the taxpayer had filed a paper Iowa return.

There is no statutory requirement that provides that individuals must file their Iowa income tax return electronically; therefore, taxpayers have the option to file by paper. The department may provide a variety of paperless filing options and will determine the criteria for each option on an annual basis. These options may include electronic filing, TeleFiling, or WebFiling.

39.13(1) *Definitions.* For the purpose of this rule, the following definitions apply, unless the context otherwise requires:

"Acknowledgment (ACK)" means a report generated by the department and sent to a transmitter indicating receipt of all transmissions.

"Declaration control number (DCN)" means a unique 14-digit number assigned by the ERO or transmitter to each electronic return.

"Department" means the Iowa department of revenue.

"Direct deposit" means an electronic transfer of a refund into a taxpayer's financial institution account.

"Electronic filing" means any paperless filing option approved by the department, including federal/state electronic filing (piggyback), federal/state electronic filing (state-only), TeleFile, and WebFile.

"Electronic return originator (ERO)" means an entity that originates the electronic submission of income tax returns.

"Federal/state electronic filing (piggyback)" means a process that allows the federal and state income tax returns to be simultaneously filed electronically.

"Federal/state electronic filing (state-only)" means a process that allows the Iowa income tax return to be filed electronically without filing the federal return, but an electronic copy of the federal information is still sent to Iowa. Current-year amended returns may also be filed using this process.

"IA 8453" means a taxpayer declaration form that authenticates the electronic IA 1040, authorizes its transmission, and designates payment method of any refund, including consent to direct deposit if requested.

"PIN signature alternative" means a process that allows filing a completely paperless tax return. The 5-digit PIN number is selected by the taxpayer and input by the ERO.

"Software developer" means an E-file provider that, according to IRS and Iowa specifications, develops software for the purposes of formatting electronic portions of returns or transmitting the electronic portions of returns directly to the IRS, or both. A software developer may also sell its software.

"Stockpiling" means collecting returns from taxpayers or from other electronic filers and waiting more than three calendar days to transmit the returns to the department after receiving the information necessary for transmission.

"TeleFile" means a process that allows taxpayers to file Iowa income tax returns by telephone.

"Transmitter" means an E-file provider that transmits electronic portions of returns directly to the IRS.

"WebFile" means a process that allows taxpayers to file Iowa tax returns over the Internet at the department's Web site.

39.13(2) *Completion of the electronic return.* All amounts must be in whole dollars and must match the information on the electronic record for the return. The DCN on the state return must match that used on the taxpayer's federal return when filing piggyback. The department has adopted the PIN signature alternative as implemented by the IRS. If the ERO elects not to use this signature alternative, the IA 8453 must be completed, signed by the preparer, ERO, and taxpayer(s) and retained by the preparer. The PIN signature alternative is not an option for state-only returns.

If the ERO makes changes to the electronic return after the taxpayer(s) has signed the return but before it is transmitted, and the net income differs by more than $50 or any of the other amounts on the IA 8453 differ by more than $14, a new form must be completed and signed by the taxpayer(s) before the return is transmitted.

The ERO must provide the taxpayer with the following information: copy of the data transmitted, copies of the IA 8453, W-2s, 1099s, and any other schedules. The ERO should also provide a payment voucher and mailing address, if applicable.

The taxpayer and ERO shall retain all tax documentation for three years. The IA 8453 must be signed by the taxpayer(s), preparer and ERO unless the PIN signature alternative is used. The IA 8453 and accompanying schedules are to be furnished to the department only when specifically requested.

In situations in which the ERO ceases operation, the ERO is required to send the IA 8453 forms and all supporting documents to the department, if the income tax return is dated within three years from the due date or date filed. If the ERO is unable to retain the IA 8453 forms and all supporting documents, the ERO may request permission to deliver them to the department.

39.13(3) *Direct deposit.* Taxpayers may designate direct deposit of the Iowa refund on electronically filed returns. Taxpayers must provide proof of account ownership to the ERO. The department is not responsible for the misapplication of a direct deposit of a refund caused by error, negligence, or wrongdoing on the part of the taxpayer, electronic filer, financial institution or any agent of the above. The account designated to receive the direct deposit must be in the taxpayer's name. If the taxpayer's filing status on the return is "married filing a joint return" or "married filing separately on this combined return," the account may be in either spouse's name or both spouses' names. If the filing status is married filing separately, the account may be in the taxpayer's name or may be a joint account in both spouses' names. If the filing status is "married filing separate returns," a direct deposit cannot be made if the account is only in the name of the other spouse.

The taxpayer's signature or taxpayers' signatures on the IA 8453 provide irrevocable approval of a direct deposit. Once the return has been transmitted, the direct deposit information may not be corrected. The department may, when processing procedures require, convert a request for direct deposit to a paper warrant. If refunds are sent to an incorrect bank account, the department will issue a paper refund check once the funds are returned by the financial institution.

39.13(4) *Software approval.* Software developers are required to submit a letter of intent, including the name, address, and telephone number of a contact person and a copy of IRS Form 8633 (Application to Participate in the Electronic Filing Program) in order to be considered for participation in the Iowa electronic filing program. The department will provide an application form, specifications, test package and procedures for companies wishing to develop software for electronic filing of Iowa returns. Specifications for the software developers are explained in IRS Publication 1346 and Iowa Publication 16-107, "Electronic Return File Specifications and Record Layouts." The developers will also be provided with test data and instructions so that developers may test their programs for processing electronic returns with the department. Software developers are required to pass transmission tests before the developers' software will be approved for electronic filing of Iowa income tax returns. The test period shall be defined annually by the department.

39.13(5) *ERO approval.* Only returns transmitted by EROs that are approved by the IRS will be accepted by the department. Once accepted by the IRS as an ERO for a specific tax year, the ERO is automatically accepted to file Iowa returns. There is no additional notification or approval process required by the department.

39.13(6) *Suspension of an electronic filer from participation in the Iowa electronic filing program.* The department may immediately suspend, without notice, an electronic filer from the Iowa electronic filing program. However, in most cases, a suspension from the Iowa electronic filing program is effective as of the date of the letter informing the electronic filer of the suspension. Before suspending an electronic filer, the department may issue a warning letter which describes specific corrective action required because of deviations from this rule.

If an electronic filer is either denied participation in the federal electronic filing program or is suspended from the federal program, the electronic filer shall automatically be prohibited from participation in the Iowa electronic filing program.

An electronic filer who is eligible to participate in the federal electronic filing program may be suspended from the Iowa electronic filing program if the electronic filer has allowed any of the following conditions to occur. This list is not all-inclusive.

a. Deterioration in the format of transmissions of individual Iowa returns;

b. Unacceptable cumulative error or rejection rate or failure to correct errors in transmission of Iowa returns;

c. Untimely received, illegible, incomplete, missing, or unapproved substitute IA 8453 forms;

d. Stockpiling returns at any time while participating in the Iowa electronic filing program;

e. Failure on the part of the transmitter to retrieve an acknowledgment file within two working days of transmission by the department;

f. Failure on the part of the transmitter to initiate the communication of acknowledgment files to the electronic return originator (ERO) within two working days of transmission by the department;

g. Significant complaints about the electronic filer;

h. Failure on the part of the electronic filer to cooperate with the department's efforts to monitor electronic filers, investigate electronic filing abuse, and investigate the possible filing of fraudulent returns;

i. Submitting the electronic portion of a return with information which is not identical to information on the IA 8453;

j. Transmitting the Iowa return with software that was not approved for use in the Iowa electronic filing program;

k. Failure on the part of the electronic filer to provide W-2s, 1099s, or out-of-state tax returns when requested.

39.13(7) *Administrative procedure for denial of an electronic filer's participation in the Iowa electronic filing program or for suspension of an electronic filer from the Iowa electronic filing program.* In a situation in which an electronic filer has requested participation in the Iowa electronic filing program but there is a reason to deny the electronic filer's participation, the department will send the electronic filer a letter to advise that the electronic filer will be denied entry into the program. In another situation in which an electronic filer is a participant in the Iowa electronic filing program but the electronic filer is to be suspended from the program for any conditions described in subrule 39.13(6), the department will send the electronic filer a letter to notify the filer about the electronic filer's suspension from the program.

In cases in which the electronic filer either disagrees with the denial of participation letter or the suspension from participation letter, the electronic filer must file a written protest to the department within 60 days of the date of the denial letter or the suspension letter. The written protest must be filed pursuant to rule 701—7.41(17A). During the administrative review process, the denial of an electronic filer's participation in or the suspension of an electronic filer from the Iowa electronic filing program will remain in effect.

This rule is intended to implement Iowa Code sections 422.21 and 422.68.

701—39.14(422) Tax benefits for persons serving in support of the Bosnia-Herzegovina hazardous duty area. For tax years beginning on or after January 1, 1995, a number of state tax benefits are authorized for individuals serving in a location designated by the President and Congress as a qualified hazardous duty area or other persons serving in support of the individuals in the hazardous duty area. Public Law No. 104-117 was enacted by Congress on March 20, 1996, and designated Bosnia, Herzegovina, Croatia, and Macedonia as a qualified hazardous duty area so that troops performing peacekeeping duties in the area would be eligible for tax benefits for federal income tax purposes on the same basis they would have been eligible for the same benefits if they had served in a combat zone under prior law.

For Iowa tax purposes, persons serving peacekeeping duties in the hazardous duty area or other persons serving overseas in support of the persons in the hazardous duty area will be eligible for the same tax benefits that were previously only available to persons serving military duties in a combat zone. The tax benefits that are available for persons serving in the hazardous duty area or persons serving overseas in support of the persons in the hazardous duty area are described in rule 39.12(422).

This rule is intended to implement Iowa Code section 422.3 as amended by 1996 Iowa Acts, Senate File 2168.

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CHAPTER 40
DETERMINATION OF NET INCOME
[Prior to 12/17/86, Revenue Department[730]]

701—40.1(422) Net income defined. Net income for state individual income tax purposes shall mean federal adjusted gross income as properly computed under the Internal Revenue Code and shall include the adjustments in 40.2(422) to 40.10(422). The remaining provisions of this rule and 40.12(422) to 40.65(422) shall also be applicable in determining net income.

This rule is intended to implement Iowa Code section 422.7.

701—40.2(422) Interest and dividends from federal securities. For individual income tax purposes, the state is prohibited by federal law from taxing dividends from corporations owned or sponsored by the federal government, or interest derived from obligations of the United States and its possessions, agencies, and instrumentalities. Therefore, if the federal adjusted gross income of an individual, taxable by Iowa, includes dividends or interest of this type, an adjustment must be made by deducting the amount of the dividend or interest. If the inclusion of an amount of income or the amount of a deduction is based upon federal adjusted gross income and federal adjusted gross income includes dividends from corporations owned or sponsored by the federal government, or interest derived from obligations of the United States and its possessions, agencies, and instrumentalities, a recomputation of the amount of income or deduction must be made excluding dividends or interest of this type from the calculations.

A federal statute exempts stocks and obligations of the United States Government, as well as the interest on the obligations, from state income taxation (see 31 USCS Section 3124(a)).

"Obligations of the United States" are those obligations issued "to secure credit to carry on the necessary functions of government." *Smith v. Davis* (1944) 323 U.S. 111, 119, 89 L.Ed. 107, 113, 65 S.Ct. 157, 161. The exemption is aimed at protecting the "borrowing" and "supremacy" clauses of the United States Constitution. *Society for Savings v. Bowers* (1955) 349 U.S. 143, 144, 99 L.Ed.2d 950, 955, 75 S.Ct. 607, 608; *Hibernia v. City and County of San Francisco* (1906) 200 U.S. 310, 313, 50 L.Ed. 495, 496, 26 S.Ct. 265, 266.

Tax-exempt credit instruments possess the following characteristics:

1. They are written documents,
2. They bear interest,
3. They are binding promises by the United States to pay specified sums at specified dates, and
4. They have Congressional authorization which also pledges the faith and credit of the United States in support of the promise to pay. *Smith v. Davis*, supra.

A governmental obligation that is secondary, indirect, or contingent, such as a guaranty of a nongovernmental obligor's primary obligation to pay the principal amount of and interest on a note, is not an obligation of the type exempted under 31 USCS Section 3124(1). *Rockford Life Ins. Co. v. Department of Revenue*, 107 S.Ct. 2312 (1987).

The following list contains widely held United States Government obligations, but is not intended to be all-inclusive.

This noninclusive listing indicates the position of the department with respect to the income tax status of the listed securities. It is based on current federal law and the interpretation thereof by the department. Federal law or the department's interpretation is subject to change. Federal law precludes all states from imposing an income tax on the interest income from direct obligations of the United States Government. Also, preemptive federal law may preclude state taxation of interest income from the securities of federal government-sponsored enterprises and agencies and from the obligations of U.S. territories. Any profit or gain on the sale or exchange of these securities is taxable.

40.2(1) Federal obligations and obligations of federal instrumentalities the interest on which is exempt from Iowa income tax.

a. United States Government obligations: United States Treasury—Principal and interest from bills, bonds, and notes issued by the United States Treasury exempt under 31 USCS Section 3124[a].

1. Series E, F, G, and H bonds
2. United States Treasury bills
3. U.S. Government certificates
4. U.S. Government bonds
5. U.S. Government notes

b. Territorial obligations:

1. Guam—Principal and interest from bonds issued by the Government of Guam (48 USCS Section 1423[a]).
2. Puerto Rico—Principal and interest from bonds issued by the Government of Puerto Rico (48 USCS Section 745).
3. Virgin Islands—Principal and interest from bonds issued by the Government of the Virgin Islands (48 USCS Section 1403).
4. Northern Mariana Islands—Principal and interest from bonds issued by the Government of the Northern Mariana Islands (48 USCS Section 1681(c)).

c. Federal agency obligations:

1. Commodity Credit Corporation—Principal and interest from bonds, notes, debentures, and other similar obligations issued by the Commodity Credit Corporation (15 USCS Section 713a-5).
2. Banks for Cooperatives—Principal and interest from notes, debentures, and other obligations issued by Banks for Cooperatives (12 USCS Section 2134).
3. Farm Credit Banks—Principal and interest from systemwide bonds, notes, debentures, and other obligations issued jointly and severally by Banks of the Federal Farm Credit System (12 USCS Section 2023).
4. Federal Intermediate Credit Banks—Principal and interest from bonds, notes, debentures, and other obligations issued by Federal Intermediate Credit Banks (12 USCS Section 2079).
5. Federal Land Banks—Principal and interest from bonds, notes, debentures, and other obligations issued by Federal Land Banks (12 USCS Section 2055).
6. Federal Land Bank Association—Principal and interest from bonds, notes, debentures, and other obligations issued by the Federal Land Bank Association (12 USCS Section 2098).
7. Financial Assistance Corporation—Principal and interest from notes, bonds, debentures, and other obligations issued by the Financial Assistance Corporation (12 USCS Section 2278b-10[b]).
8. Production Credit Association—Principal and interest from notes, debentures, and other obligations issued by the Production Credit Association (12 USCS Section 2077).
9. Federal Deposit Insurance Corporation (FDIC)— Principal and interest from notes, bonds, debentures, and other such obligations issued by the Federal Deposit Insurance Corporation (12 USCS Section 1825).
10. Federal Financing Bank—Interest from obligations issued by the Federal Financing Bank. Considered to be United States Government obligations (12 USCS Section 2288, 31 USCS Section 3124[a]).
11. Federal Home Loan Bank—Principal and interest from notes, bonds, debentures, and other such obligations issued by any Federal Home Loan Bank and consolidated Federal Home Loan Bank bonds and debentures (12 USCS Section 1433).

This rule is intended to implement Iowa Code sections 217.39 and 422.7.

701—40.56(422) Taxation of income from the sale of obligations of the state of Iowa and its political subdivisions. For tax years beginning on or after January 1, 2001, income from the sale of obligations of the state of Iowa and its political subdivisions shall be added to Iowa net income to the extent not already included. Gains or losses from the sale or other disposition of bonds issued by the state of Iowa or its political subdivisions shall be included in Iowa net income unless the law authorizing these obligations specifically exempts the income from the sale or other disposition of the bonds from the Iowa individual income tax.

This rule is intended to implement Iowa Code section 422.7 as amended by 2001 Iowa Acts, chapter 116.

701—40.57(422) Installment sales by taxpayers using the accrual method of accounting. For tax years beginning on or after January 1, 2000, and prior to January 1, 2002, taxpayers who use the accrual method of accounting and who have sales or exchanges of property that they reported on the installment method for federal income tax purposes must report the total amount of the gain or loss from the transaction in the tax year of the sale or exchange pursuant to Section 453 of the Internal Revenue Code as amended up to and including January 1, 2000.

EXAMPLE 1. Taxpayer Jones uses the accrual method of accounting for reporting income. In 2001, Mr. Jones sold farmland he had held for eight years for $200,000 which resulted in a capital gain of $50,000. For federal income tax purposes, Mr. Jones elected to report the transaction on the installment basis, where he reported $12,500 of the gain on his 2001 federal return and will report capital gains of $12,500 on each of his federal returns for the 2002, 2003 and 2004 tax years.

However, for Iowa income tax purposes, Mr. Jones must report on his 2001 Iowa return the entire capital gain of $50,000 from the land sale. Although Taxpayer Jones must report a capital gain of $12,500 on each of his federal income tax returns for 2002, 2003 and 2004, from the installment sale of the farmland in 2001, he will not have to include the installments of $12,500 on his Iowa income tax returns for those three tax years because Mr. Jones had reported the entire capital gain of $50,000 from the 2001 transaction on his 2001 Iowa income tax return.

EXAMPLE 2. Taxpayer Smith uses the accrual method of accounting for reporting income. In 2002, Mr. Smith sold farmland he had held for eight years for $500,000 which resulted in a capital gain of $100,000. For federal income tax purposes, Mr. Smith elected to report the transaction on the installment basis, where he reported $20,000 of the gain on his 2002 federal return and will report the remaining capital gains on federal returns for the four subsequent tax years. Because this installment sale occurred in 2002, Mr. Smith shall report $20,000 of the capital gain on his Iowa income tax return for 2002 and will report the balance of the capital gains from the installment sale on Iowa returns for the next four tax years, the same as reported on his federal returns for those years.

This rule is intended to implement Iowa Code section 422.7 as amended by 2002 Iowa Acts, House File 2116.

701—40.58(422) Exclusion of distributions from retirement plans by national guard members and members of military reserve forces of the United States. For tax years beginning on or after January 1, 2002, members of the Iowa national guard or members of military reserve forces of the United States who are ordered to active state service or federal service or duty are not subject to Iowa income tax on the amount of distributions received during the tax year from qualified retirement plans of the members to the extent the distributions were taxable for federal income tax purposes. In addition, the members are not subject to state penalties on the distributions even though the members may have been subject to federal penalties on the distributions for early withdrawal of benefits. Because the distributions described above are not taxable for Iowa income tax purposes, a national guard member or armed forces reserve member who receives a distribution from a qualified retirement plan may request that the payer of the distribution not withhold Iowa income tax from the distribution.

This rule is intended to implement Iowa Code section 422.7 as amended by 2002 Iowa Acts, House File 2622.

701—40.59(422) Exemption of payments received by a beneficiary from an annuity purchased under an employee's retirement plan when the installment has been included as part of a decedent employee's estate. All payments received on or after July 1, 2002, by a beneficiary of a deceased pensioner or annuitant are exempt from Iowa income tax to the extent the payments are from an annuity purchased under an employee's pension or retirement plan when the commuted value of the installments has been included as a part of the decedent employee's estate for Iowa inheritance tax purposes. Thus, a lump sum payment received by a beneficiary from an annuity purchased under an employee's pension or retirement plan is exempt from Iowa income tax to the extent the commuted value of the annuity was included as part of the decedent employee's estate for Iowa inheritance tax purposes. Under prior law, only installment payments of an annuity received by a beneficiary were exempt from Iowa income tax if the commuted value of the installments had been included as part of the decedent employee's estate for Iowa inheritance tax purposes.

This rule is intended to implement Iowa Code section 422.7 as amended by 2002 Iowa Acts, Senate File 2305.

701—40.60(422) Additional first-year depreciation allowance. For tax periods ending on or after September 10, 2001, but beginning before May 5, 2003, the additional first-year depreciation allowance ("bonus depreciation") of 30 percent authorized in Section 168(k) of the Internal Revenue Code, as enacted by Public Law No. 107-147, Section 101, does not apply for Iowa individual income tax. For tax periods beginning on or after May 5, 2003, but beginning before January 1, 2005, the bonus depreciation of 50 percent authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 108-27, Section 201, does not apply for Iowa individual income tax. Taxpayers who claim the bonus depreciation on their federal income tax return must add the total amount of depreciation claimed on assets placed in service after September 10, 2001, but before January 1, 2005, and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both depreciation and the gain or loss on the sale of qualifying assets placed in service after September 10, 2001, but before January 1, 2005, can be calculated on Form IA 4562A.

See rule 701—53.22(422) for examples illustrating how this rule is applied.

This rule is intended to implement Iowa Code section 422.7 as amended by 2003 Iowa Acts, Senate File 442.

701—40.61(422) Exclusion of active duty pay of national guard members and armed forces military reserve members for service under orders for Operation Iraqi Freedom, Operation Noble Eagle or Operation Enduring Freedom. For tax years beginning on or after January 1, 2003, active duty pay received by national guard members and armed forces reserve members is excluded to the extent the income is included in federal adjusted gross income and to the extent the active duty pay is for service under military orders for Operation Iraqi Freedom, Operation Noble Eagle or Operation Enduring Freedom. National guard members and military reserve members receiving active duty pay on or after January 1, 2003, for service not covered by military orders for one of the three operations specified above are subject to Iowa income tax on the active duty pay to the extent the active duty pay is included in federal adjusted gross income. An example of a situation where the active duty pay may not be included in federal adjusted gross income is when the active duty pay was received for service in an area designated as a combat zone or in an area designated as a hazardous duty area so the income may be excluded from federal adjusted gross income. That is, if an individual's active duty military pay is not subject to federal income tax, the active duty military pay will not be taxable on the individual's Iowa income tax return.

National guard members and military reserve members who are receiving active duty pay for service on or after January 1, 2003, that is exempt from Iowa income tax, may complete an IA W-4 Employee Withholding Allowance Certificate and claim exemption from Iowa income tax for active duty pay received during the time they are serving on active duty pursuant to military orders for Operation Iraqi Freedom, Operation Noble Eagle or Operation Enduring Freedom.

This rule is intended to implement Iowa Code section 422.7 as amended by 2003 Iowa Acts, House File 674.

701—40.62(422) Deduction of up to $1,500 for overnight expenses not reimbursed for travel away from home of more than 100 miles for performance of service as a member of the national guard or armed forces military reserve. A taxpayer may subtract, in computing net income, the costs not reimbursed, not to exceed $1,500, that were incurred for overnight transportation, meals and lodging expenses for travel away from the taxpayer's home more than 100 miles, to the extent the travel expenses were incurred for the performance of services on or after January 1, 2003, by the taxpayer as a national guard member or an armed forces military reserve member.

This rule is intended to implement Iowa Code section 422.7 as amended by 2003 Iowa Acts, House File 674.

701—40.63(422) Exclusion of income from military student loan repayments. Individuals serving on active duty in the national guard, armed forces military reserve or the armed forces of the United States may subtract, to the extent included in federal adjusted gross income, income from military student loan repayments made on or after January 1, 2003.

This rule is intended to implement Iowa Code section 422.7 as amended by 2003 Iowa Acts, House File 674.

701—40.64(422) Exclusion of death gratuity payable to an eligible survivor of a member of the armed forces, including a member of a reserve component of the armed forces who has died while on active duty. An eligible survivor of a member of the armed forces, including a member of a reserve component of the armed forces, who has died while on active duty may subtract, to the extent included in federal adjusted gross income, a gratuity death payment made to the eligible survivor of a member of the armed forces who died while on active duty after September 10, 2001. This exclusion applies to a gratuity death payment made to the eligible survivor of any person in the armed forces or a reserve component of the armed forces who died while on active duty after September 10, 2001.

The purpose of the death gratuity is to provide a cash payment to assist a survivor of a deceased member of the armed forces to meet financial needs during the period immediately following a service member's death and before other survivor benefits, if any, become available.

This rule is intended to implement Iowa Code section 422.7 as amended by 2003 Iowa Acts, House File 674.

701—40.65(422) Section 179 expensing. For tax periods beginning on or after January 1, 2003, but beginning before January 1, 2006, the increase in the expensing allowance for qualifying property authorized in Section 179(b) of the Internal Revenue Code, as enacted by Public Law No. 108-27, Section 202, does not apply for Iowa individual income tax. The expensing allowance is limited to $100,000 for federal tax purposes, but the expensing allowance is limited to $25,000 for Iowa tax purposes. Taxpayers who claim an expensing allowance on their federal income tax return in excess of $25,000 must limit their deduction on the Iowa return to $25,000. The difference between the federal Section 179 expensing allowance on such property, if in excess of $25,000, and the Iowa expensing allowance of $25,000 can be depreciated using the modified accelerated cost recovery system (MACRS) applicable under Section 168 of the Internal Revenue Code without regard to the bonus depreciation provision in Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable Section 179 and related depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both the Section 179 expense allowance and related depreciation, along with the gain or loss on the sale of qualifying assets placed in service on or after January 1, 2003, but before January 1, 2006, can be calculated on Form IA 4562A.

See rule 701—53.23(422) for examples illustrating how this rule is applied.

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For tax years beginning on or after January 1, 2002, but before July 1, 2003, a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol may elect to transfer all or a portion of its tax credit to its members. For tax years beginning on or after July 1, 2003, a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return may elect to transfer all or a portion of its tax credit to its members. The amount of tax credit transferred and claimed by a member shall be based upon the pro-rata share of the member's earnings in the cooperative. The Iowa department of economic development will issue a tax credit certificate to each member of the cooperative to whom the credit was transferred provided that tax credit certificates which total no more than $4 million are issued during a fiscal year. The tax credit certificate must be attached to the tax return for the tax year during which the tax credit is claimed.

42.2(11) *Research activities credit.* Effective for tax years beginning on or after January 1, 2000, the taxes imposed for individual income tax purposes will be reduced by a tax credit for increasing research activities in this state. See subrule 42.2(6) for the research activities credit that was applicable for individual income tax purposes for tax years beginning on or after January 1, 1985, but prior to January 1, 2000.

a. The credit equals the sum of the following:

(1) Six and one-half percent of the excess of qualified research expenses during the tax year over the base amount for the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities.

(2) Six and one-half percent of the basic research payments determined under Section 41(e)(1)(A) of the Internal Revenue Code during the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities. The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in this state to total qualified research activities.

b. In lieu of the credit computed under paragraph *"a"* of this subrule, a taxpayer may elect to compute the credit amount for qualified research expenses incurred in this state in a manner consistent with the alternative incremental credit described in Section 41(c)(4) of the Internal Revenue Code. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year and the taxpayer may use another method or this same method for any subsequent tax year. For purposes of this alternative research credit computation, the credit percentages applicable to qualified research expenses described in clauses (i), (ii), and (iii) of Section 41(c)(4)(A) of the Internal Revenue Code are 1.65 percent, 2.20 percent, and 2.75 percent, respectively.

For purposes of this subrule, the terms "base amount," "basic research payment," and "qualified research expense" mean the same as defined for the federal credit for increasing research activities under Section 41 of the Internal Revenue Code, except that, for purposes of the alternative incremental credit described in paragraph *"b"* of this subrule, such amounts are limited to research activities conducted within this state. For purposes of this subrule, "Internal Revenue Code" means the Internal Revenue Code in effect on January 1, 2004.

c. An individual may claim a research activities credit incurred by a partnership, S corporation, limited liability company, estate, or trust electing to have the income of the business entity taxed to the individual. The amount claimed by an individual from the business entity is to be based upon the pro-rata share of the individual's earnings from a partnership, S corporation, estate or trust. Any research credit in excess of the individual's tax liability, less the credits authorized in Iowa Code sections 422.11A, 422.12 and 422.12B may be refunded to the individual or may be credited to the individual's tax liability for the following tax year.

This rule is intended to implement Iowa Code Supplement section 15.333, Iowa Code section 422.10 as amended by 2004 Iowa Acts, Senate File 2296, and Iowa Code sections 422.11A, 422.12, and 422.12B.

701—42.3(422) Nonresident and part-year resident credit. For tax years beginning on or after January 1, 1982, an individual who is a nonresident of Iowa for the entire tax year, or an individual who is an Iowa resident for a portion of the tax year, is allowed a credit against the individual's Iowa income tax liability for the Iowa income tax on the portion of the individual's income which was earned outside Iowa while the person was a nonresident of Iowa. This credit is computed on Schedule IA 126 which is included in the Iowa individual income tax booklet. The following subrules clarify how the nonresident and part-year resident credit is computed for nonresidents of Iowa and taxpayers who are part-year residents of Iowa during the tax year.

42.3(1) *Nonresident/part-year resident credit for nonresidents of Iowa.* A nonresident of Iowa is to complete the Iowa individual return by reporting the individual's total net income, including incomes earned outside Iowa, on the front of the IA 1040 return form similar to the way an Iowa resident completes the return form. A nonresident individual is allowed the same deduction for federal income tax and the same itemized deductions as an Iowa resident taxpayer with identical deductions for these expenditures. Thus, a nonresident with a taxable income of $40,000 would have the same initial Iowa income tax liability as a resident taxpayer with a taxable income of $40,000 before the nonresident/part-year resident credit is computed.

The nonresident/part-year resident credit is computed on Schedule IA 126. The lines referred to in this subrule are from Schedule IA 126 and Form IA 1040 for the 1997 tax year. Similar lines on the schedule and form may apply for subsequent tax years. The individual's Iowa source net income from lines 1 through 25 of the schedule is totaled on line 26 of the schedule. If the nonresident's Iowa source net income is less than $1,000, the taxpayer is not subject to Iowa income tax and is not required to file an Iowa income tax return for the tax year. However, if the Iowa source net income amount is $1,000 or more, the Iowa source net income is then divided by the person's all source net income on line 27 of Schedule IA 126 to determine the percentage of the Iowa net income to all source net income. This Iowa income percentage is inserted on line 28 of the schedule, and this percentage is then subtracted from 100 percent to arrive at the nonresident/part-year resident credit percentage or the percentage of the individual's total income which was earned outside Iowa. The nonresident/part-year resident credit percentage is entered on line 29 of Schedule IA 126. The Iowa income tax on total income from line 43 of the IA 1040 is entered on line 30 of Schedule IA 126. The total of nonrefundable credits from line 50 of the IA 1040 is then shown on line 31 of Schedule IA 126. The amount on line 31 is subtracted from the amount on line 30 which leaves the Iowa total tax after nonrefundable credits on line 32. This Iowa tax after credits amount is multiplied by the nonresident/part-year resident credit percentage from line 29 to compute the nonresident/part-year resident credit. The amount of the credit is inserted on line 33 of Schedule IA 126 and on line 52 of the IA 1040.

EXAMPLE A. A single resident of Nebraska had Iowa source net income of $15,000 in 1997 from wages earned from employment in Iowa. The rest of this person's income was attributable to sources outside Iowa. This nonresident of Iowa had an all source net income of $40,000 and a taxable income of $30,000 due to a federal tax deduction of $7,000 and itemized deductions of $3,000. The Iowa income percentage is computed by dividing the Iowa source net income of $15,000 by the taxpayer's all source net income of $40,000, which results in a percentage of 37.5. This percentage is subtracted from 100 percent which leaves a nonresident/part-year resident credit percentage of 62.5.

The Iowa tax from line 43 of the IA 1040 is $1,789. The total nonrefundable credit from line 50 is $20, which leaves a tax amount of $1,769 when the credit is subtracted from $1,789. When $1,769 is multiplied by the nonresident/part-year resident credit percentage of 62.5 percent, a nonresident credit of $1,106 is computed which is entered on line 33 of Schedule IA 126 as well as on line 52 of the IA 1040 for 1997.

EXAMPLE B. A California resident, who was married, had $20,000 of Iowa source income in 1997 from an Iowa farm. This individual had an additional $80,000 in income that was attributable to sources outside Iowa, but the individual's spouse had no income. The taxpayers had paid $18,000 in federal income tax in 1997 and had itemized deductions of $12,000 in 1997.

(16) Fees paid for general materials for shop class, agriculture class, home economics class, or auto repair class and general fees for equivalent classes.

(17) Fees for a dependent's bus trips to attend school if paid to the school.

b. The following are specific examples of expenditures related to a dependent's participation in or attendance at extracurricular activities that will not qualify for the tuition and textbook credit.

(1) Purchase of a musical instrument used in a school band or orchestra.

(2) Purchase of basketball shoes or other athletic shoes that are readily adaptable to street wear.

(3) Amounts paid for special testing such as SAT or PSAT, and for Iowa talent search tests.

(4) Payments for senior trips, band trips, and other overnight school activity trips which involve payment for meals and lodging.

(5) Fees paid to K-12 schools for courses for college credit.

(6) Amounts paid for T-shirts, sweatshirts and similar clothing that is appropriate for street wear.

(7) Amounts paid for special programs at universities and colleges for high school boys or girls.

(8) Payment for private instrumental lessons, voice lessons or similar lessons.

(9) Amounts paid for a school yearbook, annual or class ring.

(10) Fees for special materials paid for shop class, agriculture class, auto repair class, home economics class and similar classes. For purposes of this paragraph, "special materials" means materials used for personal projects of the dependents, such as materials to make furniture for personal use, automobile parts for family automobiles and other materials for projects for personal or family benefit.

This rule is intended to implement Iowa Code section 422.12.

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◊Two ARCs

52.7(1) *Qualified expenditures in Iowa are:*

a. Wages for qualified research services performed in Iowa.

b. Cost of supplies used in conducting qualified research in Iowa.

c. Rental or lease cost of personal property used in Iowa in conducting qualified research. Where personal property is used both within and without Iowa in conducting qualified research, the rental or lease cost must be prorated between Iowa and non-Iowa use by the ratio of days used in Iowa to total days used both within and without Iowa.

d. Sixty-five percent of contract expenses paid by a corporation to a qualified organization for basic research performed in Iowa.

52.7(2) *Total qualified expenditures are:*

a. Wages paid for qualified research services performed everywhere.

b. Cost of supplies used in conducting qualified research everywhere.

c. Rental or lease cost of personal property used in conducting qualified research everywhere.

d. Sixty-five percent of contract expenses paid by a corporation to a qualified organization for basic research performed everywhere.

Qualifying expenditures for increasing research activities is the smallest of the amount by which the qualified research expenses for the taxable year exceed the base period research expenses or 50 percent of the qualified research expenses for the taxable year.

A shareholder in an S corporation may claim the pro-rata share of the Iowa credit for increasing research expenditures on the shareholder's individual income tax return. The S corporation must provide each shareholder with a schedule showing the computation of the corporation's Iowa credit for increasing research expenditures and the shareholder's pro-rata share. The shareholder's pro-rata share of the Iowa credit for increasing research activities must be in the same ratio as the shareholder's pro-rata share in the earnings of the S corporation.

Any research credit in excess of the corporation's tax liability less the credits authorized in Iowa Code sections 422.33, 422.91 and 422.111 may be refunded to the taxpayer or credited to the estimated tax of the taxpayer for the following year.

52.7(3) *Research activities credit for tax years beginning in 2000.* Effective for tax years beginning on or after January 1, 2000, the taxes imposed for corporate income tax purposes will be reduced by a tax credit for increasing research activities.

a. The credit equals the sum of the following:

(1) Six and one-half percent of the excess of qualified research expenses during the tax year over the base amount for the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities.

(2) Six and one-half percent of the basic research payments determined under Section 41(e)(1)(A) of the Internal Revenue Code during the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities.

The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in this state to total qualified research expenditures.

b. In lieu of the credit computed under paragraph *"a"* of this subrule, a taxpayer may elect to compute the credit amount for qualified research expenses incurred in this state in a manner consistent with the alternative incremental credit described in Section 41(c)(4) of the Internal Revenue Code. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year and the taxpayer may use another method or this same method for any subsequent tax year.

For purposes of this alternative research credit computation, the credit percentages applicable to qualified research expenses described in clauses (i), (ii), and (iii) of Section 41(c)(4)(A) of the Internal Revenue Code are 1.65 percent, 2.20 percent, and 2.75 percent, respectively.

c. For purposes of this subrule, the terms "base amount," "basic research payment," and "qualified research expense" mean the same as defined for the federal credit for increasing research activities under Section 41 of the Internal Revenue Code, except that, for purposes of the alternative incremental credit described in paragraph *"b"* of this subrule, such amounts are limited to research activities conducted within this state. For purposes of this rule, "Internal Revenue Code" means the Internal Revenue Code in effect on January 1, 2004.

d. A shareholder in an S corporation may claim the pro-rata share of the Iowa credit for increasing research activities on the shareholder's individual return. The S corporation must provide each shareholder with a schedule showing the computation of the corporation's Iowa credit for increasing research activities and the shareholder's pro-rata share. The shareholder's pro-rata share of the Iowa credit for increasing research activities must be in the same ratio as the shareholder's pro-rata share in the earnings of the S corporation.

Any research credit in excess of the corporation's tax liability less the credits authorized in Iowa Code sections 422.33, 422.91 and 422.111 may be refunded to the taxpayer or credited to the estimated tax of the corporation for the following year.

52.7(4) *Research activities credit for an eligible business.* Effective for tax years beginning on or after January 1, 2000, an eligible business may claim a tax credit for increasing research activities in this state during the period the eligible business is participating in the new jobs and income program with the Iowa department of economic development. An eligible business must meet all the conditions listed under Iowa Code section 15.329, which include requirements to make an investment of $10 million as indexed for inflation and the creation of a minimum of 50 full-time positions. The research credit authorized in this subrule is in addition to the research activities credit described in 701—subrule 42.2(11) or the research credit described in subrule 52.7(3).

a. The additional research activities credit for an eligible business is computed under the criteria for computing the research activities credit under 701—subrule 42.2(11) or under subrule 52.7(3), depending on which of those subrules the initial research credit was computed. The same qualified research expenses and basic research expenses apply in computation of the research credit for an eligible business as were applicable in computing the credit in 701—subrule 42.2(11) or 52.7(3). In addition, if the alternative incremental credit method was used to compute the initial research credit under 701—subrule 42.2(11) or 52.7(3), that method would be used to compute the research credit for an eligible business. Therefore, if a taxpayer that met the qualifications of an eligible business had a research activities credit of $200,000 as computed under subrule 52.7(3), the research activities credit for the eligible business would result in an additional credit for the taxpayer of $200,000.

b. If the eligible business is a partnership, S corporation, limited liability company, estate or trust where the income from the eligible business is taxed to the individual owners of the business, these individual owners may claim the additional research activities credit allowed to the eligible business. The research credit is allocated to each of the individual owners of the eligible business on the basis of the pro-rata share of that individual's earnings from the eligible business.

52.7(5) *Corporate tax research credit for increasing research activities within a quality jobs enterprise zone.* Effective for tax years beginning on or after January 1, 2000, the taxes imposed for corporate income tax purposes will be reduced by a tax credit for increasing research activities within an area designated as a quality jobs enterprise zone. This credit for increasing research activities is in lieu of the research activities credit described in 701—subrule 42.2(11) or the research activities credit described in subrule 52.7(3).

a. The credit equals the sum of the following:

(1) Thirteen percent of the excess of qualified research expenses during the tax year over the base amount for the tax year based upon the state's apportioned share of the qualifying expenditures for research activities.

(2) Thirteen percent of the basic research payments determined under Section 41(e)(1)(A) of the Internal Revenue Code during the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities. The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in the quality jobs enterprise zone to total qualified research expenditures.

b. In lieu of the credit computed under paragraph *"a"* of this subrule, a taxpayer may elect to compute the credit amount for qualified research expenses incurred in the quality jobs enterprise zone in a manner consistent with the alternative incremental credit described in Section 41(c)(4) of the Internal Revenue Code. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year and the taxpayer may use another method or this same method for any subsequent tax year. For purposes of this alternative research credit computation, the credit percentages applicable to qualified research expenses described in clauses (i), (ii), and (iii) of Section 41(c)(4)(A) of the Internal Revenue Code are 3.30 percent, 4.40 percent, and 5.50 percent, respectively.

c. For purposes of this subrule, the terms "base amount," "basic research payment," and "qualified research expense" mean the same as defined for the federal credit for increasing research activities under Section 41 of the Internal Revenue Code, except that, for purposes of the alternative incremental credit described in subrule 52.7(3) of this rule, such amounts are limited to research activities conducted within the quality jobs enterprise zone. For purposes of this rule, "Internal Revenue Code" means the Internal Revenue Code in effect on January 1, 2004.

d. Any research credit in excess of the corporation's tax liability for the taxable year may be refunded to the taxpayer or credited to the corporation's tax liability for the following year.

This rule is intended to implement Iowa Code section 422.33 as amended by 2004 Iowa Acts, Senate File 2296.

701—52.8(422) New jobs credit. A tax credit is available to a corporation which has entered into an agreement under Iowa Code chapter 260E and has increased employment by at least 10 percent.

52.8(1) *Definitions.*

a. The term *"new jobs"* means those jobs directly resulting from a project covered by an agreement authorized by Iowa Code chapter 260E (Iowa Industrial New Jobs Training Act) but does not include jobs of recalled workers or replacement jobs or other jobs that formerly existed in the industry in the state.

b. The term *"jobs directly related to new jobs"* means those jobs which directly support the new jobs but does not include in-state employees transferred to a position which would be considered to be a job directly related to new jobs unless the transferred employee's vacant position is filled by a new employee.

EXAMPLE A. A taxpayer who has entered into a chapter 260E agreement to train new employees for a new product line transfers an in-state employee to be supervisor of the new product line but does not fill the transferred employee's position. The new supervisor's position would not be considered a job directly related to new jobs even though it directly supports the new jobs because the transferred employee's old position was not refilled.

EXAMPLE B. A taxpayer who has entered into a chapter 260E agreement to train new employees for a new product line transfers an in-state employee to be supervisor of the new product line and fills the transferred employee's position with a new employee. The new supervisor's position would be considered a job directly related to new jobs because it directly supports the new jobs and the transferred employee's old position was filled by a new employee.

The burden of proof that a job is directly related to new jobs is on the taxpayer.

c. The term *"taxable wages"* means those wages upon which an employer is required to contribute to the state unemployment fund as defined in Iowa Code subsection 96.19(37) for the year in which the taxpayer elects to take the new jobs tax credit. For fiscal-year taxpayers, "taxable wages" shall not be greater than the maximum wage upon which an employer is required to contribute to the state unemployment fund for the calendar year in which the taxpayer's fiscal year begins.

d. The term *"agreement"* means an agreement entered into under Iowa Code chapter 260E after July 1, 1985, an amendment to that agreement, or an amendment to an agreement entered into before July 1, 1985, if the amendment sets forth the base employment level as of the date of the amendment. The term "agreement" also includes a preliminary agreement entered into under Iowa Code chapter 260E provided the preliminary agreement contains all the elements of a contract and includes the necessary elements and commitment relating to training programs and new jobs.

e. The term *"base employment level"* means the number of full-time jobs an industry employs at a plant site which is covered by an agreement under chapter 260E on the date of the agreement.

f. The term *"project"* means a training arrangement which is the subject of an agreement entered into under Iowa Code chapter 260E.

g. The term *"industry"* means a business engaged in interstate or intrastate commerce for the purpose of manufacturing, processing, or assembling products, conducting research and development, or providing services in interstate commerce, but excludes retail, health or professional services. Industry does not include a business which closes or substantially reduces its operations in one area of the state and relocates substantially the same operation in another area of the state. Industry is a business engaged in the above listed activities rather than the generic definition encompassing all businesses in the state engaged in the same activities. For example, in the meat-packing business, an industry is considered to be a single corporate entity or operating division, rather than the entire meat-packing business in the state.

h. The term *"new employees"* means the same as new jobs or jobs directly related to new jobs.

i. The term *"full-time job"* means any of the following:

(1) An employment position requiring an average work week of 35 or more hours;

(2) An employment position for which compensation is paid on a salaried full-time basis without regard to hours worked; or

(3) An aggregation of any number of part-time or job-sharing employment positions which equal one full-time employment position. For purposes of this subrule each part-time or job-sharing employment position shall be categorized with regard to the average number of hours worked each week as one-quarter, half, three-quarters, or full-time position, as set forth in the following table:

Average Number of Weekly Hours	Category
More than 0 but less than 15	¼
15 or more but less than 25	½
25 or more but less than 35	¾
35 or more	1 (full-time)

701—52.14(422) Enterprise zone tax credits. An eligible business in an enterprise zone may take the following tax credits:

1. New jobs credit from withholding as provided in Iowa Code section 15.331 (see rule 701—52.8(422)).
2. Investment tax credit as provided in Iowa Code section 15.333 (see rule 701—52.10(15)).
3. Research activities credit as provided in Iowa Code section 15.335 (see rule 701—52.10(15) for tax years ending after May 1, 1994, but prior to tax years beginning on or after January 1, 2000) and subrule 52.7(5) for the research credit for increasing research activities within a quality jobs enterprise zone for tax years beginning on or after January 1, 2000.

If an eligible business in an enterprise zone fails to maintain the requirements of the enterprise zone program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of the enterprise zone program. This is because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

Effective July 1, 2003, eligible businesses in an enterprise zone may also be required to repay all or a portion of the tax incentives received on Iowa returns if the eligible business experiences a layoff of employees in Iowa or closes any of its facilities in Iowa.

This rule is intended to implement Iowa Code section 15A.9(8) as amended by 2004 Iowa Acts, Senate File 2296, Iowa Code Supplement section 15E.193, and Iowa Code section 15E.186.

701—52.15(15E) Eligible housing business tax credit. A corporation which qualifies as an eligible housing business may receive a tax credit of up to 10 percent of the new investment which is directly related to the building or rehabilitating of homes in an enterprise zone. The tax credit may be taken on the tax return for the tax year in which the home is ready for occupancy.

An eligible housing business is one which meets the criteria in Iowa Code section 15E.193B.

52.15(1) *Computation of tax credit.* New investment which is directly related to the building or rehabilitating of homes includes but is not limited to the following costs: land, surveying, architectural services, building permits, inspections, interest on a construction loan, building materials, roofing, plumbing materials, electrical materials, amounts paid to subcontractors for labor and materials provided, concrete, labor, landscaping, appliances normally provided with a new home, heating and cooling equipment, millwork, drywall and drywall materials, nails, bolts, screws, and floor coverings.

New investment does not include the machinery, equipment, hand or power tools necessary to build or rehabilitate homes.

A taxpayer may claim on the taxpayer's corporation income tax return the pro-rata share of the Iowa eligible housing business tax credit from a partnership, limited liability company, estate, or trust. The portion of the credit claimed by the taxpayer shall be in the same ratio as the taxpayer's pro-rata share of the earnings of the partnership, limited liability company, or estate or trust.

Any Iowa eligible housing business tax credit in excess of the corporation's tax liability may be carried forward for seven years or until it is used, whichever is the earlier.

If the eligible housing business fails to maintain the requirements of Iowa Code section 15E.193B, to be an eligible housing business, the taxpayer may be required to repay all or a part of the tax incentives the business received. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the income tax credit may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of Iowa Code section 15E.193B. This is because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability.

Prior to January 1, 2001, the tax credit cannot exceed 10 percent of $120,000 for each home or individual unit in a multiple dwelling unit building. Effective January 1, 2001, the tax credit cannot exceed 10 percent of $140,000 for each home or individual unit in a multiple dwelling unit building.

Effective for tax periods beginning on or after January 1, 2003, the taxpayer must receive a tax credit certificate from the Iowa department of economic development to claim the eligible housing business tax credit. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the date the project was completed, the amount of the eligible housing business tax credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 52.15(2). The tax credit certificate must be attached to the income tax return for the tax period in which the home is ready for occupancy.

52.15(2) *Transfer of the eligible housing business tax credit.* For tax periods beginning on or after January 1, 2003, the eligible housing business tax credit certificates may be transferred to any person or entity if low-income housing tax credits authorized under Section 42 of the Internal Revenue Code are used to assist in the financing of the housing development.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the Iowa department of economic development, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the Iowa department of economic development will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the housing business tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The replacement tax credit certificate must contain the same information that was on the original certificate and must have the same expiration date as the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax period for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code section 15E.193B as amended by 2001 Iowa Acts, Senate File 441.

701—52.16(422) Franchise tax credit. For tax years beginning on or after January 1, 1998, a shareholder in a financial institution as defined in Section 581 of the Internal Revenue Code which has elected to have its income taxed directly to the shareholders may take a tax credit equal to the shareholder's pro-rata share of the Iowa franchise tax paid by the financial institution.

The credit must be computed by recomputing the amount of tax computed under Iowa Code section 422.33 by reducing the shareholder's taxable income by the shareholder's pro-rata share of the items of income and expenses of the financial institution and deducting from the recomputed tax the credits allowed by Iowa Code section 422.33. The recomputed tax must be subtracted from the amount of tax computed under Iowa Code section 422.33 reduced by the credits allowed in Iowa Code section 422.33.

The resulting amount, not to exceed the shareholder's pro-rata share of the franchise tax paid by the financial institution, is the amount of tax credit allowed the shareholder.

This rule is intended to implement Iowa Code section 422.33, as amended by 1999 Iowa Acts, chapter 95.

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CHAPTER 53
DETERMINATION OF NET INCOME
[Prior to 12/17/86, Revenue Department[730]]

701—53.1(422) Computation of net income for corporations. Net income for state purposes shall mean federal taxable income, before deduction for net operating losses, as properly computed under the Internal Revenue Code, and shall include the adjustments in 53.2(422) to 53.13(422) and 53.17(422) to 53.23(422). The remaining provisions of this rule and 53.14(422) to 53.16(422) shall also be applicable in determining net income.

In the case of a corporation which is a member of an affiliated group of corporations filing a consolidated income tax return for the taxable year for federal income tax purposes, but files a separate return for state purposes, taxable income as properly computed for federal purposes is determined as if the corporation had filed a separate return for federal income tax purposes for the taxable year and each preceding taxable year for which it was a member of an affiliated group. For purposes of this paragraph, the taxpayer's separate taxable income shall be determined as if the election provided by Section 243(b)(2) of the Internal Revenue Code had been in effect for all those years.

When a federal short period return is filed and the federal taxable income is required to be adjusted to an annual basis, the Iowa taxable income shall also be adjusted to an annual basis. The tax liability for a short period is computed by multiplying the taxable income for the short period by 12 and dividing the result by the number of months in the short period. The tax is determined on the resulting total as if it were the taxable income, and the tax computed is divided by 12 and multiplied by the number of months in the short period. This adjustment shall apply only to income attributable to business carried on within the state of Iowa.

This rule is intended to implement Iowa Code section 422.35.

701—53.2(422) Net operating loss carrybacks and carryovers. In years beginning after December 31, 1954, net operating losses shall be allowed or allowable for Iowa corporation income tax purposes to the same extent they are allowed or allowable for federal corporation income tax purposes for the same period, provided the following adjustments are made:

53.2(1) *Additions to income.*

a. Refunds of federal income taxes due to net operating loss and investment credit carrybacks or carryovers shall be reflected in the following manner:

(1) Accrual basis taxpayers shall accrue refunds of federal income taxes to the year in which the net operating loss occurs.

(2) Cash basis taxpayers shall reflect refunds of federal income taxes in the return for the year in which the refunds are received.

b. Iowa income tax deducted on the federal return for the loss year shall be reflected as an addition to income in the year of the loss.

c. Interest and dividends received in the year of the loss on federally tax-exempt securities shall be reflected as additions to income in the year of the loss.

53.2(2) *Reductions of income.*

a. Federal income tax paid or accrued during the year of the net operating loss shall be reflected to the extent allowed by law as an additional deduction in the year of the loss.

b. Iowa income tax refunds reported as income for federal return purposes in the loss year shall be reflected as reductions of income in the year of the loss.

c. Interest and dividends received from federal securities during the loss year shall be reflected in the year of the loss as a reduction of income.

53.2(3) If a corporation does business both within and without Iowa, it shall make adjustments reflecting the apportionment and allocation of its operating loss on the basis of business done within and without the state of Iowa after completing the provisions of subrules 53.2(1) and 53.2(2).

a. After making the adjustments to federal taxable income as provided in 53.2(1) and 53.2(2), the total net allocable income or loss shall be added to or deducted from, as the case may be, the net federal income or loss as adjusted for Iowa tax purposes. The resulting income or loss so determined shall be subject to apportionment as provided in rules 701—54.5(422), 54.6(422) and 54.7(422). The apportioned income or loss shall be added or deducted, as the case may be, to the amount of net allocable income or loss properly attributable to Iowa. This amount is the taxable income or net operating loss attributable to Iowa for that year.

b. The net operating loss attributable to Iowa, as determined in rule 53.2(422), shall be subject to a 3-year carryback and a 15-year carryover provision. This loss shall be carried back or over to the applicable year as a reduction or part of a reduction of the net income attributable to Iowa for that year. However, an Iowa net operating loss shall not be carried back to a year in which the taxpayer was not doing business in Iowa. If the election under Section 172(b)(3) of the Internal Revenue Code is made, the Iowa net operating loss shall be carried forward 15 taxable years. A copy of the federal election made under Section 172(b)(3) of the Internal Revenue Code must be attached to the Iowa corporation income tax return filed with the department.

c. For tax years beginning after August 5, 1997, a net operating loss attributable to Iowa, as determined in rule 701—53.2(422), incurred in a presidentially declared disaster area by a corporation engaged in a small business or in the trade or business of farming must be carried back 3 taxable years and carried forward 20 taxable years. All other net operating losses attributable to Iowa must be carried back 2 taxable years and carried forward 20 taxable years. This loss shall be carried back or over to the applicable year as a reduction or part of a reduction of the net income attributable to Iowa for that year. However, an Iowa net operating loss shall not be carried back to a year in which the taxpayer was not doing business in Iowa. If the election under Section 172(b)(3) of the Internal Revenue Code is made, the Iowa net operating loss shall be carried forward 20 taxable years. A copy of the federal election made under Section 172(b)(3) of the Internal Revenue Code must be attached to the Iowa corporation income tax return filed with the department.

d. For tax years beginning on or after January 1, 1998, for a taxpayer who is engaged in the trade or business of farming as defined in Section 263A(e)(4) of the Internal Revenue Code and has a loss from farming as defined in Section 172(b)(1)(F) of the Internal Revenue Code including modifications prescribed by rule by the director, the Iowa loss from the trade or business of farming is a net operating loss which may be carried back five taxable years prior to the taxable year of the loss. If the taxpayer has elected for federal income tax purposes to carry a net operating loss from the trade or business of farming back two years, the taxpayer must carry the Iowa net operating loss from the trade or business of farming back two years. However, an Iowa net operating loss shall not be carried back to a year in which the taxpayer was not doing business in Iowa.

When the taxpayer carries on more than one trade or business within a corporate shell or files a consolidated Iowa corporation income tax return, the income or loss from each trade or business must be combined to determine the amount of net operating loss that exists and whether it is a net operating loss from the trade or business of farming.

EXAMPLE 1. The taxpayer carries on the trade or business of farming and also the trade or business of trucking for entities outside the corporate shell. For the tax year, the taxpayer had a net operating loss from farming of $25,000 and net income from trucking of $10,000 for a net operating loss for the year of $15,000 which is a net operating loss from the trade or business of farming which may be carried back 5 tax years and forward 20 tax years.

701—53.20(422) Employer social security credit for tips. Employers in the food and beverage industry are allowed a credit under Section 45B of the Internal Revenue Code for a portion of the social security taxes paid or incurred after 1993 on employee tips. The credit is equal to the employer's FICA obligation attributable to tips received which exceed tips treated as wages for purposes of satisfying minimum wage standards of the Fair Labor Standards Act. The credit is allowed only for tips received by an employee in the course of employment from customers on the premises of a business for which the tipping of employees serving food or beverages is customary. To the extent that an employer takes the credit for a portion of the social security taxes paid or incurred, the employer's deduction for the social security tax is reduced accordingly. For Iowa income tax purposes, the full deduction for the social security tax paid or incurred is allowed for tax years beginning on or after January 1, 1994. No social security tax credit is allowed on the Iowa corporation income tax return.

This rule is intended to implement Iowa Code section 422.35 as amended by 1995 Iowa Acts, chapter 152.

701—53.21(422) Deduction of gifts, grants, or donations. For tax years ending on or after July 1, 1998, to the extent that any gift, grant, or donation to the endowment fund of the Iowa educational savings plan trust made on or after that date has not been deducted in computing federal taxable income, the amount may be deducted for Iowa income tax purposes.

This rule is intended to implement Iowa Code section 422.35 as amended by 1998 Iowa Acts, House File 2119.

701—53.22(422) Additional first-year depreciation allowance. For tax periods ending on or after September 10, 2001, but beginning before May 5, 2003, the additional first-year depreciation allowance ("bonus depreciation") of 30 percent authorized in Section 168(k) of the Internal Revenue Code, as enacted by Public Law No. 107-147, Section 101, does not apply for Iowa corporation income tax. For tax periods beginning on or after May 5, 2003, but beginning before January 1, 2005, the bonus depreciation of 50 percent authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 108-27, Section 201, does not apply for Iowa corporation income tax. Taxpayers who claim the bonus depreciation on their federal income tax return must add the total amount of depreciation claimed on assets placed in service after September 10, 2001, but before January 1, 2005, and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both depreciation and the gain or loss on the sale of qualifying assets placed in service after September 10, 2001, but before January 1, 2005, can be calculated on Form IA 4562A.

The following nonexclusive examples illustrate how this rule applies:

EXAMPLE 1: Taxpayer purchased a $100,000 qualifying asset on January 1, 2002, which has a five-year life for depreciation purposes. Using the bonus depreciation provision in Section 168(k) of the Internal Revenue Code, taxpayer was entitled to a $44,000 depreciation deduction on the federal return for 2002. For Iowa purposes, taxpayer must use the MACRS depreciation method which results in a $20,000 depreciation deduction on the Iowa return for 2002. Therefore, a $24,000 ($44,000 - $20,000) increase to net income relating to this depreciation adjustment must be made on the Iowa return for 2002.

EXAMPLE 2: Taxpayer purchased a $1,000,000 qualifying asset on January 1, 2002, which has a ten-year life for depreciation purposes. This asset was sold on December 31, 2005, for $500,000. Using the bonus depreciation provision, taxpayer claimed $677,440 of depreciation deductions on the federal returns for 2002-2005. This results in a basis for this asset of $322,560 ($1,000,000 - $677,440), and a gain of $177,440 ($500,000 - $322,560) on the federal return for 2005 on the sale of the asset.

Using the MACRS depreciation method, taxpayer claimed $539,200 of depreciation deductions on the Iowa returns for 2002-2005. This results in a basis for this asset of $460,800 ($1,000,000 - $539,200), and a gain of $39,200 ($500,000 - $460,800) on the Iowa return for 2005 on the sale of the asset. Therefore, a decrease to net income of $138,240 ($177,440 - $39,200) relating to this gain adjustment must be made on the Iowa return for 2005.

This rule is intended to implement Iowa Code section 422.35 as amended by 2003 Iowa Acts, Senate File 442.

701—53.23(422) Section 179 expensing. For tax periods beginning on or after January 1, 2003, but beginning before January 1, 2006, the increase in the expensing allowance for qualifying property authorized in Section 179(b) of the Internal Revenue Code, as enacted by Public Law No. 108-27, Section 202, does not apply for Iowa corporation income tax. The expensing allowance is limited to $100,000 for federal tax purposes, but the expensing allowance is limited to $25,000 for Iowa tax purposes. Taxpayers who claim an expensing allowance on their federal income tax return in excess of $25,000 must limit their deduction on the Iowa return to $25,000. The difference between the federal Section 179 expensing allowance on such property, if in excess of $25,000, and the Iowa expensing allowance of $25,000 can be depreciated using the modified accelerated cost recovery system (MACRS) applicable under Section 168 of the Internal Revenue Code without regard to the bonus depreciation provision set forth in Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable Section 179 and related depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both the Section 179 expensing allowance and related depreciation, along with the gain or loss on the sale of qualifying assets placed in service on or after January 1, 2003, but before January 1, 2006, can be calculated on Form IA 4562A.

The following nonexclusive examples illustrate how this rule applies:

EXAMPLE 1: Taxpayer purchased a $110,000 qualifying asset on January 1, 2003, which has a five-year life for depreciation purposes. Taxpayer was entitled to a $100,000 Section 179 expensing allowance, a $5,000 bonus depreciation deduction under Section 168(k) of the Internal Revenue Code, and an additional depreciation deduction under Section 168 of the Internal Revenue Code for a total deduction of $106,000 for federal tax purposes. For Iowa purposes, taxpayer is entitled to a $25,000 Section 179 expensing allowance and a $17,000 depreciation deduction using MACRS, for a total Iowa deduction of $42,000. Therefore, a $64,000 ($106,000 - $42,000) increase to net income relating to this Section 179 and depreciation adjustment must be made on the Iowa return for 2003.

EXAMPLE 2: Assume the same facts as given in Example 1, and the qualifying asset was sold on December 31, 2005, for $50,000. Taxpayer would have claimed $108,560 of Section 179 and depreciation deductions on the federal returns for 2003-2005. This results in a basis for this asset of $1,440 ($110,000 - $108,560), and a gain of $48,560 ($50,000 - $1,440) on the federal return for 2005 on the sale of the asset.

Taxpayer would have claimed $85,520 of Section 179 and depreciation deductions using the Section 179 limit of $25,000 and the MACRS depreciation method on the Iowa returns for 2003-2005. This results in a basis for this asset of $24,480 ($110,000 - $85,520), and a gain of $25,520 ($50,000 - $24,480) on the Iowa return for 2005 on the sale of the assets. Therefore, a decrease to net income of $23,040 ($48,560 - $25,520) relating to this gain adjustment must be made to the Iowa return for 2005.

This rule is intended to implement Iowa Code section 422.35.

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701—59.23(422) Additional first-year depreciation allowance. For tax periods ending on or after September 10, 2001, but beginning before May 5, 2003, the additional first-year depreciation allowance ("bonus depreciation") of 30 percent authorized in Section 168(k) of the Internal Revenue Code, as enacted by Public Law No. 107-147, Section 101, does not apply for Iowa franchise tax. For tax periods beginning on or after May 5, 2003, but beginning before January 1, 2005, the bonus depreciation of 50 percent authorized in Section 168(k) of the Internal Revenue Code, as amended by Public Law No. 108-27, Section 201, does not apply for Iowa franchise income tax. Taxpayers who claim the bonus depreciation on their federal income tax return must add the total amount of depreciation claimed on assets placed in service after September 10, 2001, but before January 1, 2005, and subtract the amount of depreciation taken on such property using the modified accelerated cost recovery system (MACRS) depreciation method applicable under Section 168 of the Internal Revenue Code without regard to Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both depreciation and the gain or loss on the sale of qualifying assets placed in service after September 10, 2001, but before January 1, 2005, can be calculated on Form IA 4562A.

See rule 701—53.22(422) for examples illustrating how this rule is applied.

This rule is intended to implement Iowa Code sections 422.35 and 422.61 as amended by 2003 Iowa Acts, Senate File 442.

701—59.24(422) Section 179 expensing. For tax periods beginning on or after January 1, 2003, but beginning before January 1, 2006, the increase in the expensing allowance for qualifying property authorized in Section 179(b) of the Internal Revenue Code, as enacted by Public Law No. 108-27, Section 202, does not apply for Iowa franchise tax. The expensing allowance is limited to $100,000 for federal tax purposes, but the expensing allowance is limited to $25,000 for Iowa tax purposes. Taxpayers who claim an expensing allowance on their federal income tax return in excess of $25,000 must limit their deduction on the Iowa return to $25,000. The difference between the federal Section 179 expensing allowance on such property, if in excess of $25,000, and the Iowa expensing allowance of $25,000 can be depreciated using the modified accelerated cost recovery system (MACRS) applicable under Section 168 of the Internal Revenue Code without regard to the bonus depreciation provision in Section 168(k).

If any such property was sold or disposed of during the tax year, the applicable Section 179 and related depreciation catch-up adjustment must be made to adjust the basis of the property for Iowa tax purposes. The gain or loss reported on the sale or disposition of these assets for federal tax purposes must be adjusted for Iowa tax purposes to account for the adjusted basis of assets.

The adjustment for both the Section 179 expensing allowance and related depreciation, along with the gain or loss on the sale of qualifying assets placed in service on or after January 1, 2003, but before January 1, 2006, can be calculated on Form IA 4562A.

See rule 701—53.23(422) for examples illustrating how this rule is applied.

This rule is intended to implement Iowa Code sections 422.35 and 422.61.

ALLOCATION AND APPORTIONMENT

701—59.25(422) Basis of franchise tax. Iowa Code section 422.60 imposes a franchise tax on financial institutions (as defined in 701—subrule 57.1(2)) for the privilege of doing business within the state. The tax is measured by net income. For financial institutions subject to the tax, the tax is levied and collected only on income which may accrue or be recognized to the financial institutions from business done or carried on in the state plus net income from certain sources without the state which by rule follows the commercial domicile of the financial institution.

If a financial institution carries on business entirely within the state of Iowa, no allocation or apportionment of its income may be made. The financial institution will be presumed to be carrying on its business entirely within the state of Iowa if its activities are carried on only within Iowa, even though it receives income from sources outside the state in the form of interest, dividends, royalties, and other sources of income from intangibles.

59.25(1) *Definition—doing business.* The term "doing business" is used in a comprehensive sense and includes all activities or any transactions for the purpose of financial or pecuniary gain or profit. Irrespective of the nature of its activities, every financial institution organized for profit and carrying out any of the purposes of its organization shall be deemed to be "doing business." In determining whether a financial institution is doing business, it is immaterial whether its activities actually result in a profit or loss.

59.25(2) *Definition—carrying on business partly within and partly without the state.* "Carrying on business partly within and partly without the state" means having business activities in at least one other state sufficient to meet the minimum constitutional standards for doing business in a state under the due process and commerce clauses of the United States Constitution. The determination of whether a financial institution is carrying on business partly within and partly without the state must be made on a tax-year-by-tax-year basis. The activities of past or future years have no bearing on the current year.

The following nonexclusive activities if done on a regular and continuing basis by financial institution officers or employees in at least one other state would constitute the minimum activities which would meet the constitutional standards for doing business in a state under the due process and commerce clauses of the United States Constitution:

a. Solicitation of loans by traveling loan officers.

b. Collection of overdue accounts.

c. Any other activities carried on in advancement, promotion, or fulfillment of the business of the financial institution.

This rule is intended to implement Iowa Code sections 422.60 and 422.63.

701—59.26(422) Allocation and apportionment.

59.26(1) The classification of income by the labels customarily given, such as interest, dividends, rents, and royalties, is of no aid in determining whether that income is business or nonbusiness income. Interest, dividends, rents and royalties shall be apportioned as business income to the extent the income was earned as a part of a financial institution's unitary business, a portion of which is conducted in Iowa. *Mobil Oil Corp. v. Commissioner of Taxes,* 455 U.S. 425 (1980); *ASARCO, Inc. v. Idaho State Tax Commission,* 458 U.S. 307, 73 L.Ed.2d 787, 102 S.Ct. 3103 (1982); *F. W. Woolworth Co. v. Taxation and Revenue Dept.,* 458 U.S. 354, 73 L.Ed.2d 819, 102 S.Ct. 3128 (1982); *Container Corporation of America v. Franchise Tax Board,* 463 U.S. 159, 77 L.Ed.2d 545, 103 S.Ct. 2933 (1983). Whether income is part of a financial institution's unitary business income depends upon the facts and circumstances in the particular situation. The burden of proof is upon the taxpayer to show that the treatment of income on the return as filed is proper. There is a rebuttable presumption that an affiliated group of financial institutions in the same line of business have a unitary relationship, although that is not the only element used in determining unitariness.

59.26(2) Application of related expense to nonbusiness income. Subrule 59.26(1) deals with the separation of "net" income, therefore, determination and application of related expenses must be made, as hereinafter directed, before allocation and apportionment within and without Iowa. Related expenses shall mean those expenses directly related.

A directly related expense shall mean an expense which can be specifically attributed to an item of income. Interest expense shall be considered directly related to a specific property which generates, has generated, or could reasonably have been expected to generate gross income if the existence of all of the facts and circumstances described below is established. Such facts and circumstances are as follows:

a. The indebtedness on which the interest was paid was specifically incurred for the purpose of purchasing, maintaining, or improving the specific property;

b. The proceeds of the borrowing were actually applied to the specified purpose;

c. The creditor can look only to the specific property (or any lease or other interest therein) as security for the loan;

d. It may be reasonably assumed that the return on or from the property will be sufficient to fulfill the terms and conditions of the loan agreement with respect to the amount and timing of payment of principal and interest; and

e. There are restrictions in the loan agreement on the disposal or use of the property consistent with the assumptions described in *"c"* and *"d"* above.

A deduction for interest may not be considered definitely related solely to specific property, even though the above facts and circumstances are present in form, if any of the facts and circumstances are not present in substance. Any expense directly attributable to allocable interest, dividends, rents and royalties shall be deducted from income to arrive at net allocable income.

EXAMPLE: For purposes of this example, it is assumed that the taxpayer has nonbusiness rental income. The taxpayer invests in a 20-story office building. Under the terms of the lease agreements, the taxpayer provides heat, electricity, janitorial services, and maintenance. The taxpayer also pays the property taxes. Construction of the building was funded through borrowings which meet the criteria of a direct expense under the provisions of this paragraph. The directly related expenses to the operation of the property are:

Interest expense	$1,200,000
Property taxes	500,000
Depreciation	500,000
Electricity	300,000
Heat	200,000
Insurance	150,000
Janitorial services	100,000
Repairs	50,000
Total expenses	$3,000,000

The directly related expense of the allocable rental income is $3,000,000.

This rule is intended to implement Iowa Code section 422.63.

701—59.27(422) Net gains and losses from the sale of assets. For purposes of administration of this rule, a capital gain or loss shall mean the sale price or value at the time of disposal of an asset less the adjusted basis, whether reportable as short-term or long-term capital gain or ordinary income for federal income tax purposes.

59.27(1) Gain or loss from the sale, exchange, or other disposition of real or tangible or intangible personal property, if the property while owned by the taxpayer was used in the taxpayer's trade or business, shall be apportioned by the business activity ratio applicable to the year the gain or loss is reported on the federal income tax return and may at the taxpayer's election be included in the computation of the business activity ratio as follows:

a. Gain from the sale, exchange, or other disposition of real property shall be included in the numerator if the property is located in this state.

b. Gain from the sale, exchange, or other disposition of tangible personal property shall be included in the numerator if:

(1) The property has a situs in this state at the time of sale; or

(2) The taxpayer's commercial domicile is in this state and the taxpayer is not taxable in the state in which the property had a situs.

c. Gains from the sale, exchange, or other disposition of intangible personal property shall be included in the numerator if the taxpayer's commercial domicile is in this state.

d. All gains shall be included in the denominator of the activity ratio.

A taxpayer cannot elect to exclude or include gains or loss from the sale of assets where the election would result in an understatement of income reasonably attributable to Iowa. Noninclusive examples of gains or loss from the sale, exchange or other disposition of real or tangible or intangible property which may not be included in the computation of the business activity ratio because to do so would result in an understatement of net income reasonably attributable to Iowa are the gain recognized under an election pursuant to Section 338 of the Internal Revenue Code or gain recognized under Section 631(a) of the Internal Revenue Code.

59.27(2) Gain or loss from the sale, exchange, or other disposition of property not used in the taxpayer's trade or business shall be allocated as follows:

a. Gains or losses from the sale, exchange, or other disposition of real property located in this state are allocable to this state.

b. Gains or losses from the sale, exchange, or other disposition of tangible personal property are allocable to this state if:

(1) The property has a situs in this state at the time of sale; or

(2) The taxpayer's commercial domicile is in this state and the taxpayer is not taxable in the state in which the property had a situs.

c. Gains or losses from the sale, exchange, or other disposition of intangible personal property are allocable to this state if the taxpayer's commercial domicile is in this state.

This rule is intended to implement Iowa Code section 422.63.

701—59.28(422) Apportionment factor. In determining the total net taxable income, the apportionable income attributable to this state, as determined by use of the apportionment fraction, shall be added to the nonapportionable income allocable to this state.

59.28(1) Receipts derived from transactions and activities in the regular course of trade or business which produce business income are included in the denominator of the apportionment factor. Income which is not subject to the Iowa franchise tax shall not be included in the computation of the apportionment factor.

59.28(2) The numerator of the apportionment factor is that portion of the total receipts included in the denominator of the taxpayer attributable to this state during the income year determined as follows:

a. Receipts from the lease, rental, or other use of real property shall be included in the numerator if the real property is located in Iowa.

b. Receipts from the sale of tangible personal property shall be included in the numerator if the property is delivered or shipped to a purchaser in this state regardless of the f.o.b. point or other conditions of the sales.

c. Receipts from the use of tangible personal property shall be included in the numerator of the business activity formula to the extent that property is utilized in Iowa. The extent of utilization of tangible personal property in a state is determined by multiplying the rent by a fraction, the numerator of which is the number of days of physical location of the property in the state during the rental period in the taxable year and the denominator of which is the number of days of physical location of the property everywhere during all rental periods in the taxable year. If the physical location of the property during the rental period is unknown or not ascertainable by the taxpayer, tangible personal property is utilized in the state in which the property was located at the time the rental payer obtained possession.

d. All royalty income from intangible personal property determined to be business income shall be included in the numerator of the business activity formula if the taxpayer's commercial domicile is in Iowa. All royalty income from tangible personal property or real property determined to be business income shall be included in the numerator of the business activity formula if the situs of the tangible personal property or real property is within Iowa.

e. Interest and other receipts from assets in the nature of loans (including federal funds sold and banker's acceptances) and installment obligations shall be attributed to the state where the borrower is located.

f. Interest income from a participating bank's portion of participation loan shall be attributed to the state where the borrower is located.

g. Interest income from loans solicited by traveling loan officers shall be attributed to the state where the borrower is located.

h. Interest or service charges from bank, travel, and entertainment credit card receivables and credit card holders' fees shall be attributed to the state in which the credit card holder resides in the case of an individual or, if a corporation, to the state of the corporation's commercial domicile.

i. Merchant discount income derived from bank and financial corporation credit card holder transactions with a merchant shall be attributed to the state in which the merchant is located. It shall be presumed that the location of the merchant is the address on the invoice submitted by the merchant to the taxpayer.

j. Receipts for the performance of fiduciary services are attributable to the state where the services are principally performed.

k. Receipts from investments of a bank in securities, the income from which constitutes business income, shall be attributed to its commercial domicile except that:

(1) Receipts from securities used to maintain reserves against deposits to meet federal and state reserve deposit requirements shall be attributed to each state based upon the ratio that total deposits in the state bear to total deposits everywhere.

(2) Receipts from securities owned by a bank but held by a state treasurer or other public official or pledged to secure public or trust funds deposited in the bank shall be attributed to the banking office at which the secured deposit is maintained.

l. Receipts (fees or charges) from the issuance of traveler's checks and money orders shall be attributed to the state where the taxpayer's office is located that issued the traveler's checks. If the traveler's checks are issued by an independent representative or agent of the taxpayer, the fees or charges shall be attributed to the state where the independent representative or agent issued the traveler's checks.

m. Fees, commissions, or other compensation for financial services rendered for a customer located in this state or an account maintained within this state.

n. Any other gross receipts resulting from the operation as a financial organization within the state to the extent the items do not represent a recapture of an expense.

o. Receipts from management services if the recipient of the management services is located in this state.

This rule is intended to implement Iowa Code section 422.63.

701—59.29(422) Allocation and apportionment of income in special cases. If a taxpayer feels that the allocation and apportionment method as prescribed by rule 701—59.28(422) in the taxpayer's case results in an injustice, the taxpayer may petition the department for permission to determine the taxable net income, both allocable and apportionable, to the state on some other basis.

The taxpayer must first file the return as prescribed by rule 701—59.28(422) and pay the tax shown due thereon. If a change to some other method is desired, a statement of objections and schedules detailing the alternative method shall be submitted to the department. The department shall require detail and proof within the time as the department may reasonably prescribe. In addition, the alternative method of allocation and apportionment will not be allowed where the taxpayer fails to produce, upon request of the department, any information the department deems necessary to analyze the request for an alternative method of allocation and apportionment. The petition must be in writing and shall set forth in detail the facts upon which the petition is based. The burden of proof will be on the taxpayer as to the validity of the method and its results. The mere fact that an alternative method of apportionment or allocation produces a lesser amount of income attributable to Iowa is, per se, insufficient proof that the statutory method of allocation and apportionment is invalid. *Moorman Manufacturing Company v. Bair,* 437 U.S. 267, 57 L.Ed.2d 197 (1978). In essence, a comparison of the statutory method of apportionment with another formulary apportionment method is insufficient to prove that the taxpayer would be entitled to the alternative formulary apportionment method. *Moorman Manufacturing Company v. Bair,* supra.

One of the possible alternative methods of allocation and apportionment is separate accounting provided the taxpayer's activities in Iowa are not unitary with the taxpayer's activities outside Iowa. Any corporation deriving income from business operations partly within and partly without Iowa must determine that net business income attributable to this state by the prescribed formula for apportioning net income, unless the taxpayer proved by clear and cogent evidence that the statutory formula apportions income to Iowa out of all reasonable proportion to the business transacted within Iowa. *Moorman Manufacturing Company v. Bair,* supra.

Separate accounting is not allowable for a unitary business where the separate accounting method fails to consider factors of profitability resulting from functional integration, centralization of management, and economics of scale. *Shell Oil Company v. Iowa Department of Revenue,* 414 N.W.2d 113 (Iowa 1987).

The burden of proof that the statutory method of apportionment attributes to Iowa income out of all reasonable proportion to the business transacted within Iowa is on the taxpayer. In order to utilize separate accounting, the taxpayer's books and records must be kept in a manner that accurately depicts the exact geographical source of profits. In any petition to utilize separate accounting, the taxpayer must submit schedules which accurately depict net income by division or product line and the amount of income earned within Iowa.

There are alternative methods of separate accounting utilizing different accounting principles. A mere showing that one separate accounting method produces a result substantially different than the statutory method of apportionment is not sufficient to justify the granting of the separate accounting method shown. The taxpayer must not only show that the separate accounting method advocated by the taxpayer in comparison with the statutory method of apportionment produces a result which, if the statutory method of apportionment were used, would be out of all reasonable proportion to the business transacted within Iowa. The taxpayer must also show that all other conceivable reasonable separate accounting methods would show, when compared with the statutory method of apportionment, that the statutory method of apportionment substantially produces a distorted result.

As used in this rule, "statutory method of apportionment" means the apportionment factor set forth in rule 701—59.28(422).

All requests to use an alternative method of allocation and apportionment submitted to the department will be considered by the compliance division if the request is the result of an audit or by the policy section of the compliance division if the request is received prior to audit. If the department concludes that the statutory method of allocation and apportionment is, in fact, both inapplicable and inequitable, the department shall prescribe a special method. The special method of allocation and apportionment prescribed by the department may be that requested by the taxpayer or some other method of allocation and apportionment which the department deems to equitably attribute income to business activities carried on within Iowa.

If the taxpayer disagrees with the determination of the department, the taxpayer may file a protest within 60 days of the date of the letter setting forth the department's determination and the reasons therefor in accordance with rule 701—7.41(17A). The department's determination letter shall set forth the taxpayer's rights to protest the department's determination.

If no protest is filed within the 60-day period, then no hearing will be granted on the department's determination under this rule. However, this does not preclude the taxpayer from subsequently raising this question in the event that the taxpayer protests an assessment or denial of a timely refund claim, but this issue will only be dealt with for the years involved in the assessment or timely refund claim.

The use of an alternative method of allocation and apportionment would only be applicable to the years under consideration at the time the special method of allocation and apportionment is prescribed. The taxpayer's continued use of a prescribed method of allocation and apportionment will be subject to review and change within the statutory, or legally extended period(s).

If there is a material change in the business operations or accounting procedures from those in existence at the time the taxpayer was permitted to determine the net income earned within Iowa by an alternative method of allocation and apportionment, the taxpayer shall apprise the department of such changes prior to filing the taxpayer's return for the current year. After reviewing the information submitted, along with any other information the department deems necessary, the department will notify the taxpayer if the alternative method of allocation and apportionment is deemed applicable.

This rule is intended to implement Iowa Code section 422.63.

Rules 701—59.25(422) to 701—59.29(422) are effective for tax years beginning on or after June 1, 1989.

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◊Two ARCs

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◊Two ARCs

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