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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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CHAPTER 33
FORFEITED PROPERTY

61—33.1(809A) Scope of rules. These rules apply to property forfeited under the authority of Iowa Code section 809A.25. They do not apply to property seized for forfeiture by the department of natural resources under Iowa Code section 483A.33.

61—33.2(809A) Maintenance and storage of property during pendency of proceedings. The seizing agency that initiates a seizure for forfeiture must arrange for and pay costs associated with the proper care of property seized for forfeiture within the following guidelines:

33.2(1) Motor vehicles.

a. Motor vehicles must be stored in a manner which will minimize deterioration due to lack of operation and maintenance.

b. The use of commercial towing and storage facilities is at the expense of the seizing agency. The department will not assume responsibility for such fees, whether before or after forfeiture, unless the department decides to retain ownership of the vehicle for its use instead of transferring title to the seizing agency.

33.2(2) Cash. Where possible, a seizing agency should, in cooperation with the prosecuting attorney, secure a court order authorizing cash to be deposited in an interest-bearing account. The department will not claim any interest in income derived from such account, but the interest must be accounted for as provided by these rules.

33.2(3) Real property.

a. Unoccupied structures of value must be equipped with alarm systems or otherwise safeguarded to protect them from unlawful entry and damage by fire. The seizing agency should consider the value of the property, the condition of existing gates and locks, and the potential threat to public safety when determining whether alarm systems or other safeguards are appropriate.

b. Real property that complies with local and state building and housing code standards at the time of seizure must be maintained to local and state building and housing code standards as well as to the standard of neighboring properties, including mowing and removal of snow as necessary. Seized property that does not comply with code standards at the time of seizure must not be allowed to degrade and should be maintained in a condition that does not present a threat to public safety.

33.2(4) Other property. Property other than listed above shall be cared for as appropriate, giving due consideration to the nature of the property.

61—33.3(809A) Notice to department.

33.3(1) An agency which seizes property for forfeiture must notify the department within ten days of the seizure. Notice shall include the identity of the party from whom the property was seized, the date and county of seizure, and an inventory of the property seized for forfeiture.

33.3(2) A prosecuting attorney who obtains a declaration of forfeiture or an order forfeiting property must provide the department with a copy of the declaration or the order forfeiting the property within ten working days of receiving the order.

[ARC 8476B, IAB 1/13/10, effective 2/17/10]

61—33.4(809A) Disposition of forfeited property.

33.4(1) Controlled substances. An agency in possession of a controlled substance which has been forfeited shall dispose of it as required by Iowa Code section 124.506.

33.4(2) Obscene materials. Materials which violate the provisions of Iowa Code chapter 728 shall be destroyed. An inventory and a record of the destruction of obscene materials shall be maintained by the agency.

33.4(3) Firearms and ammunition. Forfeited firearms and ammunition must be disposed of pursuant to the rules of the department of public safety.

33.4(4) Real property. An agency seizing real property for forfeiture must do the following:

a. Accept transfer of title from the department.

b. Pay all costs associated with transfer of title, including abstracting costs, property taxes and assessments.

c. Indemnify the state for any expenses it might become liable for by being the owner of the property during the forfeiture and transfer process, including but not limited to environmental cleanup costs, abstracting costs, and any expenses the department incurs to comply with reasonable community standards of maintenance.

d. Indemnify the state for any expenditures incurred as a result of liability to a third party for any injury associated with the property which occurs during the period from seizure through transfer of ownership to the agency.

e. The department will retain 20 percent of the gross sale price of the real property. The balance of the proceeds, 80 percent, will be given to the seizing agency for its use or for division among law enforcement agencies and prosecutors pursuant to agreement.

33.4(5) *Alcoholic beverages and beer.* Alcoholic beverages and beer shall be destroyed. An inventory and a record of the destruction of forfeited alcoholic beverages and beer shall be maintained by the agency.

33.4(6) *Motor vehicles.*

a. Orders forfeiting motor vehicles must include a physical description of the vehicle, as well as the vehicle identification number.

b. Motor vehicles must be titled to the department prior to being transferred to the seizing agency or its designee.

c. The department requires payment of a fee of \$200 for processing the transfer of title to a vehicle.

33.4(7) *Cash.*

a. The department will retain 20 percent of forfeited cash. The balance of forfeited cash, 80 percent, will be given to the seizing agency for its use or for division among law enforcement agencies and prosecutors pursuant to agreement.

b. In the event of a cash forfeiture in excess of \$400,000, amounts over \$400,000 shall be apportioned as follows: 40 percent to the seizing agency or agencies; 40 percent to other law enforcement agencies within the region; and 20 percent to be retained by the department.

[ARC 8476B, IAB 1/13/10, effective 2/17/10]

61—33.5(809A) Use by the department. The department will review each item of forfeited property to determine if it is of a nature that would be useful to the department in enforcement of the law. If such a use exists, the department may take possession of the property and retain ownership instead of transferring it to the seizing agency.

[ARC 8476B, IAB 1/13/10, effective 2/17/10]

61—33.6(809A) Gifts to other law enforcement agencies.

33.6(1) If the department determines that it does not have use for an item of forfeited property, the seizing agency must accept ownership of the property and use or dispose of it under these guidelines.

33.6(2) If the department determines that property is available for gift to agencies involved in the investigation or prosecution of a case but is presented with conflicting requests for its gift, the department may refuse to give the property to any of the agencies.

33.6(3) Forfeited property, including cash, must be used to enhance the enforcement of the criminal law and cannot be used to supplant or otherwise replace normally budgeted items. Questions regarding the propriety of the disposition of forfeited assets should be directed to the department.

61—33.7(809A) Record keeping. An agency which seizes property for forfeiture shall maintain records showing the disposition, including destruction, of forfeited property for a period of three years from the date of forfeiture. The records shall comply with any recommendations of the state auditor but must, at a minimum, include the following:

1. The date of forfeiture, a description of the property and the name(s), if available, of the person(s) who owned the property and person(s) in possession of the property at the time of seizure.

2. The manner in which all forfeited property has been used by the agency.

3. The disposition of all forfeited property which has been sold or otherwise disposed of, and of the proceeds derived therefrom.

4. The manner of use of all forfeited funds and proceeds from the sale of forfeited property.

61—33.8(809A) Failure to comply. If the department determines that an agency is not in compliance with these rules, the department may suspend, temporarily or permanently, the agency's privilege of receiving gifts of forfeited property.

61—33.9(809A) Appeal. An agency may appeal a decision to suspend its privilege to receive gifts of forfeited property under rule 61—33.8(809A) or other departmental action upon the basis that it has not been done according to these rules as follows:

33.9(1) Appeal to deputy attorney general for criminal justice. An applicant may file a notice of appeal to the deputy attorney general within 30 days of the departmental action that forms the basis of appeal. The deputy attorney general shall review the matter, taking testimony if necessary, and issue a written decision.

33.9(2) Appeal to attorney general. An agency may further appeal from a denial of appeal by the supervising deputy to the attorney general within 30 days of the date the supervising deputy's written decision was mailed.

33.9(3) Appeal to district court. An agency which disagrees with the decision of the attorney general has the right to appeal to the district court within 30 days of receipt of the attorney general's final decision.

61—33.10(809A) Interest holders.

33.10(1) The term "interest holder" shall include an entity which owns or holds a properly perfected mortgage, security interest, or other interest in real or personal property.

33.10(2) An interest holder with an exempt interest in forfeited property may be appointed as an agent to act in disposing of forfeited property. An interest holder acting as an agent in disposing of forfeited property shall be relieved of any and all duties that would be imposed on the lienholder if it were acting in its capacity as a lienholder.

These rules are intended to implement Iowa Code chapter 809A.

[Filed 6/29/98, Notice 2/11/98—published 7/15/98, effective 8/19/98]

[Filed ARC 8476B (Notice ARC 8257B, IAB 11/4/09), IAB 1/13/10, effective 2/17/10]

ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]

[Created by 1986 Iowa Acts, chapter 1245]
[Prior to 1/14/87, see Iowa Development Commission[520] and Planning and Programming[630]]

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261—47.1(15E,83GA,SF478) Purpose. The purpose of endow Iowa tax credits is to encourage individuals, businesses, and organizations to invest in community foundations and to enhance the quality of life for citizens of this state through increased philanthropic activity.

[ARC 8474B, IAB 1/13/10, effective 2/17/10]

261—47.2(15E,83GA,SF478) Definitions.

“Act” means Iowa Code sections 15E.301 to 15E.306 as amended by 2009 Iowa Acts, Senate File 478.

“Community affiliate organization” means a group of five or more community leaders or advocates organized for the purpose of increasing philanthropic activity in an identified community or geographic area in the state with the intention of establishing a community affiliate endowment fund.

“Department” or “IDED” means the Iowa department of economic development.

“Endow Iowa qualified community foundation” means a community foundation organized or operating in this state that substantially complies with the national standards for U.S. community foundations established by the National Council on Foundations as determined by the department in collaboration with the Iowa Council of Foundations.

“Endowment gift” means an irrevocable contribution to a permanent endowment held by an endow Iowa qualified community foundation.

“Permanent endowment fund” means a fund held in an endow Iowa qualifying community foundation to provide benefit to charitable causes in the state of Iowa. Endowed funds are intended to exist in perpetuity, and to implement an annual spend rate not to exceed 5 percent.

“Tax credit” means the amount an individual may claim against the taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, and against the moneys and credits tax imposed in Iowa Code section 533.24.

[ARC 8474B, IAB 1/13/10, effective 2/17/10]

261—47.3(15E,83GA,SF478) Allocation of funds. The department shall authorize tax credits to qualified individuals who provide an endowment gift to an endow Iowa qualified community foundation or a community affiliate organization affiliated with an endow Iowa qualified community foundation for a permanent endowment fund within the state of Iowa in accordance with the following provisions:

47.3(1) Approved tax credits shall be allowed against taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, and against the moneys and credits tax imposed in Iowa Code section 533.24.

47.3(2) Beginning January 1, 2010, approved tax credits will be equal to 25 percent of a taxpayer’s gift to a permanent endowment held in an endow Iowa qualified community foundation. The amount of the endowment gift for which the endow Iowa tax credit is claimed shall not be deductible in determining taxable income for state income tax purposes.

47.3(3) The amount of tax credits authorized pursuant to this rule shall not exceed a total of \$3 million annually, plus an additional amount pursuant to Iowa Code section 99F.11(3)“e”(3). The maximum amount of tax credits granted to a single taxpayer annually shall not exceed \$100,000. If the department receives applications for tax credits in excess of the amount available, the applications shall be prioritized by the date the department received the applications. If the number of applications exceeds the amount of annual tax credits available, the department shall establish a wait list for the next year’s allocation of tax credits and applications shall first be funded in the order listed on the wait list.

47.3(4) Any tax credit in excess of the taxpayer’s tax liability for the tax year may be credited to the tax liability for the following five years or until depleted, whichever occurs first.

47.3(5) A tax credit shall not be carried back to a tax year prior to the tax year in which the taxpayer claims the tax credit.

47.3(6) A tax credit shall not be transferable to any other taxpayer.

[ARC 8474B, IAB 1/13/10, effective 2/17/10]

261—47.4(15E,83GA,SF478) Distribution process and review criteria. The department shall develop and make available a standardized application pertaining to the allocation of endow Iowa tax credits.

47.4(1) Twenty-five percent of the annual amount available for tax credits shall be reserved for those permanent endowment gifts made to community affiliate organizations. If by September 1 of any year the entire 25 percent reserved for permanent endowment gifts corresponding to community affiliate organizations is not allocated, the amount remaining shall be available for other applicants.

47.4(2) Ten percent of the annual amount available for tax credits shall be reserved for those permanent endowment gifts totaling \$30,000 or less. If by September 1 of any year the entire 10 percent reserved for permanent endowment gifts totaling \$30,000 or less is not allocated, the amount remaining shall be available for other applicants.

47.4(3) Applications will be accepted and awarded on an ongoing basis. The department will make public by June 1 and December 1 of each calendar year the total number of requests for tax credits and the total amount of requested tax credits that have been submitted and awarded.

[ARC 8474B, IAB 1/13/10, effective 2/17/10]

261—47.5(15E,83GA,SF478) Reporting requirements. By January 31 of each calendar year, the department shall publish an annual report of the activities conducted pursuant to these rules during the previous calendar year and shall submit the report to the governor and general assembly. The annual report shall include the information required by Iowa Code section 15.104(9) “h.”

[ARC 8474B, IAB 1/13/10, effective 2/17/10]

These rules are intended to implement Iowa Code sections 15E.301 to 15E.306 as amended by 2009 Iowa Acts, Senate File 478.

[Filed 11/20/03, Notice 10/1/03—published 12/24/03, effective 1/28/04]

[Filed 10/21/05, Notice 8/3/05—published 11/9/05, effective 12/14/05]

[Filed ARC 8474B (Notice ARC 8228B, IAB 10/7/09), IAB 1/13/10, effective 2/17/10]

PART XIII
IOWA BROADBAND DEPLOYMENT GOVERNANCE BOARD
CHAPTER 410
BOARD STRUCTURE AND PROCEDURES

261—410.1(83GA,SF376) Purpose. Pursuant to 2009 Iowa Acts, Senate File 376, section 13(5), the Iowa broadband deployment governance board is charged with establishing a comprehensive broadband plan and a competitive process for granting funds to deploy and sustain high-speed broadband services. The Iowa broadband deployment governance board was established by the IUB, IDED and ITTC. Administrative support and planning costs will be provided jointly by the IUB, IDED and ITTC. [ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—410.2(83GA,SF376) Definitions. As used in these rules, unless the context otherwise requires: “Administrative support and planning costs” means costs that include, but are not limited to, providing staff to perform the following functions for the governance board:

1. Review and summarize grant applications.
2. Offer technical and other advice to the board.
3. Prepare and distribute public notices, record meetings, prepare minutes, attend board meetings, and complete other tasks related to board meetings.
4. Assist and advise the board in preparing a comprehensive plan for high-speed broadband access.
5. Assist and advise the board in developing and implementing a competitive process for disbursing funds.

6. Establish and maintain separate accounts for the use of bond proceeds and non-bond proceeds. “Board” or “governance board” means the Iowa broadband deployment governance board created by IUB, IDED, and ITTC as authorized by 2009 Iowa Acts, Senate File 376, section 13(5).

“IDED” means the Iowa department of economic development created by Iowa Code section 15.103.

“ITTC” means the telecommunications and technology commission created by Iowa Code section 8D.3.

“IUB” means the Iowa utilities board created by Iowa Code section 474.1.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—410.3(83GA,SF376) Iowa broadband deployment governance board.

410.3(1) Composition. The board shall be comprised of one member from each of the following categories:

1. Educational users.
2. Cities.
3. Counties.
4. Urban residential users.
5. Rural residential users.
6. Cable providers.
7. Wireline providers.
8. Wireless providers.
9. Utilities board.
10. Economic development board.
11. Telecommunications and technology commission.
12. House majority party (nonvoting member).
13. House minority party (nonvoting member).
14. Senate majority party (nonvoting member).
15. Senate minority party (nonvoting member).

410.3(2) Quorum. A quorum of the board shall be a majority of the voting members.

410.3(3) Terms. Board members shall be appointed for three-year terms.

410.3(4) Officers. The board shall annually elect a chairperson of the board and a vice-chairperson of the board. The board may annually elect such other officers as the board deems proper. The chairperson,

vice-chairperson, and any other officers of the board shall be elected by a majority vote of the voting members who are present.

410.3(5) Board committees.

a. Advisory committees. The board may establish an application review committee and may create such other advisory committees as deemed necessary by the board to perform its duties. The board shall elect the members of committees by majority vote. The board chairperson shall designate the chairperson and vice-chairpersons of all committees.

b. Nominations committee. The board chairperson may appoint a nominations committee for the purpose of making recommendations regarding the election of a board chairperson, board vice-chairperson, and membership on board committees and the appointment of committee chairpersons and committee vice-chairpersons.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—410.4(83GA,SF376) Board duties. The board shall perform the duties as outlined in 2009 Iowa Acts, Senate File 376, section 13(5), and other functions as necessary and proper to carry out its responsibilities. The board's duties include the following:

410.4(1) Comprehensive plan for broadband access. The board shall establish a comprehensive statewide plan for the deployment and sustainability of high-speed broadband access in areas capable of timely implementation of such access. The plan shall be consistent with federal requirements established for federal funds made available for the purposes of projects that may be considered by the board. The plan shall require collaboration involving qualified private providers and public entities as appropriate. The plan shall allow for the participation of public entities to accomplish project purposes that are financially feasible in areas of the state that remain unserved or underserved as a result of a lack of private sector investment.

410.4(2) Competitive grant program for broadband deployment. The board shall establish a competitive process for the disbursement of funds in the form of grants for the deployment and sustainability of high-speed broadband services.

410.4(3) Legislative recommendations. The board shall make recommendations to the general assembly regarding any necessary legislation needed to further the purposes of the board.

410.4(4) Program oversight and transparency. The board shall establish a process for the oversight and transparency of grants distributed by the board.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—410.5(83GA,SF376) Board and committee procedures.

410.5(1) Meetings and agendas. Meetings of the board and committee(s) are generally held monthly. By notice of the regularly published meeting agenda, the board and committee may hold regular or special meetings at locations within the state. Meeting agendas are available at the following Web site: www.broadband.iowa.gov.

410.5(2) Meeting procedures.

a. Any interested party may attend and observe board and committee meetings except for such portion as may be closed pursuant to Iowa Code section 21.5.

b. Observers may use cameras or recording devices during the course of a meeting so long as the use of such devices does not materially hinder the proceedings. The chairperson may order that the use of these devices be discontinued if they cause interference and may exclude any person who fails to comply with that order.

c. Open-session proceedings may be electronically recorded. Minutes of open meetings shall be available for viewing at www.broadband.iowa.gov.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—410.6(83GA,SF376) Conflicts of interest.

410.6(1) Definition.

“Conflict of interest” means that a member of the board:

1. Has a significant employment relationship with an applicant; or

2. Is a member of the board of directors or a stockholder of a corporate applicant; or
3. Has a financial relationship with an applicant, including but not limited to an investor, a contractor, or a consultant; or
4. Is an immediate family member of a person who has a conflict of interest under this rule. For the purposes of this rule, “immediate family” means a member’s spouse, children, grandchildren and parents.

410.6(2) Procedures. As soon as a member of the board or a committee becomes aware of a conflict of interest in a project for which applications are filed with the board or for which potential applications are discussed by the board or committee, the member shall follow these procedures:

- a. If the conflict is known before a meeting, the member shall fully disclose the interest to the chairperson of the board in writing at least 24 hours before the meeting.
- b. If the conflict is discovered during a meeting, the member shall orally inform the board, and the nature of the conflict shall be reported in writing to the chairperson of the board within 24 hours after the meeting.
- c. The member who has the conflict shall not participate in discussion or vote on any issues concerned with the project.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

These rules are intended to implement 2009 Iowa Acts, Senate File 376, section 13(5).

[Filed Emergency ARC 8218B, IAB 10/7/09, effective 9/17/09]

[Filed ARC 8473B (Notice ARC 8219B, IAB 10/7/09), IAB 1/13/10, effective 2/17/10]

CHAPTER 411
IOWA BROADBAND DEPLOYMENT PROGRAM

261—411.1(83GA,SF376) Purpose. These rules are intended to implement 2009 Iowa Acts, Senate File 376, section 13(5), relating to public broadband technology grants for the deployment and sustainability of high-speed broadband access. The purpose of the Iowa broadband deployment program is to promote universal access to sustainable high-speed broadband services, at speeds to exceed federal requirements, throughout the state for the benefit of Iowans, by awarding state grant funds to be used as matching funds for the federal funds available for broadband infrastructure projects.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—411.2(83GA,SF376) Definitions. In addition to the definitions in 261—Chapter 410, the following definitions shall apply to the Iowa broadband deployment program:

“Affordable rates” means the current price for high-speed broadband services being charged for similar services in areas with two or more broadband providers, as demonstrated by published or advertised unbundled prices. If there are no existing high-speed broadband services in the proposed funded service area or if there is only one existing provider of high-speed broadband services in the proposed funded service area, projects will be evaluated on the ability of applicants to demonstrate that their proposed pricing is affordable for the service area.

“Areas capable of timely implementation of high-speed broadband access” means those areas in Iowa where broadband infrastructure projects can be deployed or completed consistent with requirements established for federal funding.

“Community anchor institutions” means schools, libraries, medical and health care providers, public safety entities, community colleges and other institutions of higher education, and other community support organizations and agencies that provide outreach, access, equipment, and support services to facilitate greater use of broadband service by vulnerable populations, including low-income, unemployed, and the aged.

“Critical community facilities” means public facilities that provide community services essential for supporting the safety, health, and well-being of residents, including, but not limited to, emergency response and other public safety activities, hospitals and clinics, libraries and schools.

“Economically sustainable” means that a broadband project funded by the board will require no further government assistance beyond the funding period to remain viable into the future. A broadband project shall not be deemed “economically sustainable” if the broadband project will only continue beyond the funding period with the assistance of additional government grants. Notwithstanding anything to the contrary in this definition, “government assistance” shall not include: (1) fees or other revenues paid from government users in exchange for the ordinary use of broadband services, or (2) ongoing government funding provided by the federal Universal Service Fund. For purposes of this definition, “government” refers to any branch or level of government, including the federal government, any state government, or any political subdivision.

“Federal funds” means funding available for broadband infrastructure initiatives under the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (Feb. 17, 2009) that will be awarded by either the U.S. Department of Agriculture Rural Utilities Service through the Broadband Initiatives Program (BIP) or the U.S. Department of Commerce National Telecommunications and Information Administration through the Broadband Technology Opportunities Program (BTOP).

“Federal requirements” means requirements established for the receipt of federal funds for broadband infrastructure initiatives pursuant to the American Recovery and Reinvestment Act of 2009.

“Grant agreement” means the agreement between the grantee and the ITTC, on behalf of the board for grants awarded under the program, including any amendments thereto.

“Grantee” means the recipient of a grant under the program.

“Grant funds” means state funds provided pursuant to a grant made under the program.

“High-speed broadband service” or *“broadband”* means providing two-way data transmission with advertised speeds that exceed 768 kilobits per second (kbps) downstream and at least 200 kbps

upstream to end users, or providing sufficient capacity in a middle mile project to support the provision of broadband service to end users.

“Last mile project” means any infrastructure project the predominant purpose of which is to provide broadband service to end users or end-user devices (including households, businesses, community anchor institutions, public safety entities, and critical community facilities).

“Middle mile project” means a broadband infrastructure project that does not predominantly provide broadband service to end users or to end-user devices, and may include interoffice transport, backhaul, Internet connectivity, or special access.

“Program” means the Iowa broadband deployment program administered by the governance board to award funds available for broadband deployment pursuant to the competitive grant process established in these rules and to oversee the establishment and implementation of a statewide high-speed broadband deployment plan.

“Qualified private providers” means nongovernmental local exchange carriers, cable television companies, commercial mobile radio service companies, or other entities that offer or are capable of offering broadband services in Iowa and that make minimum broadband capacity available to all business, government, educational, and residential locations within the project area.

“State broadband mapping project” means the statewide broadband data collection, mapping, and planning project conducted by the state’s designated eligible entity in cooperation with the Iowa utilities board under the Broadband Data Improvement Act of 2008 (BDIA), Title I of Public Law 110-385, 122 Stat. 4096 (Oct. 10, 2008) and as funded by the State Broadband Data and Development Grant Program.

“Synchronous data transmission” means broadband transmission services where the upstream and downstream speeds are equal.

“Underserved areas of the state” means, for last mile projects, a proposed funded service area composed of one or more contiguous census blocks where (1) no more than 50 percent of the households have access to facilities-based, terrestrial broadband service at speeds that exceed the minimum broadband transmission speeds set forth in the definition of “broadband” above; (2) no fixed or mobile broadband service provider advertises broadband transmission speeds of at least three megabits per second downstream; or (3) the rate of broadband subscription is 40 percent of households or less. A proposed funded service area may qualify as underserved for middle mile projects if one interconnection point terminates in a proposed funded service area that qualifies as unserved or underserved for last mile projects.

“Unserved areas of the state” means a proposed funded service area composed of one or more contiguous census blocks where at least 90 percent of households in the proposed funded service area lack access to facilities-based, terrestrial broadband service, either fixed or mobile, at speeds that exceed the minimum broadband transmission speeds set forth in the definition of “broadband” above. A household has access to broadband service if the household can readily subscribe to that service upon request.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—411.3(83GA,SF376) Eligible applicants. The following entities are eligible to apply for assistance:

1. State agencies and local governments, including municipal utilities;
2. A nonprofit foundation, a nonprofit corporation, a nonprofit institution, or a nonprofit association, or other nonprofit entities; and
3. Qualified private providers.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—411.4(83GA,SF376) Forms of assistance. Financial assistance for an application approved by the board will be provided in the form of a grant. Grants shall be subject to the provisions of 2009 Iowa Acts, Senate File 376, section 13(5), the administrative rules in 261—Chapters 410 through 412, and the terms and conditions of a grant agreement.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—411.5(83GA,SF376) Threshold application requirements. Applicants must satisfy threshold eligibility requirements to qualify for funding. Applications that fail to meet threshold eligibility requirements will not be considered by the board. An applicant must meet each of the following threshold eligibility factors in order to be considered for a grant award by the board:

411.5(1) Fully completed application. Applicants must submit a complete application and provide all supporting documentation required for the application.

411.5(2) Timely project completion. A project is eligible only if the application demonstrates that the project can be completed within 24 months of the award date or by December 31, 2012, whichever date is earlier.

411.5(3) Fully funded project costs. A project is eligible only if, after approval of the grant and any federal grants and loans, all project costs can be fully funded. To demonstrate this, applicants must include with the application evidence of all funding necessary to support the project.

411.5(4) Capital projects. A project is eligible only if the proposed project is for capital expenditures. Program grant funds shall only be used for capital expenditures. The board may require applicants to submit descriptions and itemized lists of capital expenditures for which the applicants intend to use grant money. Additionally, all uses and proposed uses of grant funds shall be subject to review by the board, attorneys for the board or the state of Iowa, and any accountants or auditors retained by the board or the state of Iowa. If a use or proposed use of grant funds is not for capital expenditures, as defined by the board's legal counsel or generally accepted accounting principles, the board may withdraw all or part of a grant award and the board may seek recovery of any grant funds already disbursed to the grantee. Nothing in this subrule shall be construed as limiting the board's authority or any remedies available to the board to ensure that grant awards are spent only on capital expenditures. Furthermore, nothing in this subrule shall be construed as limiting the board's authority to impose additional restrictions on the use of grant funds in award contracts with grantees.

411.5(5) Economically sustainable. Only projects that are economically sustainable are eligible for an award. Applicants must demonstrate through a viable business plan that any project undertaken and funded by the board shall be economically sustainable.

411.5(6) Minimum broadband capacity. Only projects that intend to provide "high-speed broadband service," as defined in 261—411.2(83GA,SF376), throughout the project area are eligible for an award.

411.5(7) Federal funds. Only projects that will further the purposes of 2009 Iowa Acts, Senate File 376, section 13(5), and that have received a notice of an award of federal funds under either the BIP or BTOP Program are eligible for an award.

411.5(8) Project meets statutory requirements. 2009 Iowa Acts, Senate File 376, section 13(5), establishes minimum eligibility requirements for the program. Only projects that meet these statutory requirements for assistance are eligible for an award. To qualify, projects must be designed to accomplish all of the following:

a. Provide minimum broadband capacity throughout the area as determined by the governance board consistent with any applicable state and federal law or guidelines. The governance board shall ensure that the minimum broadband capacity established exceeds any federal requirements established with regard to the availability of federal funds.

b. Make broadband connections available to all business, government, educational, and residential locations within the project area, as appropriate for the type of project.

c. Utilize, where appropriate and feasible, existing privately owned telecommunications fiber infrastructure and wireless facilities to establish universal access to high-speed broadband services, as appropriate and consistent with the priorities established by the governance board for the program.

d. Demonstrate that any project undertaken and funded by the governance board shall be economically sustainable with no further government assistance based upon expected revenue generation.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—411.6(83GA,SF376) Application process.

411.6(1) *Notice of intent to apply for state broadband deployment funds.* Potential applicants are encouraged to submit a Notice of Intent to Apply form to the board prior to submitting an application with the board. A copy of the form is available at www.broadband.iowa.gov. Failure to complete and submit a Notice of Intent to Apply form shall not preclude an entity from applying for or receiving a grant from the board. Furthermore, the board shall not prejudice or take other adverse action against an entity because that entity failed to complete and submit a Notice of Intent to Apply form.

411.6(2) *Application contents.* The board shall develop a standardized application for the program and make the application available at www.broadband.iowa.gov.

411.6(3) *Application time line and submittal.* Applicants for state broadband deployment funds shall submit a completed application within 15 calendar days after being notified that the applicant has been awarded federal funds under either the BIP or BTOP Program. Along with the completed state broadband grant application, all applicants shall submit: (1) a copy of the applicant's federal application and all information required to be submitted with the applicant's federal application, and (2) all records the applicant received from the BIP and BTOP Programs that relate to the applicant's federal award, including but not limited to any award letters. Completed state broadband grant applications and all information required to be submitted with the application shall be submitted to ITTC via the Iowa Grant Notification Storefront and Electronic Grant Management System (www.iowagrants.gov).

411.6(4) *Request for confidential treatment.* Applicants who would like to request that the board treat a record or part of a record as a confidential record must comply with the fair information practices listed at 751—Chapter 2.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—411.7(83GA,SF376) Application review procedures.**411.7(1) *Application review committee and final board action.***

a. Application review committee. Applications meeting the threshold requirements of rule 261—411.5(83GA,SF376) will be reviewed by an application review committee (“the committee”). The committee shall consist of at least two board members and at least five staff members jointly provided by IDED, ITTC, and IUB.

b. Committee review and recommendation to the board. The committee members will score the applications according to the criteria set forth in subrule 411.7(2). A copy of the application scoring sheet that will be used by the committee is available for viewing at www.broadband.iowa.gov. The committee shall use consensus scoring and shall rank order the applications. The committee shall prepare a summary of the applications and the rank order scoring results and shall present to the board the committee's recommendations for approval, denial, or deferral of applications.

c. Board action. All eligible applications and any summaries and recommendations by the application review committee will be reviewed by the board. Summaries, scores, and recommendations by the application review committee shall be wholly advisory and shall be for the board's convenience. The board shall not be bound by any findings or conclusions of the application review committee, and the board shall not be required to give deference to any determination by the application review committee. The board may create summaries, award scores, or make conclusions that depart in whole or in part from those conclusions reached by the application review committee. The board shall make the final decision on all applications.

411.7(2) *Evaluation criteria.* The application review committee shall evaluate and score applications based on the following criteria:

a. Project purpose. (0-25 points) An application will be reviewed to evaluate the purpose of the project and its consistency with statutory intent for this program. Rating factors for this criterion include, but are not necessarily limited to, the following:

(1) Promote universal access. The degree to which a project will provide service to unserved areas or improve service to underserved areas of Iowa as identified by current broadband availability data or as ultimately determined by the state broadband mapping project.

1. If a project proposes to serve an unserved area, the percentage of households in the proposed service area (as defined by census block) that will be served by the project.

2. If a project proposes to improve service to an underserved area, the percentage of households in the proposed service area (as defined by census block) that will have improved service.

Points will be awarded on a sliding scale. The higher the percentage of households that will be served or that will have improved service, the more points awarded.

(2) Private enterprise. Whether the applicant is a qualified private provider. Additional consideration will be given to applications from qualified private providers of broadband service.

(3) Public-private partnership. Whether public and private collaboration is required for the project, as appropriate.

(4) Public entities. Whether participation by the public entity will promote access in an area that remains unserved or underserved due to lack of private sector investment.

b. Project benefits. (0-25 points) Applications will be reviewed to evaluate the degree to which the proposed project will offer service at an advertised speed which exceeds the federal requirements. Rating factors for this criterion include, but are not necessarily limited to, the following:

(1) Advertised speeds above federal minimums. For wireline last mile projects and wireless last mile projects, the advertised downstream and upstream speeds. More points will be awarded for higher speeds.

(2) Middle mile projects. For middle mile projects, the degree to which the proposed project is sustainable and supports the goal of universal access to high-speed broadband service for the benefit of Iowans. Consideration will be given to the project's impact on the area, including proposed connections to last mile networks and benefit to community anchor institutions or public safety entities; the level of need for the project in the area, including whether projected end users are located in unserved or underserved areas; and network capacity, i.e., whether the network provides sufficient capacity to serve last mile networks, community anchor institutions and public safety entities.

(3) Synchronous data transmission. Whether the proposal contemplates synchronous data transmission capabilities and at what speed.

(4) Affordability of services offered. Proposed pricing will be evaluated based on comparison to published unbundled prices and speeds for existing broadband services in the proposed funded service area. If there are no existing broadband services present, an applicant must demonstrate that proposed pricing is appropriate for the proposed service area.

(5) Community impact. How the project impacts job creation and economic development and provides other benefits to the targeted community.

(6) Speed of completion. How quickly the project will be completed.

c. Project viability. (0-25 points) Applications will be reviewed to evaluate the viability of the proposed project. Rating factors for this criterion include, but are not necessarily limited to, the following:

(1) Economic sustainability. The extent to which the proposed project will not require any additional funding from the state in the course of normal operations.

(2) Applicant's track record. Whether the applicant possesses a record of accomplishment for historically similar projects.

(3) Financial metrics. How the project compares to similar projects, including but not limited to return on investment, internal rate of return, net present value, payback, break-even analysis, capital cost per household, and debt metrics.

d. Project budget and sustainability. (0-25 points) Applications will be reviewed to evaluate the reasonableness of the budget and sustainability of the proposed project. Rating factors for this criterion include, but are not necessarily limited to, the following:

(1) Reasonableness of the budget. Points will be awarded based on adequacy and completeness of the proposed budget.

(2) Ratio of state funding request to number of households passed (cost of funding request per household). Points will be awarded on a sliding scale. More points will be awarded for lower cost per household.

(3) Funding leverage (outside funding/government funding). The degree to which the proposed project leverages outside funding sources. The higher the ratio, the more points awarded.
 [ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—411.8(83GA,SF376) Administration of awards.

411.8(1) Notice of award and conditions. Applicants will be notified in writing of the board's decision, including any conditions and terms of approval. Award conditions may include but are not limited to the following:

a. Awards conditioned on completion of external requirements. Certain activities may require that permits or clearances be obtained from other state or local agencies before the activity may proceed. Awards may be conditioned upon the timely completion of these requirements.

b. Awards conditioned on other financial sources. Awards may be conditioned upon commitment of other sources of funds necessary to complete the activity, including the receipt of federal grants or loans.

c. Awards conditioned on implementation plan. Awards may be conditioned upon ITTC's receipt and approval on behalf of the board of an implementation plan for the funded activity.

411.8(2) Contract required.

a. Contract contents. A contract shall be executed between the recipient and ITTC on behalf of the board. The rules in 261—Chapters 410 to 412 and applicable state laws and regulations shall be part of the contract. The agreement will include, but is not limited to:

(1) A description of the project to be completed by the recipient.

(2) Length of the project period.

(3) Conditions to disbursement as approved by the board.

(4) Reporting requirements, to be made to the board consistent with federal requirements, on the use and effectiveness of the grant funding.

(5) The reimbursement requirements of the recipient or other penalties imposed on the recipient in the event the recipient does not meet the commitments set forth in the contract, in the documentation provided to establish eligibility, or in other provisions negotiated on a project-by-project basis.

b. Contract amendments. Any substantive change to a funded project will require a contract amendment approved by the board. Substantive changes include, but are not limited to, contract time extension, budget revisions, and significant alterations of existing activities or beneficiaries.

411.8(3) Deadline for contract execution. A recipient must execute and return the contract to ITTC within 60 days after the contract is sent to the recipient. Failure to do so may be cause for the board to terminate the award.

411.8(4) Accounting. On behalf of the board, the telecommunications and technology commission shall establish separate accounts for the bond proceeds and non-bond proceeds received to fund Iowa broadband deployment program grants.

411.8(5) Grant information posted on Web site. All disbursements and related, nonconfidential information for each grant will be posted on www.broadband.iowa.gov and will be accessible by the public within 30 days after distribution of funds.

411.8(6) Project status reports.

a. Quarterly status reports and contents. Each grantee shall submit a quarterly state status report to the board on or before each of the following dates: March 31, June 30, September 30, and December 31. Each quarterly status report shall, at a minimum, include the following information:

(1) The total amount of the grant from the board;

(2) The total amount of grant funds that the grantee has expended or obligated; and

(3) A detailed list of all projects or activities for which Iowa grants were expended or obligated, including:

1. The name of the project or activity,

2. A description of the project or activity,

3. An evaluation of the completion status of the project or activity, and

4. An estimate of the number of jobs created and the number of jobs retained by the project or activity.

b. Copies of federal status reports. At the time the grantee submits this state quarterly status report, the grantee shall also submit copies of the grantee's most recent federal status reports.

c. Final project completion report. Within 30 days of completing a project funded by grant funds, a grantee shall submit to the board a final report that summarizes the grantee's quarterly filings, describes the nature of the completed project, and states whether the project's goals have been satisfied.

411.8(7) Report to legislature. The board shall provide a report to the general assembly, the legislative services agency, and the department of management on the status of all projects completed or in progress. The board shall submit the report each year, on or before January 15.

a. The report shall include the following information about each project funded by grants awarded by the board:

- (1) A description of the project,
- (2) The work completed on the project,
- (3) The total estimated costs of the project,
- (4) A list of all revenue sources being used to fund the project,
- (5) The amount of funds expended on the project,
- (6) The amount of funds obligated to the project, and
- (7) The date the project was completed or an estimated completion date of the project.

b. The report may include any other information related to the board and the board's activities, including but not limited to descriptions of significant board actions and requests for additional legislation that would further the purposes of the board.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

These rules are intended to implement 2009 Iowa Acts, Senate File 376, section 13(5).

[Filed Emergency ARC 8218B, IAB 10/7/09, effective 9/17/09]

[Filed ARC 8473B (Notice ARC 8219B, IAB 10/7/09), IAB 1/13/10, effective 2/17/10]

CHAPTER 412
FAIR INFORMATION PRACTICES, WAIVER AND VARIANCE,
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261—412.1(83GA,SF376) Fair information practices. The board shall follow ITTC's rules in 751—Chapter 2, regarding public records and fair information practices.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—412.2(83GA,SF376) Waiver and variance. The board shall follow IDED's rules in 261—Chapter 199, regarding waivers and variances of administrative rules.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

261—412.3(83GA,SF376) Petition for rule making. The board shall follow IDED's rules in 261—Chapter 197, regarding petitions for rule making.

[ARC 8218B, IAB 10/7/09, effective 9/17/09; ARC 8473B, IAB 1/13/10, effective 2/17/10]

These rules are intended to implement 2009 Iowa Acts, Senate File 376, section 13(5).

[Filed Emergency ARC 8218B, IAB 10/7/09, effective 9/17/09]

[Filed ARC 8473B (Notice ARC 8219B, IAB 10/7/09), IAB 1/13/10, effective 2/17/10]

IOWA FINANCE AUTHORITY[265]

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CHAPTER 9
TITLE GUARANTY DIVISION

265—9.1(16) Definitions. The following words and phrases, when used in this chapter, shall have the meanings set forth below unless a meaning is inconsistent with the manifest intent or the context of a particular rule:

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

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

“Certificate” means the division certificate to guarantee title, including any part or schedule thereof and any endorsements thereto.

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

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

“Division” means the title guaranty division of the Iowa finance authority.

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

“Division closer” means a participating attorney, a participating abstractor, or an independent closer who is authorized by the division to conduct a division closing under the protection of a closing protection letter.

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

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

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

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

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

“Field issuer” means a participating attorney, a participating abstractor, or an independent closer authorized by the division to issue commitments and certificates.

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

“Grandfathered attorney” means a participating attorney who has been providing abstract services continuously from November 12, 1986, to the date of application to be a participating abstractor, either personally or through persons under the participating attorney’s supervision and control, who is exempt from the requirement to own or lease a title plant.

“Independent closer” means a person or entity, other than a participating attorney or a participating abstractor, conducting a division closing and authorized to close a transaction under protection of a closing protection letter.

“Manual” means a title guaranty reference book approved by the division board containing division certificate forms and certain Iowa statutory requirements.

“Nonpurchase financing,” for the purposes of the title guaranty program, means a refinanced or junior mortgage securing an amount fixed by the division board and included in the manual.

“Participant” means a participating attorney or a participating abstractor.

“Participating abstractor” means an abstractor who is authorized to participate in the title guaranty program and who is in full compliance with the abstractor’s participation agreement, the Code of Iowa, these rules, the manual, staff supplements, and any other written or oral instructions or requirements given by the division.

“Participating attorney” means an attorney who is authorized to participate in the title guaranty program, who is in full compliance with the attorney’s participation agreement, the Code of Iowa, these rules, the manual, staff supplements, and any other written or oral instructions or requirements given by the division, and who is not subject to current disciplinary proceedings by the Iowa supreme court that preclude the attorney from practicing law in this state.

“Person” shall have the same meaning as in Iowa Code section 4.1(20).

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

“Supervision and control,” for the purposes of the title guaranty program, means that a participant’s or independent closer’s shareholders, partners, associates, secretaries, paralegals, and other persons under the participant’s or independent closer’s supervision or control who transact the business of abstracting, which includes but is not limited to any manner of title search or review, opining on titles to real estate, or issuing commitments or certificates at the direction of or in the name of the participant or independent closer, shall comply with the requirements of the contracts, forms, the manual, staff supplements, and any other written or oral instructions or requirements given by the division. A participant or independent closer shall be liable to the division for loss or damage suffered by the division resulting from acts or omissions of the participant’s or independent closer’s shareholders, partners, associates, secretaries, paralegals, and other persons under the participant’s or independent closer’s supervision or control who transact the business of abstracting, which includes but is not limited to any manner of title search or review, opining on titles to real estate, or issuing commitments or certificates at the direction of or in the name of the participant or independent closer as an agent of the division as though the act or omission were that of the participant or independent closer.

“Title guaranty report of title,” for the purpose of nonpurchase financing, means a written or electronic short form of the abstract of title covering the borrower’s title, liens, and encumbrances. The division board shall approve requirements and procedures for the title guaranty report of title in the manual.

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

[ARC 8458B, IAB 1/13/10, effective 2/17/10]

265—9.2(16) Purpose. This chapter describes the mission, organization, programs and operations of the division, including the office where and the means by which interested persons may obtain information and make submissions or requests.

[ARC 8458B, IAB 1/13/10, effective 2/17/10]

265—9.3(16) Mission. The mission of the division is to operate a program that offers guaranties of real property titles in order to provide, as an adjunct to the abstract-attorney’s title opinion system, a low-cost mechanism to facilitate mortgage lenders’ participation in the secondary market and add to the integrity of the land-title transfer system in the state. Surplus funds in the title guaranty fund shall be transferred to

the authority's housing program fund after providing for adequate reserves and for the operating expenses of the division.

[ARC 8458B, IAB 1/13/10, effective 2/17/10]

265—9.4(16) Organization.

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

9.4(2) Division board. A chair and vice-chair shall be elected annually by the members of the division board, generally at the first meeting following July 1 of each year, which is the beginning of the fiscal year.

9.4(3) Meetings. Meetings of the division board shall be held quarterly on the date and time determined by the board. Meetings of the division board may also be held at the call of the chair or on written request of two members. The division will give advance public notice of the specific date, time and place of each division board meeting, and will post the tentative agenda for each meeting at least 24 hours before commencement of the meeting at the main office of the authority, as well as on the authority's Web site. Meetings may occasionally be conducted by electronic means. Any interested person may attend and observe division board meetings except for any portion of a meeting that may be closed pursuant to Iowa Code section 21.5. The minutes of the division board meetings are available for viewing at the main office of the authority or via the authority's Web site. Three members of the division board constitute a quorum. An affirmative vote of a majority of the appointed board members is necessary for any substantive action taken by the division board. The majority shall not include any board member who has a conflict of interest, and a statement of a conflict of interest shall be conclusive for this purpose.

[ARC 8458B, IAB 1/13/10, effective 2/17/10]

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

265—9.6(16) Title guaranty program.

9.6(1) Operation. The division operates a program to offer guaranties of real property titles in the state through the issuance of title guaranty commitments and certificates by the division, by participating abstractors for the division pursuant to subrule 9.6(4), paragraph "c," herein, or by participating attorneys pursuant to Iowa Code section 16.91(7).

9.6(2) Application for title guaranty commitments or certificates. The division may authorize entities engaged in the real estate industry to apply directly to the division staff, an independent closer, a participating attorney, or a participating abstractor for a title guaranty commitment or certificate. The applicant shall complete and submit such forms and other information as the division may require and pay the appropriate fee. Entities engaged in the real estate industry that the division may authorize to apply include, but are not limited to, mortgage lenders as defined in Iowa Code section 16.1(1) "y," and closing and escrow companies.

9.6(3) Participating attorneys. An attorney licensed to practice law in the state of Iowa may participate in the title guaranty program upon approval by the division director of an application submitted by the licensed attorney to the division and upon execution and acceptance by the division director of the attorney's participation agreement.

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

b. Underwriting determinations. A participating attorney shall make all underwriting determinations prior to or at the time of closing. If the participating attorney does not attend the closing and is not available by telephone during the closing, all underwriting determinations must

have been made by the participating attorney issuing the opinion, commitment or certificate prior to closing. For purposes of this rule, the term “underwriting determinations” includes, but is not limited to, guaranteeing access, reviewing gap searches, possible judgments, survey matters (including encroachments), unreleased mortgages or other liens, and any other matters disclosed by the opinion, commitment or other sources of title information. A participating attorney who causes or allows an erroneous underwriting determination to be made by someone other than a member of the division’s legal staff or the participating attorney who issued the opinion, commitment or certificate shall be strictly liable to the division for loss or damage the division may suffer as a result of the erroneous underwriting determination.

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

1. Generally accepted and prudent title examining methods; and
2. Procedures implemented by the division and outlined in these rules, the manual, staff supplements, and any other written or oral instructions or requirements given by the division.

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

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

9.6(4) Participating abstractors. An abstractor or abstracting concern may participate in the title guaranty program upon approval by the division director of an application to the division and upon execution and acceptance by the division director of an abstractor’s participation agreement.

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

b. Title plant exemption. Grandfathered attorneys and attorneys and abstractors who have received a waiver of the use of an up-to-date plant described in Iowa Code section 16.91(5) “a”(2), either personally or through persons under their supervision and control, shall be exempt from the requirement to own or lease a title plant. This exemption is a personal exemption of the individual participant, is not transferable, and terminates at such time as the participant ceases providing abstracting services or upon the death or incapacity of the participant.

c. Issuing title guaranty. Pursuant to a written contract with the division director, a participating abstractor may be authorized to issue a title guaranty commitment or certificate for the division when the participating attorney who prepares the opinion allows issuance by the participating abstractor. Written contractual approval by the division director for division issuance will be based upon the completion of a division request form by a participating abstractor and the attachment of all disclosures required by the division. A participating abstractor authorized to issue a title guaranty commitment or certificate must comply with the Code of Iowa, these rules, the manual, staff supplements, and any other written or oral instructions or requirements given by the division and in no other manner whatsoever. The rights of the participating abstractor under the preceding sentence are not exclusive and are subject to the rights of the authority, the division, and other field issuers of the division to issue commitments or certificates and

are further subject to the right of the division to appoint other field issuers. A participating abstractor's right to issue commitments and certificates is a privilege for the convenience of the division and may be terminated pursuant to the written contract with the division.

d. Authority of participating abstractor. A participating abstractor is authorized to act as an agent of the division but only for the purposes and in the manner set forth in the abstractor's participation agreement, the Code of Iowa, these rules, the manual, staff supplements, and any other written or oral instructions or requirements given by the division and in no other manner whatsoever. The authority of the participating abstractor under the preceding sentence is not exclusive and is subject to the rights of the authority, the division, and other participating abstractors, agents, or representatives of the division to transact the business of abstracting, which includes but is not limited to any manner of title search or review of titles to real estate, and is further subject to the right of the division to appoint other participating abstractors.

9.6(5) Participation requirements.

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

(1) The division will inform the Iowa State Bar Association, the Iowa Land Title Association, and any person requesting such information of any proposed change in the amount of required errors and omissions insurance at least 30 days prior to the date of the meeting at which the matter will be considered.

(2) Interested parties may submit evidence or statements in support of or in opposition to the proposal in writing or by personal appearance before the division board.

b. Participation fees. A participant shall pay a participation fee set by resolution of the division board subject to the approval of the authority board.

(1) The division will inform the Iowa State Bar Association, the Iowa Land Title Association, and any person requesting such information of any proposed change in the amount of participation fees at least 30 days prior to the date of the meeting at which the matter will be considered.

(2) Interested parties may submit evidence or statements in support of or in opposition to the proposal in writing or by personal appearance before the division board.

9.6(6) Abstract of title. All abstracts of title shall be prepared and conducted in compliance with division procedures as specified in the manual, staff supplements, and any other written or oral instructions or requirements given by the division that are in effect at the time of abstracting. A participating abstractor shall retain a written or electronic copy of each abstract of title prepared for a title guaranty certificate and shall provide such copy to the division upon request.

9.6(7) Attorney title opinion. All attorney title opinions shall be prepared and issued in compliance with division procedures as specified in the manual, staff supplements, and any other written or oral instructions or requirements given by the division that are in effect at the time of issuance. A participating attorney who is a field issuer may issue a commitment as the preliminary attorney title opinion and the certificate as the final attorney title opinion in compliance with division procedures. A written or electronic copy of each attorney title opinion shall be retained by a field issuer, and a copy thereof shall be provided to the division upon request.

9.6(8) Closing protection letters.

a. Issuance of closing protection letters. Division closers may be authorized to receive a closing protection letter approved by the division board when:

- (1) A division closer has completed division forms and procedures training,
- (2) The division director has approved the application, and
- (3) A division commitment is issued.

b. Application. Application for designation of division closer status shall be on forms provided by the division, and all requested information shall be provided with the application form. The division may consider an application withdrawn if it does not contain all of the information required and the information is not submitted to the division within 30 days after the division requests the information. The application shall be accompanied by a fee to be set by the division board. The division director shall

approve or deny the application within 90 days after the application has been accepted for processing and send written notice thereof to the applicant.

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

- (1) The needs of the public and the needs of existing or potential customers of the applicant that are served by a designation of division closer status.
- (2) A history of operation and management of the applicant's business.
- (3) Character, fitness, financial responsibility and experience of the applicant and the applicant's employees.
- (4) Criminal background checks for felony or misdemeanor convictions of the applicant or the applicant's employees involving moral turpitude.
- (5) A record of defaulting by the applicant or the applicant's employees in the payment of moneys collected for others in this state or other states.
- (6) A history of discharge of debts by the applicant or the applicant's employees through bankruptcy proceedings.
- (7) The applicant's credit report, which is to be submitted directly to the division director at the expense of the applicant.
- (8) Other factors as determined by the division director to be relevant.

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

e. Revocation. The division director has discretion to revoke a division closer's status for reasons including but not limited to the following:

- (1) When the financial condition of the division closer deteriorates.
- (2) When the division director determines that the division closer's activities are being conducted unlawfully or in an unsafe or unsound manner.

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

A division closer shall obtain the written authorization of a member of the division's legal staff prior to issuing a commitment or certificate which exceeds such amounts as the division board may set from time to time by resolution. If any authorization required under 9.6(8) "f" is not obtained through the act or omission of the division closer, the division closer shall be strictly liable to the division for any resulting loss or damage.

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

9.6(9) General provisions.

a. Commitment and certificate amount limitations. A field issuer shall obtain the written authorization of a member of the division's legal staff prior to issuing a commitment or certificate which exceeds such amounts as the division board may set from time to time by resolution. If any authorization required under this paragraph is not obtained through the act or omission of the field

issuer, the field issuer shall be strictly liable to the division for any loss or damage resulting from issuance of the commitment or certificate.

b. Title/closing files and forms. A participant or independent closer shall maintain separate title, client and closing files or maintain client files in such a manner that information pertaining to activities of the participant or the independent closer is readily available to the division. A participant or independent closer shall maintain files for a period of ten years after the effective date of the commitment and certificate or certificates.

(1) The division will provide forms to a participant or independent closer for use in acting for the division. A participant or independent closer may not alter any form supplied by the division, or use a form supplied by another person or entity to bind the division, or otherwise bind the division to liability with a form, other writing or representation not supplied or authorized by the division. In addition, the participant or independent closer shall:

1. Return the original of any canceled certificate to the division, and
2. Not transfer or attempt to transfer unissued commitments or certificates to another participant, independent closer, or other person or entity unless authorized in writing by the division.

(2) If a participant or independent closer fails to comply with the requirements of 9.6(9)“b,” in addition to the division’s other rights and remedies, the division may refuse to supply any forms to the participant or independent closer until the participant or independent closer complies with the requirements of 9.6(9)“b” to the satisfaction of the division.

(3) The participant or independent closer shall be liable to the division for loss or damage sustained by the division by reason of the loss of, misuse of, or inability of the participant or independent closer to account for any form supplied by the division, or the failure of the participant or independent closer to comply with the requirements of 9.6(9)“b.”

c. Training. The division director may require a participant, an independent closer, and the participant’s and independent closer’s staff to attend training sessions or continuing education seminars as deemed necessary by the division director in order to ensure compliance with division requirements and procedures.

d. Office audits. The division may, with or without notice to a participant or an independent closer, audit the participant or independent closer at the participant’s or independent closer’s office. This audit may include, but need not be limited to, a review of the participant’s or independent closer’s commitment and certificate issuance procedures, an audit of serialized forms, an audit and test of title plants and tract indices, an audit of closing operation and closing procedures, an audit of the division escrow account(s), and verification of the participant’s or independent closer’s compliance with division rules, participation agreements, the Code of Iowa, these rules, the manual, staff supplements, and any other written or oral instructions or requirements given by the division.

e. Interest in property. No participant or independent closer shall prepare an abstract of title, issue attorney title opinions, commitments, or certificates, or conduct a closing upon property in which the participant or independent closer has an interest without prior authorization of the division.

[ARC 8458B, IAB 1/13/10, effective 2/17/10]

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

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

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

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

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

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

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

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

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

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

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

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

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

- a. The name, business address, E-mail address, and telephone number of the abstractor for whom a waiver is being requested;
- b. The type of waiver being requested, as described in subrule 9.7(8);
- c. A general description of the applicant's business;
- d. A description of intention to develop a 40-year tract index;
- e. The relevant facts that the applicant believes would justify a waiver under subrules 9.7(7) and 9.7(8); and
- f. A signed statement from the applicant attesting to the accuracy of the facts provided in the application.

9.7(5) Notification and response.

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

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

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

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

9.7(6) Board meeting action.

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

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

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

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

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

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

b. The waiver is:

(1) Clearly in the public interest; or

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

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

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

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

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

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

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

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

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

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

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

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

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

- The applicant's abstract experience. The board shall give considerable weight to an applicant's experience abstracting under the personal supervision and control of an exempt attorney-abstractor with whom the applicant has had a close working relationship or with whom the applicant is a legal partner or associate.

- Professional references. The board shall give considerable weight to a recommendation from the exempt attorney-abstractor or grandfathered attorney who personally supervised the applicant's abstracting for a period of two years or more and who attests in writing or in person before the division board regarding the applicant's ability to abstract.

- Samples of abstracts prepared by the applicant.

- The division board shall give consideration to the number of participating abstractors physically located in the county or counties where the applicant seeks to abstract in determining whether a waiver should be granted.

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

- The applicant's abstract experience;

- Professional references;

- Samples of abstracts prepared by the applicant;

- The applicant's business plan;

- Evidence of clients and volume of additional transactions that will be brought into the title guaranty abstract/attorney system as a result of the waiver;

- The number, availability, service and quality of other abstractors available to perform abstracting and whether the grant of a permanent waiver will adversely impact the business of other participating abstractors;

- Whether the applicant demonstrates the inability to abstract under the supervision and control of an exempt attorney.

c. Permanent waivers for non-attorneys.

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

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

1. The applicant's abstract experience, maintenance of a title plant by the applicant in any other county, and degree of participation by the applicant in the title guaranty division standards in excellence program;

2. Professional references;

3. Samples of abstracts prepared by the applicant;

4. The applicant's business plan;

5. Evidence of clients and volume of additional transactions that will be brought into the title guaranty abstract/attorney system as a result of the waiver;

6. The number, availability, service and quality of other abstractors available to perform abstracting and whether the grant of a permanent waiver will adversely impact the business of other participating abstractors.

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

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

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

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

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

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

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

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

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

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

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

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

265—9.8(16) Title guaranty contracts, forms, manual, and staff supplements. The division shall adopt and issue such contracts, forms, and the manual as the division deems necessary to set out standards and requirements, and such other matters that the division deems necessary for implementation and effective administration of the title guaranty program. The contents of the contracts, forms, and the manual shall be applicable to participants and independent closers in the title guaranty program.

9.8(1) Division board adoption. The form of title guaranty commitments and certificates will be adopted, revised, or amended by resolution of the division board, and the form of such commitments and certificates is subject to the approval of the authority board. The manual will be adopted, revised, or amended on approval of a majority vote of the division board.

a. The division will inform the Iowa State Bar Association, the Iowa Land Title Association, and any person requesting such information of any proposed adoption of or change to the form of title guaranty commitments and certificates at least 30 days prior to the date of the division board meeting at which the matter will be considered.

b. Interested parties may submit evidence or statements in support of or in opposition to the proposal in writing or by personal appearance before the division board.

9.8(2) Division staff adoption. Under the direction of the division director, the division staff shall adopt and issue staff supplements as the division deems necessary to set out standards and requirements of these rules, applicable statutes, and the manual; to address nonresidential, extraordinary and unusual risk situations; and to address such other matters that the division deems necessary for implementation and effective administration of the title guaranty program.
[ARC 8458B, IAB 1/13/10, effective 2/17/10]

265—9.9(16) Mortgage release certificate. Pursuant to Iowa Code section 16.92, the division is charged with the administration of a system, after notification to lenders, to clear paid-off mortgages from real estate titles in Iowa by executing and filing with county recorders release certificates for mortgages that have been paid in full.

9.9(1) Definitions. As used in this rule, unless the context otherwise requires:

“*Certificate*” means the certificate of release or partial release of mortgage issued by the division.

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

“*Effective release*” or “*satisfaction*” means a release or satisfaction of mortgage pursuant to Iowa Code chapter 655.

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

1. \$20 million for mortgages paid off by the division staff or a division closer within a division closing, unless prior written approval is obtained from the division director.
2. \$1 million for all other mortgages.

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

9.9(2) Request for certificate. Applications, forms, procedures and practices for the implementation of an effective mortgage release certificate by the division pursuant to Iowa Code section 16.92 shall be provided in the staff supplements. Further, any fee to be charged for the mortgage release application shall be set by the division board upon the recommendation of the division director.

9.9(3) Authority to sign certificate. The division director or designee of the division director may execute and record the certificates pursuant to Iowa Code section 16.92 and this rule.

9.9(4) Additional remedies. In addition to any other remedy provided by law, the division may recover from the real estate lender or closer who requested the certificate all expenses incurred, and all damages including punitive or exemplary damages paid to the mortgagee or mortgage service provider, in satisfaction or resolution of a claim for damages.
[ARC 8458B, IAB 1/13/10, effective 2/17/10]

265—9.10(16) Rates. The rate or fee, if any, for the owner’s guaranty, the lender’s guaranty, the various endorsements, and the closing protection letter will be fixed by the division board by resolution. In situations involving extraordinary risk, unusual transactions, or unique or multiple endorsements, the division, under the direction of the division director, may make additional charges that are added to and become part of the rate or fee. The rates or fees of any other products or services that will be offered by the division shall be set by the division board upon the recommendation of the division director.

A participant or independent closer shall calculate the title guaranty fees and premiums according to the applicable rate schedule in effect on the effective date of the commitment or the certificate, whichever is earlier. A participant or independent closer shall collect the fee in effect for any other product or service offered by the division at the time the product or service is sold. Additional participant or independent closer responsibilities with regard to the collection and use of fees and premiums shall be set forth in the manual and staff supplements.
[ARC 8458B, IAB 1/13/10, effective 2/17/10]

265—9.11(16) Claims.

9.11(1) Definitions. The following words and phrases, when used in this rule, shall have the meanings set forth below unless a meaning is inconsistent with the manifest intent or the context of a particular rule:

“*Claim*” means loss or damage or potential loss or damage arising by reason of a matter actually, possibly, or allegedly within the coverage of a commitment, certificate, closing protection letter, mortgage release certificate, or by reason of any other matter for which the division is actually, possibly, or allegedly liable.

“*Claim loss*” means amounts paid by the division in the investigation and resolution of a claim including, but not limited to, payments to the guaranteed, payments to adverse claimants, attorneys’ fees, and all other expenses and costs related to or arising from the claim in accordance with the provisions of this rule.

“*Party*” means a participant, independent closer, or any other person or entity that has a contractual relationship with the division to provide coverage or services for which a claim may be brought against the division.

9.11(2) Claim procedures. In the event of a claim, the rights of the division and a party are as follows:

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

b. When a party receives a request from the division for information with respect to a claim, the party shall supply to the division any documents, correspondence, surveys, abstracts of title, title searches, other writings, or other information known by or available to the party and relevant to the claim, even if not specifically requested by the division.

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

d. The division may, with or without prior notice to the party or parties involved, investigate and resolve any claim in any manner that, in the division’s sole discretion, the division may deem advisable.

9.11(3) Claim loss recovery.

a. Any claim losses paid are recoverable from a party by the division.

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

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

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

(3) Errors in these rules, the manual, staff supplements, and any other written or oral instructions or requirements given by the division that the party relies upon in issuing an abstract of title, opinion, commitment, certificate, or endorsement;

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

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

c. The party shall reimburse the division for a claim loss when the division determines, in accordance with 9.11(3) “d,” that the party is liable and when the claim loss arises from one or more of the following:

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

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

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

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

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

(6) Failure of the party to follow these rules, the manual, staff supplements, or any other written or oral instructions or requirements given by the division with respect to any other matters not included within 9.11(3)“c.”

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

(1) In the event that a claim loss occurs for which the division may seek recovery from the party under 9.11(3)“c”(1), the division may demand reimbursement from the party if the party was grossly negligent in conducting the title search. Gross negligence includes the failure to make a search or the use of inadequate search procedures. Gross negligence under the preceding sentence includes but is not limited to failure to search certain indices, failure to search all names of parties with an interest in the real estate, or failure to search in all public offices required by the division search procedures or procedures used by prudent title searchers if the division has not established specific search procedures. In making its determination whether to seek recovery, the division may consider the complexity of the public record, the reliance of the party upon division-approved search procedures, the training and experience of the person who made the error, and the existence or nonexistence of previous search errors by the party.

(2) In the event that a claim loss occurs for which the division may seek recovery from a party under 9.11(3)“c”(2), the division may demand reimbursement from that party if the party relied upon sources of title searches or other title information that had not been approved by the division at the time of the reliance.

(3) In the event that a claim loss occurs for which the division may seek recovery from the party under 9.11(3)“c”(3), the division may demand reimbursement from the party if the party negligently examined the title information used in making a title determination, failed to raise an appropriate exception, waived an exception, or endorsed a title commitment or certificate.

1. The division may make full review of local county abstracting standards and bar title rules as a guide to determine whether the party has failed to meet the standard of skill and competence of an abstractor who prepares an abstract of title or an attorney who examines titles in the community where the claim arose.

2. The division may also consider whether the party followed these rules, the manual, staff supplements, or any other written or oral instructions or requirements given by the division in examining the title.

3. In addition, the division may seek input from other parties in the community in which the claim arose as to the standard of care of an abstractor who prepares an abstract of title or of an attorney who examines titles in that community.

(4) In the event that a claim loss occurs for which the division may seek recovery from the party under 9.11(3)“c”(4), the division may demand reimbursement from the party if the party negligently prepared and reviewed an abstract of title, opinion, commitment or certificate.

(5) In the event that a claim loss occurs for which the division may seek recovery from the party under 9.11(3)“c”(5), the division may demand reimbursement from the party if the issuance of the abstract of title, opinion, commitment or certificate constituted fraud, concealment or dishonesty, or if the issuance of the abstract of title, opinion, commitment or certificate was based upon an underwriting decision on an unusual risk that was made without contacting the division for approval.

(6) In the event that a claim loss occurs for which the division may seek recovery from the party under 9.11(3)“c”(6), the division may demand reimbursement from the party if the party failed to follow

these rules, the manual, staff supplements, or any other written or oral instructions or requirements given by the division with respect to the matter causing the claim loss.

(7) In the event the division seeks reimbursement from a party, the division shall state the basis of the reimbursement.

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

[ARC 8458B, IAB 1/13/10, effective 2/17/10]

265—9.12(16) Rules of construction. In the construction of this chapter, the following rules of construction shall be observed, unless either the rules of Iowa Code chapter 4, Construction of Statutes, or the following rules of construction are inconsistent with the manifest intent or the context of a rule:

1. The word “shall” means mandatory and not permissive and the word “may” means permissive and not mandatory.

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

3. Nothing contained in this chapter shall be construed to require a participating attorney to disclose privileged information of a client to the division or to any other person.

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

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

[ARC 8458B, IAB 1/13/10, effective 2/17/10]

265—9.13(16) Seal. The division shall have a corporate seal that may be altered from time to time. The seal shall impress the words “Title Guaranty Division Iowa Finance Authority” and may be used to authenticate acts and legal instruments of the division.

[ARC 8458B, IAB 1/13/10, effective 2/17/10]

265—9.14(16) Rules of construction. Rescinded IAB 1/13/10, effective 2/17/10.

265—9.15(16) Implementation. Rescinded IAB 1/13/10, effective 2/17/10.

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

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

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

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

265—9.20(16) Mortgage release certificate. Rescinded IAB 1/13/10, effective 2/17/10.

265—9.21(16) Seal. Rescinded IAB 1/13/10, effective 2/17/10.

265—9.22(16) Closing protection letters. Rescinded IAB 1/13/10, effective 2/17/10.

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

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[Filed ARC 7892B (Notice ARC 7702B, IAB 4/8/09), IAB 7/1/09, effective 8/5/09]

[Filed ARC 8458B (Notice ARC 8264B, IAB 11/4/09), IAB 1/13/10, effective 2/17/10]

[◇] Two or more ARCs

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

CHAPTER 26
WATER POLLUTION CONTROL WORKS AND
DRINKING WATER FACILITIES FINANCING

265—26.1(16) Statutory authority. The authority to provide loans to eligible applicants to assist in financing drinking water and wastewater treatment facilities and water pollution control projects is provided by Iowa Code sections 16.131 through 16.133.

265—26.2(16) Purpose. The Iowa finance authority provides financing to carry out the functions of the state revolving fund (SRF) loan programs. Under an agreement with the United States Environmental Protection Agency, the Iowa SRF is administered by the Iowa department of natural resources in partnership with the Iowa finance authority.

[ARC 8457B, IAB 1/13/10, effective 2/17/10]

265—26.3(16) Definitions.

“*Authority*” or “*IFA*” means the Iowa finance authority.

“*Clean Water Act*” or “*CWA*” means the federal Water Pollution Control Act of 1972, as amended by the Water Quality Act of 1987.

“*Commission*” means the environmental protection commission of the Iowa department of natural resources.

“*Common ownership*” means the ownership of an animal feeding operation as a sole proprietor, or a majority ownership interest held by a person, in each of two or more animal feeding operations as a joint tenant, tenant in common, shareholder, partner, member, beneficiary, or other equity interest holder. The majority ownership interest is a common ownership interest when it is held directly, indirectly through a spouse or dependent child, or both.

“*Department*” or “*DNR*” means the Iowa department of natural resources.

“*Director*” means the director of the authority.

“*DWSRF*” means the drinking water state revolving fund.

“*Eligible costs*” means all costs related to the completion of a project as defined in the CWA and SDWA and 567—Chapters 40 and 90.

“*EPA*” means the United States Environmental Protection Agency.

“*Intended use plan*” or “*IUP*” means the program document identifying the intended uses of funds available for loans pursuant to the WPCSRF and the DWSRF.

“*Nonpoint source*” means any project described in Section 319 of the Clean Water Act.

“*Recipient*” means the entity receiving funds from the SRF.

“*Safe Drinking Water Act*” or “*SDWA*” means Title XIV of the federal Public Health Service Act, commonly known as the “Safe Drinking Water Act,” as amended by the Safe Drinking Water Amendments of 1996.

“*SRF*” means the state revolving fund.

“*WPCSRF*” means the water pollution control state revolving fund.

[ARC 8457B, IAB 1/13/10, effective 2/17/10]

265—26.4(16) Project funding.

26.4(1) *Intended use plans/state project priority lists.* The state project priority lists shall include projects eligible for SRF loans as provided in 567—Chapters 44 and 92. The authority will consider the following when determining whether to provide a loan to an eligible recipient:

- a. Recipient’s financial capability to repay the loan and to provide operation and maintenance, replacement reserves, and, if required, debt service reserves;
- b. Recipient’s statement of willingness to accept all loan terms and conditions;
- c. The priority of the project;
- d. Funds available; and
- e. The technical review and approval of the project by the department.

26.4(2) *Phased or segmented projects.* Loan funds for future portions of phased or segmented projects cannot be ensured, although subsequent segments of a project which has been awarded financial assistance will receive priority over other new projects. Loans made for separate phases or segments of a project will be administered separately.

26.4(3) *Loan adjustments.* Loan amounts may be adjusted to reflect eligible costs.

26.4(4) *Recipient record keeping.* The recipient shall maintain records that document all costs associated with the project. Moneys from the SRF and those contributed by the recipient shall be accounted for separately. Accounting procedures shall conform to generally accepted government accounting standards. The recipient shall agree to provide access to these records to the department, the authority, the state auditor, the state or EPA, and the Office of the Inspector General at the EPA. The recipient shall retain such records and documents for inspection and audit purposes for a period of three years from the date of the final loan payment.

26.4(5) *Site access.* The recipient shall agree to provide the department and the department's agent access to the project site at all times to verify that the loan funds are being used for the intended purpose and that the construction work meets all applicable state and federal requirements. Recipients shall also agree to provide the department periodic access to the project site for the duration of the loan to ensure that the project is being operated and maintained as designed.

26.4(6) *Cross-cutting laws.* Other federal and state statutes and programs may affect an SRF project. Loan agreements will include an assurance that a recipient will comply with all applicable federal and state requirements.

265—26.5(16) WPCSRF/DWSRF infrastructure construction loans.

26.5(1) *Loan agreements.* The authority will prepare a loan agreement when the application has been determined to be in compliance with the requirements of the CWA/SDWA and applicable state rules for SRF funding. The loan shall be accompanied by an enforceability opinion in a form acceptable to the authority and, if applicable, a bond counsel opinion as to the status of interest on the obligation, in a form acceptable to the authority. A copy of the current form of the loan agreement shall be provided to the applicant upon request.

26.5(2) *Loan rates and terms.* Loan terms for point source projects shall include the following:

a. Interest rates. Loan interest rates shall be established in the IUP and shall be established by taking into account factors including, but not limited to, the following:

- (1) Interest rate cost of funds to the SRF;
- (2) Availability of other SRF funds;
- (3) Prevailing market interest rates of comparable non-SRF loans; and
- (4) Long-term SRF viability.

b. Loan initiation fee. The loan initiation fee shall be established in the IUP. The fee shall be payable on the closing date of the loan agreement.

c. Annual loan servicing fee. The annual loan servicing fee shall be established in the IUP. The fee shall be due at the time of each annual principal repayment.

d. Revenue pledge. The recipient shall establish sufficient revenue sources that are acceptable to the director for the repayment of the loan. To ensure repayment of obligations according to the terms of the loan agreement, the recipient shall agree to impose, collect, and increase, if necessary, user charges, taxes, or other dedicated revenue sources identified for the loan repayment in order to maintain annual net revenues at a level equal to at least 110 percent of the amount necessary to pay debt service on all revenue obligations during the next fiscal year, provided, however, that, at the discretion of the director, the authority may allow other revenue sources and coverage of less than 110 percent as security. In case of loan default, the authority shall have authority to require revenue adjustment, through the manner described above, to collect delinquent loan payments.

e. Security. The loan shall be secured by a first lien upon the dedicated source of repayment which may rank on a parity basis with other obligations. The dedicated source of repayment is expected to be the net revenues of the recipient's system and the loan is expected to be secured by a first lien on said net revenues. Loans secured by revenues of a system may rank on a parity basis with other outstanding

obligations or, with the approval of the director, may be subordinate in right of payment to the recipient's other outstanding revenue obligations. Loans may also be secured by a general obligation of the recipient through the provision for a levy of taxes to repay the loan.

f. Construction payment schedules. An estimated construction drawdown schedule provided by the recipient shall be part of the loan agreement.

26.5(3) Loan commitments. A loan agreement shall be a binding commitment of the recipient.

26.5(4) Purpose of payments. The recipient shall use the proceeds of the WPCSRF/DWSRF loan solely for the purpose of funding the approved project.

26.5(5) Costs. All eligible costs must be documented to the satisfaction of the authority and the department before proceeds of the loan will be disbursed.

26.5(6) Loan amount and repayment period. All loans shall be made contingent on the availability of funds, the maximum loan term will be that allowed by EPA, and repayment of the loan must begin no later than one year after the project is completed or by the date specified in the loan agreement.

26.5(7) Prepayment. The loan may be prepaid, in whole or in part, on any date with the prior written consent of the authority.

[ARC 8457B, IAB 1/13/10, effective 2/17/10]

265—26.6(16) Planning and design loans.

26.6(1) Timing of loan. Prior to a recipient's execution of a loan agreement for project construction, funds may be loaned to the recipient to pay for initial eligible costs, including the cost of facility planning and design engineering.

26.6(2) Duration. Planning and design loans may not have a duration of longer than three years from their date of execution, unless the director provides written consent to a longer term.

26.6(3) Interest rate. The interest rate will be that rate specified in the most recent IUP.

26.6(4) Rollover to construction loan. All funds borrowed by the recipient as a planning and design loan may be financed as a part of a construction loan agreement upon expiration of the term of the planning and design loan.

26.6(5) Repayment. If the recipient does not execute an SRF construction loan, the planning and design loan shall be paid in full at the end of the three-year term, unless the loan term is extended by written consent of the director.

[ARC 8079B, IAB 8/26/09, effective 8/7/09]

265—26.7(16) Disadvantaged community status.

26.7(1) Criteria for disadvantaged community status. The authority, in conjunction with the department, may develop criteria to determine disadvantaged community status. Factors included in the criteria include, but are not limited to, the community's median household income and target user charges. Criteria to determine disadvantaged community status shall be established in the IUP.

26.7(2) Interest rate. Interest rates for disadvantaged communities shall be established in the IUP.

[ARC 8457B, IAB 1/13/10, effective 2/17/10]

265—26.8(16) WPCSRF nonpoint source set-aside loan programs.

26.8(1) Nonpoint source loan assistance. Loan assistance for nonpoint source projects shall be in the form of low-interest loans or through linked deposits or loan participations through participating lending institutions.

26.8(2) Application for loan assistance. Application for loan assistance may be made at any participating lending institution or submitted to the authority or the authority's agent, as applicable. A list of participating lending institutions will be made available by the authority, financial agent or other entity that the authority may use to administer this program. Application for loan assistance shall be made on forms provided by the authority or its agent.

26.8(3) Project approval. Each project must be approved by the appropriate environmental or conservation agency as determined by the department.

26.8(4) Loan approval. For linked deposit programs, the participating lending institution shall, upon receipt of a completed loan application form, either approve or deny the loan in accordance with the

program requirements. If the loan is approved, the lending institution shall notify the authority or its agent in order to reserve funds in that amount to ensure that funds are available at the time of disbursement. If the loan is denied, the lending institution shall notify the loan applicant, clearly stating the reasons for the loan denial. For low-interest loans with the authority, the authority, or its agent, shall notify the applicant of the loan approval or denial.

26.8(5) Availability of funds. Before acting on a loan application, the lending institution shall ensure that adequate funds are available for the project and that the completed project has been inspected and approved by the appropriate environmental or conservation agency as determined by the department.

26.8(6) Property transfer. In the event of property transfer from the applicant to another person or entity during the repayment period specified in the loan agreement, the balance of the loan shall be immediately due in full.

26.8(7) Loan amount and period. All loans shall be made contingent on the availability of funds in the applicable fund or set-aside program as indicated in the IUP. The minimum and maximum loan amounts that will be considered are dependent on project type and are set forth as follows:

Type of Project	Type of Assistance	Minimum Loan Amount	Maximum Outstanding Balance	Maximum Loan Term	Project Approval Agency
General Nonpoint Source	Low-interest loans, Linked deposit or Loan participations	\$5,000	No maximum	20 years	DNR
Local Water Protection	Linked deposit	\$5,000	\$500,000 per common ownership	10 years	Division of Soil Conservation
Livestock Water Quality Facilities	Linked deposit	\$10,000	\$500,000 per common ownership	10 years*	Division of Soil Conservation
Onsite Wastewater Systems Assistance	Linked deposit	\$2,000	No maximum	10 years	County

*If the loan is made only for preparation of a comprehensive nutrient management plan, the loan period shall not exceed 5 years.

26.8(8) Prepayment. For direct loans, prepayment of the loan principal in whole or in part shall be allowed without penalty.

26.8(9) Loan adjustments. If the eligible costs exceed the loan amount, the recipient may request an increase in the loan amount. The lending institution is authorized to execute a loan for a principal amount of up to 10 percent above the amount of the loan application if the eligible costs exceed the application amount. To determine the appropriate action, the authority will evaluate the request by considering available moneys in the fund as well as the financial risk. Should the eligible costs be less than the loan amount, the loan shall be appropriately adjusted.

26.8(10) Disbursement of funds. Funds shall be disbursed in accordance with the loan agreement. The loan agreement may allow for periodic disbursement of funds.

[ARC 8457B, IAB 1/13/10, effective 2/17/10]

265—26.9(16) Termination and rectification of disputes.

26.9(1) Termination. The authority shall have the right to terminate any loan if a term of the agreement has been violated. Loans are subject to termination if construction has not begun within one year of the execution of a loan agreement. The director will establish a repayment schedule for funds already loaned to the recipient. Every termination must be in writing.

26.9(2) Rectification and disputes. Failure of the recipient to implement the approved project or to comply with the applicable requirements constitutes grounds for the authority, the authority's agent, or

the participating lending institution to withhold loan disbursements. The recipient is responsible for ensuring that the identified problem(s) is rectified. Once the deficiency is corrected, the loan funds can be released. A recipient that disagrees with the director's withholding of loan funds may request a formal review of the action. The recipient must submit to the director a written request for a formal review of the action within 30 days of receiving notice that loan disbursements will not be released.

These rules are intended to implement Iowa Code sections 16.5(17) and 16.133.

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CHAPTER 32
IOWA JOBS PROGRAM

265—32.1(16,83GA,SF376) Purpose. The Iowa jobs board is charged by the Iowa legislature and the governor with establishing, overseeing and providing approval of the administration of the Iowa jobs program. The board will encourage and support public construction projects relating to disaster relief and mitigation and to local infrastructure.

[ARC 7941B, IAB 7/15/09, effective 6/15/09]

265—32.2(16,83GA,SF376) Definitions. When used in this chapter, the following definitions apply unless the context otherwise requires:

“Authority” or *“IFA”* means the Iowa finance authority.

“Board” means the Iowa jobs board as established in 2009 Iowa Acts, Senate File 376, section 5.

“Disaster” means the severe storms, tornadoes, and flooding that occurred in Iowa between May 25, 2008, and August 13, 2008, and designated by FEMA as FEMA-1763-DR; additionally, the Iowa jobs board may, by resolution, designate an event that occurs subsequent to June 15, 2009, as a disaster.

“Financial feasibility” means the ability of a project, once completed, to be maintained and operated for its useful life with funds either generated by the project itself or from an identifiable source of funds available for such purpose.

“Future flood prevention” means measures intended to mitigate or lessen the damages caused by future flooding.

“Indirect jobs” means jobs created by suppliers of materials used in the construction or operation of the project.

“Induced jobs” means jobs collaterally created throughout the economy by a project as employed workers and firms buy other goods and services.

“Iowa jobs program review committee” or *“review committee”* means the committee established by 2009 Iowa Acts, Senate File 376, section 9(2), and constituted as described in this chapter.

“Local infrastructure” means:

1. Projects relating to disaster rebuilding;
2. Reconstruction and replacement of local public buildings;
3. Flood control and flood protection; and
4. Future flood prevention.

“Local infrastructure” does not include routine, recurring maintenance or operational expenses or leasing of a building, appurtenant structure, or utility without a lease-purchase agreement.

“Local support” means endorsement of a proposed project by local individuals, organizations, or governmental bodies that have a substantial interest in a project.

“Program” means the Iowa jobs program established in 2009 Iowa Acts, Senate File 376, sections 5 to 12.

“Public construction project” means a project for the construction of local infrastructure by a county, city, or public organization.

“Public organization” means a nonprofit organization that sponsors or supports the public needs of one or more local Iowa communities and that was in operation prior to January 1, 2009; provided that (1) such organization is described in Section 501(c)(3) or 501(c)(4) of the Internal Revenue Code and is exempt from federal tax under Section 501(a) of the Internal Revenue Code, and (2) such organization is determined by the board not to be affiliated with or controlled by a for-profit organization.

“Recipient” means an entity under contract with the Iowa jobs board to receive Iowa jobs funds and undertake a funded project.

“Sustainability” means the use, development, and protection of resources at a rate and in a manner that enables people to meet their current needs while allowing future generations to meet their own needs; “sustainability” requires simultaneously meeting environmental, economic and community needs.

[ARC 7941B, IAB 7/15/09, effective 6/15/09]

265—32.3(16,83GA,SF376) Allocation of funds. All Iowa jobs funds shall be awarded and used as specified in 2009 Iowa Acts, Senate File 376, and these rules. Any portion of an amount allocated for projects that remains unexpended or unencumbered one year after the allocation has been made by the board may be reallocated by the board to another project category, at the discretion of the board. All bond proceeds shall be expended within three years from when the allocation was initially made. The total amount of allocations for future flood prevention, reconstruction and replacement of local public buildings, disaster rebuilding, flood control and flood protection projects (pursuant to the local infrastructure competitive grant program) shall not exceed \$165 million for the fiscal year beginning July 1, 2009.

[ARC 7941B, IAB 7/15/09, effective 6/15/09]

265—32.4(16,83GA,SF376) Local infrastructure competitive grant program. The board shall assist in the development and completion of public construction projects relating to disaster relief and mitigation and to local infrastructure by overseeing and providing approval of the administration of a local infrastructure competitive grant program, as set forth herein.

32.4(1) Iowa jobs program review committee. The Iowa jobs program review committee shall comprise five members, consisting of the following members of the Iowa jobs board: three of the general public members, as appointed to the review committee by the Iowa jobs chair, the executive director of the Iowa finance authority (or designee), and the director of Iowa workforce development (or designee). The review committee shall comply with Iowa Code chapter 21 and with Iowa Code sections 69.16 and 69.16A. From its public members, the review committee shall elect a chair and a vice chair. Two-thirds of the review committee members eligible to vote shall constitute a quorum authorized to act in the name of the review committee.

32.4(2) Eligible applicants. Eligible applicants for Iowa jobs local infrastructure competitive grant program funds shall be Iowa cities, Iowa counties, and public organizations.

32.4(3) Eligible projects and forms of assistance. For a project to be eligible to receive a competitive grant from the board, the project must be a public construction project in the state of Iowa with a demonstrated substantial local, regional, or statewide economic impact. Financial assistance shall be awarded only in the form of grants. An applicant for a competitive grant shall not receive more than \$50 million in financial assistance from the Iowa jobs restricted capitals fund.

a. Any award of a competitive grant to a project shall be limited as follows:

(1) Up to 75 percent of the total cost of a project for replacing or rebuilding existing disaster-related damaged property; or

(2) Up to 50 percent of the total cost for all other projects.

b. The authority, with the approval of the chair and vice chair of the Iowa jobs board, shall have the ability to make technical corrections to an award that are within the intent of the terms of a board-approved award.

32.4(4) Ineligible projects. The board shall not approve an application for a competitive grant for either of the following purposes:

a. To refinance a loan existing prior to the date of the initial financial assistance application.

b. For a project that has previously received financial assistance under the local infrastructure competitive grant program, unless the applicant demonstrates that the financial assistance would be used for a significant expansion of such a project.

32.4(5) Threshold application requirements. To be considered for a competitive grant, an application shall meet all of the following threshold requirements:

a. Prior to filing an application, the applicant must file, on the form and in the manner prescribed by the authority, a notice of intent to apply not less than 20 days prior to submitting its application;

b. The application must be submitted by an eligible applicant, must be complete and on forms or in the format specified for such purpose by the authority (the authority may, in its discretion, require the use of a Web-based application format), and must be received by the authority by the applicable deadline;

c. The proposed project must be for the development and completion of one or more public construction projects relating to disaster relief and mitigation or to local infrastructure;

- d. There must be demonstrated local support for the proposed project;
- e. The proposed public construction project must have a demonstrated substantial local, regional, or statewide economic impact; and
- f. The application must coordinate any federal funds with state, local, and private funds and shall avoid any duplication of benefits that would limit or cause the loss of federal funding.

Prior to submitting an application to the review committee, the authority may contact the applicant to clarify information contained in the application. An application may be amended one time prior to being sent to the review committee. Applications may be otherwise amended with the approval of a majority of the review committee.

32.4(6) Application procedure.

a. Applications shall be reviewed and scored in rounds. The deadline for submission for the first round of applications shall be August 3, 2009. Subsequent rounds shall be at the discretion of the board as funding is available. Applications for each such round shall be due not later than January 1, April 1, July 1, and October 1 of each year, respectively.

b. Subject to availability of funds, applications will be reviewed by IFA staff on an ongoing basis. Applications will be reviewed by staff for completeness and eligibility. If additional information is required, the applicant shall be requested, in writing, to submit additional information. For applications that meet the threshold requirements, authority staff shall submit to the members of the review committee a copy of the application along with a review, analysis, and evaluation of complete applications.

c. The review committee members will score the applications according to the criteria set forth in subrule 32.4(7), and IFA staff shall compile the scores. To be eligible for a grant, a proposed project must receive a minimum score of at least 100 points. The review committee shall meet to review the ratings for each round of applications. Those applications meeting the minimum criteria shall be referred to the Iowa jobs board with a recommendation of final approval, denial, or deferral.

d. Once an application has been referred to the Iowa jobs board, the applicant may, upon request of the applicant and at the discretion of the chair of the board, make a presentation to the board. The board may impose reasonable limitations on the length and format of such presentations.

e. If the board determines that an application should be approved, the board shall send the application to negotiations. Negotiations shall be conducted by IFA staff, who may work in cooperation with members of the Iowa jobs board. The negotiators shall negotiate the terms and conditions of a grant agreement to recommend to the board.

f. Following negotiations, the negotiating team shall report back to the Iowa jobs board as to whether it was able to agree with the applicant on the terms of a proposed grant agreement and, if so, the proposed terms and conditions resulting from the negotiations. The Iowa jobs board shall then vote, without further substantive revision, on whether to agree to the negotiated terms.

g. If the negotiated terms are agreed to by the Iowa jobs board, a grant agreement memorializing the negotiated terms shall be executed by the chair or vice chair of the Iowa jobs board.

h. Application resources for the Iowa jobs program are available at the Iowa jobs Web site: www.ijobsiowa.gov.

i. IFA may provide technical assistance as necessary to applicants. IFA staff may conduct on-site evaluations of proposed projects.

j. A denied or deferred application may be revised and resubmitted as a new application in a subsequent round, if any. Unless a deferred application is withdrawn by the applicant or revised and resubmitted as a new application, the authority shall keep it on file, and its score shall automatically be ranked among new applications submitted for the next round, if any, once such new applications have been scored.

32.4(7) Application review criteria. The Iowa jobs program review committee shall evaluate and rank applications based on the following criteria:

a. *The total number and quality of jobs to be created and the benefits likely to accrue to areas distressed by high unemployment (0-40 points).* The number of jobs created and other measures of economic impact to areas distressed by high unemployment, including long-term tax generation, shall be evaluated. Rating factors for this criterion include, but are not necessarily limited to, the following:

(1) Number of jobs. The number of jobs reasonably projected to be created or retained and the number of hours anticipated for each such job shall be compared and ranked.

(2) Quality of jobs. The wages to be paid for each position to be created or retained, the average benefits (including health benefits) to be provided, as well as other subjective qualitative factors, such as work conditions and safety, shall be compared and ranked.

(3) Other benefits likely to accrue to areas distressed by high unemployment, such as the degree to which the project enhances the quality of life in a region and contributes to the community's efforts to retain and attract a skilled workforce.

In order to be eligible for funding, proposals must score at least 20 points on this criterion.

b. Financial feasibility, including the ability of projects to fund depreciation costs or replacement reserves, and the availability of other federal, state, local, and private sources of funds (0-40 points). The feasibility of the proposed project shall be evaluated. Rating factors for this criterion include, but are not limited to, the following:

(1) A financial analysis of the project, which shall include a description of sources of funding, project budget, and detailed projections of the project's revenues and expenses for the projected useful life of the project;

(2) An analysis of the operational plan, which shall provide detailed information about how the proposed project will be operated and maintained, including a time line for implementing the project;

(3) The availability of other federal, state, local, and private sources of funds for the project.

In order to be eligible for funding, proposals must score at least 20 points on this criterion.

c. Sustainability and energy efficiency. The sustainability and energy efficiency of the proposed project shall be evaluated. Rating factors for this criterion include, but are not limited to, the following:

(1) Sustainability (0-20 points). The extent to which the project has taken sustainability planning principles into consideration.

1. The project shall be evaluated based on the following specific factors:

- Efficient and effective use of land resources and existing infrastructure by encouraging compact development in areas with existing infrastructure or capacity to avoid costly duplication of services and costly use of land; conservation of open space and farmland and preservation of critical environmental areas; and promotion of the safety, livability, and revitalization of existing urban and rural communities. Compact development maximizes public infrastructure investment and promotes mixed uses, greater density, bicycle and pedestrian networks, and interconnection with the existing street grid.

- Provision for a variety of transportation choices, including public transit and pedestrian and bicycle traffic.

- Construction and promotion of developments, buildings, and infrastructure that conserve natural resources by reducing waste and pollution through efficient use of land, energy, water, and materials.

- Capture, retention, infiltration and harvesting of rainfall using storm water best management practices such as permeable pavement, bioretention cells, bioswales, and rain gardens to protect water resources.

- The extent to which project design, construction, and use incorporate renewable energy sources including, but not limited to, solar, wind, geothermal, and biofuels, and support the following state of Iowa plans and goals: (1) office of energy independence's Iowa energy independence plan; and (2) general reduction of greenhouse gas emissions.

2. Alternatively, in lieu of being evaluated on each of the criteria set forth above, projects which are designed to receive certification (either platinum level, gold level, silver level, or basic LEED certification) from the United States Green Building Council in the Leadership in Energy and Environmental Design (LEED) Green Building Rating System version 3.0, and which comply with the requirements of ASHRAE 90.1-2007, Energy Standard for Buildings Except Low-Rise Residential Buildings, published by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, 1791 Tullie Circle, N.E., Atlanta, GA 30329, shall receive 20 points.

(2) Energy efficiency (0-20 points). The extent to which the project has taken energy efficiency planning principles into consideration.

1. In the case of new construction, whether the project is designed to meet the current state building energy code. The application for the project must include a letter from the engineer or architect to IFA certifying whether the proposed construction meets the current state building energy code. Additionally, the application should address whether the proposed project is designed to meet energy star standards. If the project is of such a nature that the current state building energy code does not apply to it, the letter shall so state.

2. In the case of rehabilitation of existing structures, an energy audit conducted by a certified energy rater should be provided on each building prior to the preparation of the final work rehabilitation order to determine the feasibility of meeting the requirements of the current state building energy code and energy star standards prior to the start of the rehabilitation. If it is determined to be feasible to meet the current state building energy code standards and energy star standards, appropriate specifications will be written into the work order. If it is not feasible to meet the requirements of the current state building energy code and energy star standards (or either of them), the application will provide information indicating what effective and cost-effective energy improvements will be included as a part of the rehabilitation project.

d. Benefits for disaster recovery (0-40 points). The likely benefits for disaster recovery of the proposed project shall be evaluated. Wherever applicable, rating factors for this criterion include, but are not limited to, the following:

(1) Whether the proposed project replaces or repairs a structure or facility damaged by the disaster and incorporates measures for reducing or eliminating future disaster losses;

(2) Whether the proposed project would help achieve the community's or region's overall post-disaster recovery vision;

(3) Whether the proposed project benefits the economic recovery of individuals, businesses, or nonprofit organizations.

e. The project's readiness to proceed (0-40 points). The readiness of the project to proceed shall be evaluated. Wherever applicable, rating factors for this criterion include, but are not limited to, the following:

(1) Whether all engineering and architectural work required for construction to begin has been completed;

(2) Whether all financing for the project (other than competitive grant funds awarded under this chapter) has been committed and is available;

(3) Whether all real property interests (including easements and temporary construction easements) necessary for the construction of the project have been acquired;

(4) Whether all necessary governmental approvals, at the federal, state, and local levels (including, but not limited to, zoning variances, building permits, approval from the Army Corps of Engineers, etc.), have been obtained;

(5) Whether the project has demonstrated a reasonable likelihood of incurring at least 10 percent of the project's total projected development cost within three months of execution of the grant award agreement.

f. General scoring criteria.

(1) In instances where a given criterion is not applicable to a proposed project due to the nature of the project, the review committee members may adjust scoring so that the project is not disadvantaged as a result of the inapplicable criterion. For example, if an earthen levee is proposed as a means of flood control, it should not lose points relative to other proposed projects because it does not comply with the current state building energy code (which does not apply to earthen levees).

(2) Any proposed project that is identified in an Iowa great places agreement, pursuant to Iowa Code section 303.3C, shall have an additional two points added to its cumulative point total.

[ARC 7941B, IAB 7/15/09, effective 6/15/09; ARC 8103B, IAB 9/9/09, effective 8/19/09; ARC 8327B, IAB 12/2/09, effective 11/4/09; ARC 8456B, IAB 1/13/10, effective 2/17/10]

265—32.5(16,83GA,SF376) Noncompetitive grants.

32.5(1) The board shall award \$46,500,000 as follows for disaster relief and mitigation and local infrastructure grants for the following renovation and construction projects, notwithstanding any limitation on the state's percentage participation in funding as contained in Iowa Code section 29C.6(17):

a. For grants to a county with a population between 189,000 and 196,000 in the latest preceding certified federal census, to be distributed as follows:

(1) Ten million dollars for the construction of a new, shared facility between nonprofit human service organizations serving the public, especially the needs of low-income Iowans, including those displaced as a result of the disaster of 2008.

(2) Five million dollars for the construction or renovation of a facility for a county-funded workshop program serving the public and particularly persons with mental illness or developmental disabilities.

b. For grants to a city with a population between 110,000 and 120,000 in the latest preceding certified federal census, to be distributed as follows:

(1) Five million dollars for an economic redevelopment project benefiting the public by improving energy efficiency and the development of alternative and renewable energy technologies.

(2) Ten million dollars for a museum serving the public and dedicated to the preservation of an eastern European cultural heritage through the collection, exhibition, preservation, and interpretation of historical artifacts.

(3) Five million dollars for a theater serving the public and promoting culture, entertainment, and tourism.

(4) Five million dollars for a public library.

(5) Five million dollars for a public works building.

c. One million five hundred thousand dollars, to be distributed as follows:

(1) Five hundred thousand dollars to a city with a population between 600 and 650 in the latest preceding certified federal census, for a public fire station.

(2) Five hundred thousand dollars to a city with a population between 1,400 and 1,500 in the latest preceding certified federal census, for a public fire station.

(3) Five hundred thousand dollars for a city with a population between 7,800 and 7,850, for a public fire station.

32.5(2) Noncompetitive grant awards are contingent upon submission of a plan for each project by the applicable county or city governing board or, in the case of a project submitted pursuant to subparagraph 32.5(1) "b"(2), by the board of directors, to the Iowa jobs board no later than September 1, 2009, detailing a description of the project, the plan to rebuild, and the amount or percentage of federal, state, local, or private matching moneys which will be or have been provided for the project. Funds not utilized in accordance with this rule due to failure to submit a plan by the September 1 deadline shall revert to the Iowa jobs restricted capitals fund to be available for local infrastructure competitive grants.

32.5(3) A grant recipient under subparagraph 32.5(1) "b"(2) shall not be precluded from applying for a local infrastructure competitive grant pursuant to this rule and 2009 Iowa Acts, Senate File 376, section 9.

[ARC 7941B, IAB 7/15/09, effective 6/15/09]

265—32.6(16,83GA,SF376) General grant conditions. As a condition of receipt of Iowa jobs funds, recipients shall agree, at a minimum, to all of the following:

32.6(1) *Documentation of jobs created or retained.* Following the receipt of grant funds pursuant to this chapter and for two years following the completion of the project, each recipient shall report to the authority quarterly the actual number of jobs created as a result of the project along with other information relating to the quality of such jobs, including hours and wages, as requested by the authority.

32.6(2) *Recipient obligations.* In the event a recipient fails to comply with the requirements of this program or the recipient's grant agreement, the board may cancel the recipient's grant and require the return of any grant funds previously disbursed pursuant to this program. Recipients shall agree to hold

harmless and to indemnify the Iowa jobs board, the authority, the state of Iowa, and their officers, employees and agents from any claims, costs or liabilities arising out of the development or operation of the project.

32.6(3) Grant acknowledgment. Each project shall recognize in a prominent location and manner the fact that the project was made possible, in part, through a grant from the Iowa jobs program. During the construction period the recognition (including a display of the Iowa jobs logo) may be located on temporary signage. The completed project shall feature a permanent acknowledgment, such as a plaque or a similar commemoration. Other benefactors of the project may be similarly acknowledged as well.

32.6(4) Use of Iowa jobs Web site. All positions that need to be filled for a project shall be posted on Iowa workforce development's Iowa jobs Web site: www.iowajobs.org/.
[ARC 7941B, IAB 7/15/09, effective 6/15/09]

265—32.7(16,83GA,SF376) Calculation of jobs created. For purposes of this chapter, new employment positions created and filled (or to be created and filled) as a result of the project and existing positions that would not have been continued were it not for Iowa jobs funding shall be counted when estimating the number of jobs to be created during the application process and when counting the number of actual jobs created in post-grant reporting. Both permanent and temporary positions filled by the grantee, a contractor, or a subcontractor (or sub-subcontractor, etc.), including construction work, shall be counted. To be counted, a position must be compensated. Indirect jobs and induced jobs shall not be counted.

[ARC 7941B, IAB 7/15/09, effective 6/15/09]

265—32.8(16,83GA,SF376) Grant awards. The Iowa jobs board may fund a component of a proposed project if the entire project does not qualify for funding. The board shall review awards made to ensure geographic diversity. In order to promote geographic diversity, the board may defer grant decisions on applications from areas which have received previous grant awards to allow applications from other parts of the state to be considered. In the event that a competitive grant recipient, prior to execution of an Iowa jobs grant agreement, is awarded a federal grant for its project, in whole or in part, which federal grant, or the possibility thereof, was not disclosed as part of the recipient's application, the board may withdraw all or part of the Iowa jobs program grant.

[ARC 7941B, IAB 7/15/09, effective 6/15/09; ARC 8455B, IAB 1/13/10, effective 12/14/09]

265—32.9(16,83GA,SF376) Administration of awards.

32.9(1) A grant agreement shall be executed between successful applicants (under both the competitive and noncompetitive grant programs) and the Iowa jobs board. These rules and applicable state laws and regulations shall be part of the contract. The board reserves the right to negotiate wage rates as well as other terms and conditions of the contract.

32.9(2) Grant agreement.

a. Following the board's determination that a competitive grant application should be approved, authority staff shall propose a draft grant agreement to the recipient. Within 30 days of either transmission of the proposed grant agreement to the recipient or transmission of notice of how the proposed grant agreement may be accessed by the recipient via the Internet, the recipient shall notify the authority as to whether the recipient will execute the proposed agreement or whether the recipient would prefer to negotiate a different agreement. If the recipient elects to execute the proposed agreement, or if the recipient fails to make a timely election, the authority shall prepare and transmit to the recipient on behalf of the board a final contract for execution.

b. If the recipient elects to negotiate a different agreement, the recipient shall, at the time it makes such election, notify the authority of the requested changes to the proposed grant agreement. The authority shall consider the requested changes and may make such revisions to the proposed agreement as the authority determines to be prudent and in the best interests of the Iowa jobs program and the state of Iowa under the circumstances.

c. Once the authority and the recipient have reached an agreement, the authority shall prepare and transmit to the recipient on behalf of the board a final contract, subject to approval by the board.

d. If the authority and the recipient are unable to reach an agreement, the authority shall, with the board's approval, draft and transmit to the recipient on behalf of the board a final contract consisting of the Iowa jobs board's best and final offer.

32.9(3) The recipient must execute and return the contract to the Iowa jobs board within 45 days of transmittal of the final contract from the Iowa jobs board. Failure to do so may be cause for the Iowa jobs board to terminate the award.

32.9(4) Certain projects may require that permits or clearances be obtained from other state, local, or federal agencies before the activity may proceed. Awards may be conditioned upon the timely completion of these requirements.

32.9(5) Awards may be conditioned upon commitment of other sources of funds necessary to complete the project.

32.9(6) Any substantive change to a contract shall be considered an amendment. Substantive changes include time extensions, budget revisions, and significant alterations that change the scope, location, objectives or scale of an approved project. Amendments must be requested in writing by the recipient and are not considered effective until approved by the Iowa jobs board and confirmed in writing by IFA staff following the procedure specified in the contract between the recipient and the Iowa jobs board.

[ARC 7941B, IAB 7/15/09, effective 6/15/09; ARC 8455B, IAB 1/13/10, effective 12/14/09]

These rules are intended to implement Iowa Code section 16.5(1) "r" and 2009 Iowa Acts, Senate File 376, sections 5 to 12.

[Filed Emergency ARC 7941B, IAB 7/15/09, effective 6/15/09]

[Filed Emergency ARC 8103B, IAB 9/9/09, effective 8/19/09]

[Filed Emergency ARC 8327B, IAB 12/2/09, effective 11/4/09]

[Filed Emergency ARC 8455B, IAB 1/13/10, effective 12/14/09]

[Filed ARC 8456B (Notice ARC 8108B, IAB 9/9/09), IAB 1/13/10, effective 2/17/10]

CHAPTER 8
EXECUTIVE BRANCH LOBBYING

[Prior to 11/26/03, see 351—Ch 13]

351—8.1(68B) Executive branch lobbying defined. “Executive branch lobbying” means acting directly to encourage the passage, defeat, approval, veto, or modification of legislation, a rule, or an executive order by a state agency or any statewide elected official. For purposes of this chapter, “state agency” does not include the legislative branch of state government.

This rule is intended to implement Iowa Code section 68B.2(13).

351—8.2(68B) Executive branch lobbyist defined. “Executive branch lobbyist” means an individual who by acting directly does at least one of the following:

1. Receives compensation for engaging in executive branch lobbying.
2. Is a designated representative of an organization that has as one of its purposes engaging in executive branch lobbying.
3. Represents the position of a federal, state, or local agency in which the person serves or is employed as the representative designated to engage in executive branch lobbying.
4. Makes expenditures of more than \$1,000 in a calendar year to communicate in person for the purpose of engaging in executive branch lobbying.

This rule is intended to implement Iowa Code section 68B.2(13).

351—8.3(68B) Individuals not considered executive branch lobbyists. The following individuals are not considered to be executive branch lobbyists:

1. Officials and employees of a political party that is organized in the state of Iowa and that meets the requirements of Iowa Code section 43.2, when the officials and employees represent the political party in an official capacity.
2. Representatives of the news media only when engaged in the reporting and dissemination of news and editorials.
3. All federal, state, and local elected officials, while performing the duties and responsibilities of office.
4. Individuals whose activities are limited to appearances to give testimony or provide information or assistance at public hearings of state agencies or who are giving testimony or providing information or assistance at the request of public officials or employees.
5. Members of the staff of the United States Congress or the Iowa general assembly.
6. Agency officials and employees while they are engaged in activities within the agency in which they serve or are employed or with another agency within which an official’s or employee’s agency is involved in a collaborative project.
7. An individual who is a member, director, trustee, officer, or committee member of a business, trade, labor, farm, professional, religious, education, or charitable association, foundation, or organization and who is not paid compensation or is not specifically designated as an executive branch lobbyist.
8. Individuals whose activities are limited to submitting data, views, or arguments in writing, or requesting an opportunity to make an oral presentation under Iowa Code section 17A.4(1).
9. Individuals whose activities are limited to monitoring or following the progress of legislation, a rule, or an executive order, but who do not engage in executive branch lobbying.
10. Individuals who represent a client in responding to a request for proposal or otherwise receiving a contract or grant from a state agency.
11. Individuals who represent a client involved in a legal dispute with the state, including a contested case proceeding.
12. Individuals advocating for or against the appointment of a particular individual to a board or commission of the state.

Individuals who are uncertain as to whether or not they are considered executive branch lobbyists should contact the board for guidance prior to engaging in any executive branch lobbying.

This rule is intended to implement Iowa Code section 68B.2(13).

351—8.4(68B) Executive branch lobbyist client defined. “Executive branch lobbyist client” means a private person or a federal, state, or local governmental entity that pays compensation to or designates an individual to be a lobbyist before the executive branch.

This rule is intended to implement Iowa Code section 68B.2(6).

351—8.5(68B) Lobbyist compensation defined; contingency fee lobbying prohibited.

8.5(1) Lobbyist compensation defined. “Lobbyist compensation” means any money, thing of value, or financial benefit conferred in return for engaging in executive branch lobbying.

8.5(2) Contingency fee lobbying prohibited. No person shall offer, nor shall any person accept, compensation contingent upon the outcome of executive branch lobbying services rendered or to be rendered. Complaints or information alleging a violation of this subrule shall be filed with the board and governed by Iowa Code sections 68B.32B through 68B.32D.

This rule is intended to implement Iowa Code section 68B.2(7).

351—8.6(68B) Executive branch lobbying expenditures. This rule is intended to aid executive branch lobbyists in reporting expenditures as required by Iowa Code section 68B.37 that are made by lobbyists for executive branch lobbying purposes. The provisions of this rule are intended to serve as a general guideline to obtain uniform reporting.

8.6(1) Expenditures defined. The following are defined as executive branch lobbying expenditures:

a. Direct communication expenses such as telephone calls, letters, faxes, printing, and postage for purposes of engaging in executive branch lobbying.

b. Other tangible costs directly associated with engaging in executive branch lobbying as defined in rule 351—8.1(68B).

8.6(2) Lobbyist client expenses. For purposes of this rule, any of the expenses set out in subrule 8.6(1) incurred by a lobbyist’s client shall apply to the lobbyist and shall be a reportable expense by the lobbyist. However, an expenditure made by any organization for publishing a newsletter or other informational release for its members is not a reportable expenditure.

This rule is intended to implement Iowa Code section 68B.37.

351—8.7(68B) Lobbyist registration required.

8.7(1) Time of filing. Any individual engaging in executive branch lobbying activity shall register by filing an executive branch lobbyist registration statement with the board on or before the day the lobbying activity begins. Registration expires upon the commencement of a new calendar year. Persons wishing to register for a new calendar year may do so on or after December 1 of the previous year.

8.7(2) Place of filing. Executive branch lobbyist registration statements shall be filed with the board electronically through the board’s Web site at www.iowa.gov/ethics.

8.7(3) Information required. The following information shall be disclosed on the executive branch lobbyist registration statement:

a. The lobbyist’s name and business address. The lobbyist’s residential address and E-mail address are optional. The lobbyist shall indicate whether mail should be sent to the lobbyist’s office or residence.

b. A general description of the issues or interests that the lobbyist might follow and a list of agencies or offices that may be lobbied.

c. Whether or not the lobbyist is a governmental official representing the official position of the lobbyist’s department, agency, or governmental entity.

d. Each of the lobbyist’s clients, including the name and address of the client, a contact person and job title, and the contact person’s telephone number. An E-mail address is optional.

e. The lobbyist’s signature and date of filing. Registration statements filed electronically through the board’s Web site are deemed signed and dated when filed.

8.7(4) *Government employee authorization letter.* As required by Iowa Code section 68B.36(5), all federal, state, and local officials or employees representing the official positions of their departments, commissions, boards, or agencies shall submit with their registration statements letters of authorization from their department or agency heads. Federal, state, and local officials who wish to lobby in opposition to the official position of their departments, commissions, boards, or agencies shall disclose this fact on their lobbyist registration statements.

8.7(5) *Amendment to registration.* Any change or addition to the information in an executive branch lobbyist's registration statement shall be filed with the board within ten days after the change or addition is made known to the lobbyist. The lobbyist may file changes or additions by submitting an amended registration statement or by letter. If the lobbyist submits the changes or additions by letter, the letter shall contain sufficient information to notify the public and the board of the change or addition.

8.7(6) *Cancellation.* If a lobbyist's service on behalf of a client is concluded prior to the end of the calendar year, the lobbyist or client may cancel the registration and terminate the reporting requirements of Iowa Code section 68B.37 and rule 351—8.8(68B) so long as compliance with subrule 8.8(4) is achieved. Cancellation may be completed by the filing of an executive branch lobbyist termination statement or by letter.

8.7(7) *Failure to timely file registration.* An individual who fails to file an executive branch lobbyist registration statement before engaging in executive branch lobbying is in violation of Iowa Code section 68B.36 and is subject to the possible imposition of board sanctions.

This rule is intended to implement Iowa Code section 68B.36.
[ARC 8483B, IAB 1/13/10, effective 1/25/10]

351—8.8(68B) Executive branch periodic lobbyist reports.

8.8(1) Every executive branch lobbyist, unless an exemption is granted pursuant to subrule 8.8(5), shall file periodic reports disclosing all of the following:

- a. The lobbyist's name and address.
- b. The reporting period covered by the filed report, including disclosing whether the report is an original or amended report.
- c. The lobbyist's clients.
- d. The recipient and amount of campaign contributions made by the lobbyist to candidates for state office. Campaign contributions shall not be made to state officers during the time period described in Iowa Code section 68A.504 and rule 351—8.15(68A).
- e. Expenditures made by the lobbyist for executive branch lobbying purposes.
- f. The lobbyist's signature and the date filed. Reports filed electronically through the board's Web site are deemed signed and dated when filed.

8.8(2) *Place of filing.* Executive branch periodic lobbyist reports shall be filed with the board electronically through the board's Web site at www.iowa.gov/ethics.

8.8(3) *Time of filing.* An executive branch periodic lobbyist report shall be filed on or before April 30, July 31, October 31, and January 31, for the preceding calendar quarter or parts thereof during which the lobbyist was engaged in executive branch lobbying. The report must be electronically received by the board on or before 11:59 p.m. on the due date. If the report due date falls on a weekend or holiday, the due date shall be extended to the next business day.

8.8(4) *Cancellation.* If the lobbyist cancels registration on behalf of a client under rule 351—8.7(68B), the lobbyist shall file a final executive branch periodic lobbyist report on the next required due date or within 15 days of the cancellation, whichever is earlier. As required by Iowa Code section 68B.37(3), the final report shall include cumulative year-to-date information.

8.8(5) *Exemption.* As provided in Iowa Code section 68B.37(3), if the lobbyist is designated to represent an organization other than a governmental entity and is not paid compensation or does not expend more than \$1,000 to lobby, the lobbyist may file an Application for Lobbyist Quarterly Reporting Exemption form and one Executive Branch Periodic Lobbyist Report disclosing anticipated expenditures for the year in lieu of filing the quarterly reports. The exemption form and cumulative report shall be filed at the same time the lobbyist registration statement is filed.

8.8(6) *Attorney-client privilege not applicable.* Attorneys who engage in executive branch lobbying shall comply with the requirements of Iowa Code section 68B.37 and shall not avoid public disclosure of executive branch lobbying expenditures by asserting attorney-client privilege.

This rule is intended to implement Iowa Code section 68B.37.

[Editorial change: IAC Supplement 4/8/09; **ARC 8483B**, IAB 1/13/10, effective 1/25/10]

351—8.9(68B) Executive branch lobbyist client reporting.

8.9(1) Every executive branch lobbyist client shall file reports that contain the following information:

- a. The name and address of the client, including a contact person.
- b. The name of the client's lobbyists.
- c. The amount of all salaries, fees, retainers, and reimbursements paid or anticipated to be paid by the client to each lobbyist for engaging in executive branch lobbying activities for the period commencing on July 1 of the previous year through June 30 of the current year. A report shall be filed even if the client did not pay any compensation to the client's lobbyist. If no compensation was paid, the client shall disclose on the report \$0.00 as compensation paid. In the case of a salaried position when executive branch lobbying is part of the individual's duties, the reportable salary shall be based on a pro-rata basis of time spent engaging in executive branch lobbying.

d. The signature of the client's contact person and the date signed. Lobbyist client reports filed electronically through the board's Web site are deemed signed and dated when filed.

8.9(2) Place of filing. Executive branch lobbyist client reports shall be filed with the board electronically through the board's Web site at www.iowa.gov/ethics.

8.9(3) Time of filing. An executive branch lobbyist client report shall be filed on or before July 31. The report must be electronically received by the board on or before 11:59 p.m. on the due date. If the report due date falls on a weekend or holiday, the due date shall be extended to the next business day.

This rule is intended to implement Iowa Code section 68B.38.

[Editorial change: IAC Supplement 4/8/09; **ARC 8483B**, IAB 1/13/10, effective 1/25/10]

351—8.10(68B) Reception reporting form. Rescinded IAB 12/21/05, effective 1/25/06.

351—8.11(68B) Penalties for delinquent reports.

8.11(1) *Late lobbyist report.* An executive branch lobbyist who fails to timely file an executive branch periodic lobbyist report shall be subject to an automatic civil penalty according to the following schedule:

Days Delinquent	1st Delinquency	2nd Delinquency	Subsequent Delinquencies
1 to 14	\$25	\$50	\$100
15 to 30	\$50	\$100	\$200
31 and over	\$100	\$200	\$400

For purposes of this subrule, second and subsequent delinquencies apply to a report that covers any quarter of the year for which the lobbyist is registered to lobby the executive branch.

8.11(2) *Late client report.* An executive branch lobbyist client who fails to file an executive branch lobbyist client report on or before the required due date shall be subject to an automatic civil penalty according to the following schedule:

Days Delinquent	Amount
1 to 14	\$25
15 to 30	\$50
31 and over	\$100

8.11(3) *Additional penalty.* If an executive branch lobbyist or an executive branch lobbyist client fails to file a required report within 45 days of the report due date, or fails to file a complete report, a contested case proceeding may be held to determine whether a violation has occurred. If, after a contested

case proceeding, it is determined that a violation occurred, the board may impose any of the actions under Iowa Code section 68B.32D. Any action so imposed would be in addition to the automatically assessed penalty in this rule.

This rule is intended to implement Iowa Code sections 68B.32A(5) and 68B.32A(9).

[Editorial change: IAC Supplement 4/8/09]

351—8.12(68B) Request for waiver of penalty. An executive branch lobbyist or an executive branch lobbyist client that believes there are mitigating circumstances that prevented the timely filing of a report may make a written request to the board for waiver of the penalty. The board must receive the request for waiver within 30 days of the lobbyist's or lobbyist client's being notified of the civil penalty assessment by filing a Petition for Waiver of Civil Penalty form. Waivers will be granted only for exceptional or very unusual circumstances. The board will review the request and issue a waiver or denial of the request. If a waiver is granted, the board will determine how much of the penalty is waived based on the circumstances. If a denial or partial waiver is issued, the person shall promptly pay the assessed penalty or request a contested case proceeding pursuant to rule 351—8.13(68B) to appeal the board's decision.

This rule is intended to implement Iowa Code sections 68B.32A(5) and 68B.32A(9).

[Editorial change: IAC Supplement 4/8/09; ARC 7996B, IAB 7/29/09, effective 9/2/09]

351—8.13(68B) Contested case proceeding.

8.13(1) Request. If an executive branch lobbyist or an executive branch lobbyist client accepts administrative resolution of a matter through the payment of an assessed civil penalty, the matter shall be closed. If the person chooses to contest the board's decision to deny a request or grant a partial waiver of an assessed civil penalty, the person shall make a written request for a contested case proceeding within 30 days of being notified of the board's decision.

8.13(2) Procedure. Upon timely receipt of a request for a contested case proceeding, the board shall provide for the issuance of a statement of charges and notice of hearing. The hearing shall be conducted in accordance with the provisions of Iowa Code section 68B.32C and the board's rules. The burden shall be on the board's legal counsel to prove that a violation occurred.

8.13(3) Failure to request a contested case proceeding. The failure to request a contested case proceeding to appeal the board's decision on a waiver request is the failure to exhaust administrative remedies for purposes of seeking judicial review in accordance with Iowa Code chapter 17A and Iowa Code section 68B.33.

This rule is intended to implement Iowa Code sections 68B.32A(5), 68B.32A(9), and 68B.33.

[Editorial change: IAC Supplement 4/8/09]

351—8.14(68B) Payment of penalty. An assessed civil penalty shall be paid by check or money order and shall be made payable to the State of Iowa General Fund and forwarded to: Iowa Ethics and Campaign Disclosure Board, 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319. The payment shall be deposited in the general fund of the state of Iowa.

This rule is intended to implement Iowa Code sections 68B.32A(5) and 68B.32A(9).

[Editorial change: IAC Supplement 4/8/09]

351—8.15(68A) Campaign contributions by lobbyists during the regular legislative session prohibited. Pursuant to Iowa Code section 68A.504, individuals who are registered in Iowa as either executive branch or legislative branch lobbyists are prohibited from contributing to, acting as an agent or intermediary for contributions to, or arranging for the making of monetary or in-kind contributions to the campaign of an elected state official, member of the general assembly, or candidate for state office on any day during the regular legislative session. This prohibition includes a contribution that is mailed during the legislative session but received by the candidate after the legislative session has adjourned.

8.15(1) Application to governor. The prohibition on contributions to the governor or a gubernatorial candidate during session extends for an additional 30 days following the adjournment of a regular legislative session allowed for the signing of bills.

8.15(2) Exceptions. The prohibition on contributions during the regular legislative session does not apply to any of the following:

a. Contributions to an elected state official, member of the general assembly, or other state official who has taken affirmative action to seek nomination or election to a federal elective office so long as the lobbyist's contribution is placed into the candidate's federal account.

b. Contributions to a candidate for state office who filed nomination papers for a special election called or held during the regular legislative session if the candidate receives the contribution at any time during the period commencing on the date on which at least two candidates have been nominated for the office and ending on the date on which the election is held. However, elected state officials are prohibited from soliciting lobbyists for contributions to another candidate for state office when a special election is held during the regular legislative session.

c. Contributions made during a special legislative session. In the case of the governor and a gubernatorial candidate, this exception also includes the 30 days following a special legislative session unless that time period falls within 30 days of adjournment of the regular legislative session.

d. Contributions from a lobbyist's personal funds that a lobbyist makes to the lobbyist's own campaign for public office.

8.15(3) Complaints. Complaints or information provided to the board alleging a violation of Iowa Code section 68A.504 involving either executive branch lobbyists or legislative branch lobbyists shall be filed with the board and governed by the procedures in Iowa Code sections 68B.32B through 68B.32D.

8.15(4) Date of session. For purposes of Iowa Code section 68A.504 and this rule, a legislative session commences at 12 a.m. of the first day of the legislative session through 11:59:59 p.m. of the day that the legislative session adjourns sine die.

This rule is intended to implement Iowa Code section 68A.504.
[ARC 7651B, IAB 3/25/09, effective 4/29/09; Editorial change: IAC Supplement 4/8/09]

351—8.16(68B) Lobbyists prohibited from making loans. Pursuant to Iowa Code section 68B.24, an executive branch official, executive branch employee, or a candidate for statewide office shall not directly or indirectly seek or accept a loan from a person who is an executive branch lobbyist.

8.16(1) Offer of loan prohibited. An executive branch lobbyist shall not directly or indirectly offer or make a loan to an executive branch official, executive branch employee, or a candidate for statewide office.

8.16(2) Exception. The prohibitions in Iowa Code section 68B.24 do not apply to loans made in the ordinary course of business. "Ordinary course of business" means the loan is made by a person who is regularly engaged in a business that makes loans to members of the general public, and the finance charges and other terms of the loan are the same or substantially similar to the finance charges and loan terms that are available to members of the general public.

8.16(3) Complaints. Complaints or information provided to the board alleging a violation of Iowa Code section 68B.24 by an executive branch official, executive branch employee, candidate for statewide office, or an executive branch lobbyist shall be filed with the board and governed by the procedures in Iowa Code sections 68B.32B through 68B.32D.

This rule is intended to implement Iowa Code section 68B.24.

351—8.17(68B) Ban on certain lobbying activities by government personnel. Executive branch officials and executive branch employees are prohibited by Iowa Code section 68B.5A from engaging in certain types of lobbying activities during the time in which these officials and employees serve or are employed by the state. In addition, Iowa Code section 68B.5A prohibits executive branch officials and executive branch employees from accepting, under certain situations, employment as lobbyists within two years of leaving state government.

8.17(1) Lobbying restrictions—statewide elected officials and executive or administrative heads.

a. A person who serves as a statewide elected official, the executive or administrative head of an agency, or the deputy executive or administrative head of an agency shall not act as a lobbyist during the

time in which the person serves or is employed by the state unless the person is designated to represent the official position of the person's agency.

b. A person subject to this prohibition may not accept employment as a lobbyist for two years after leaving state government except as provided in subrule 8.17(4).

8.17(2) Lobbying restrictions—employees of statewide elected officials and other department or agency employees.

a. The head of a major subunit of a department or independent state agency whose position involves substantial exercise of administrative discretion or the expenditure of public funds or a full-time employee of an office of a statewide elected official whose position involves substantial exercise of administrative discretion or the expenditure of public funds shall not act as a lobbyist during the time in which the person is employed by the state before the agency that the person is employed by or before state agencies, officials, or employees with whom the person has substantial or regular contact as part of the person's duties, unless the person is designated to represent the official position of the person's agency.

b. A person subject to this prohibition may not accept employment as a lobbyist for two years after leaving state government if the employment involves lobbying before the agency that the person was employed by or before state agencies, officials, or employees with whom the person had substantial and regular contact as part of the person's former duties except as provided in subrule 8.17(4).

8.17(3) Lobbying restrictions—state employees with conflicts of interest. A state employee who is not included in subrule 8.17(1) or 8.17(2) shall not act as a lobbyist in relation to any particular case, proceeding, or application with respect to which the person is directly concerned and personally participates as part of the person's employment, unless the person is designated to represent the official position of the person's agency. Persons subject to this prohibition may not accept employment as a lobbyist for two years after leaving state government if the employment involves lobbying in relation to any particular case, proceeding, or application with respect to which the person was directly concerned and personally participated as part of the person's employment.

8.17(4) Exception. As provided in Iowa Code section 68B.5A(7), the prohibition on accepting employment as a lobbyist does not apply to a person who, within two years of leaving state service or employment, is elected to, appointed to, or employed by another office of the state, an office of a political subdivision of the state, or the federal government and represents the position of the new office or employment.

8.17(5) Complaints. Complaints or information provided to the board alleging a violation of Iowa Code section 68B.5A by an executive branch official or an executive branch employee shall be filed with the board and governed by the procedures in Iowa Code sections 68B.32B through 68B.32D.

This rule is intended to implement Iowa Code section 68B.5A.

[ARC 8002B, IAB 7/29/09, effective 9/2/09]

351—8.18(68B) False communications prohibited.

8.18(1) False material fact. An executive branch lobbyist shall not intentionally deceive or attempt to deceive any executive branch official or any executive branch employee in regard to a material fact pertinent to an administrative rule, legislation, or an executive order.

8.18(2) False communication. An executive branch lobbyist shall not cause a communication or an executive branch lobbyist registration statement to be sent to an executive branch official or an executive branch employee in the name of either of the following:

a. A fictitious person; or

b. A real person except with the consent of that person.

8.18(3) Complaints. Complaints or information provided to the board alleging a violation of this rule by an executive branch lobbyist shall be filed with the board and governed by the procedures in Iowa Code sections 68B.32B through 68B.32D.

This rule is intended to implement Iowa Code section 68B.32A(13).

[Editorial change: IAC Supplement 4/8/09; ARC 7990B, IAB 7/29/09, effective 9/2/09]

351—8.19(68B) Advisory opinions. Any person under the board's jurisdiction that is affected by Iowa Code chapter 68B or 351—Chapter 8 may seek an advisory opinion from the board pursuant to rules 351—1.2(68B) and 1.3(68B). The purpose of a board opinion is to apply a statute or rule to a particular factual situation. Advice contained in a board opinion, if followed, constitutes a defense to a subsequently filed complaint.

This rule is intended to implement Iowa Code section 68B.32A(12).
[Editorial change: IAC Supplement 4/8/09]

351—8.20(68) Retention and availability of filed forms.

8.20(1) Public record. All forms filed under this chapter are public records and shall be available in the board office for inspection and copying. A filed form shall be retained by the board for a period of at least five years from the date the form was filed.

8.20(2) Internet access. Forms filed under this chapter shall be accessible for viewing via the board's Web site at www.iowa.gov/ethics as follows:

- a. A list of registered executive branch lobbyists and executive branch lobbyist clients for the current calendar year and the two previous calendar years.
- b. An executive branch periodic lobbyist report for a period of at least three years from the report due date.
- c. An executive branch lobbyist client report for a period of at least three years from the report due date.
- d. A reception reporting form for a period of at least three years from the date the form was filed.

This rule is intended to implement Iowa Code section 68B.32A(5).
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[Filed Emergency ARC 8483B, IAB 1/13/10, effective 1/25/10]

[◇] Two or more ARCs

HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498],
see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.

Rules transferred from agency number [498] to [441] to conform with the reorganization
numbering scheme in general, IAC Supp. 2/11/87.

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[Ch 7, July 1973 IDR Supplement, renumbered as Ch 81]

[Prior to 7/1/83, Social Services[770] Ch 7]

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

PREAMBLE

This chapter applies to contested case proceedings conducted by or on behalf of the department.

441—7.1(17A) Definitions.

“*Administrative hearing*” means a type of hearing that an appellant may elect in which the presiding officer reviews the written record only and makes a decision based on the facts available within the appeal file. An administrative hearing does not require an in-person or teleconference hearing. The final determination to establish whether an administrative hearing may be held will be made by the appeals section or the presiding officer.

“*Administrative law judge*” means an employee of the department of inspections and appeals who conducts appeal hearings.

“*Agency*” means the Iowa department of human services, including any of its local, institutional, or central administrative offices.

“*Aggrieved person*” means a person against whom the department has taken an adverse action. This includes a person who meets any of the following conditions:

1. For financial assistance (including the family investment program, refugee cash assistance, child care assistance, emergency or disaster assistance, family or community self-sufficiency grants, family investment program hardship exemptions, and state supplementary assistance dependent person, in-home health related care, and residential care facility benefits), a person:

- Whose request to be given an application was denied.
- Whose application for assistance has been denied or has not been acted on in a timely manner.
- Who contests the effective date of assistance.
- Who contests the amount of benefits granted.
- Who has been notified that there will be a reduction or cancellation of assistance.
- Who has been notified that an overpayment of benefits has been established and repayment is

requested.

2. For food assistance, a person:

- Whose request to be given an application was denied.
- Whose application has been denied or has not been acted on in a timely manner.
- Who contests the effective date of assistance.
- Who contests the amount of benefits granted.
- Who has been notified that there will be a reduction or cancellation of benefits.
- Whose request to receive a credit for benefits from an electronic benefit transfer (EBT) account

has been denied.

- Who has been notified that an overpayment of benefits has been established and repayment is

requested.

3. For medical assistance, healthy and well kids in Iowa, IowaCare, family planning services, and waiver services, a person (see numbered paragraph “7” for providers):

- Whose request to be given an application was denied.
- Whose application has been denied or has not been acted on in a timely manner.
- Who has been notified that level of care requirements have not been met.
- Who has been aggrieved by a failure to take into account the appellant’s choice in assignment

to a coverage group.

- Who contests the effective date of assistance, services, or premium payments.
- Who contests the amount of health insurance premium payments, healthy and well kids in Iowa premium payments, Medicaid for employed people with disabilities premium payments, IowaCare premium payments, or the spenddown amount under the medically needy program.
- Who contests the amount of client participation.

- Whose claim for payment or prior authorization has been denied.
 - Who has been notified that the reconsideration process has been exhausted and who remains dissatisfied with the outcome.
 - Who has received notice from the medical assistance hotline that services not received or services for which an individual is being billed are not payable by medical assistance.
 - Who has been notified that there will be a reduction or cancellation of assistance or waiver services.
 - Who has been notified that an overpayment of benefits has been established and repayment is requested.
4. For social services, including, but not limited to, adoption, foster care, and family-centered services, a person (see numbered paragraph “7” for providers):
- Whose request to be given an application was denied.
 - Whose application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.
 - For whom it is determined that the person must participate in a service program.
 - Whose claim for payment of services has been denied.
 - Who has been notified that a protective or vendor payment will be established.
 - Who has been notified that there will be a reduction or cancellation of services.
 - Who has been notified that an overpayment of services has been established and repayment is requested.
 - Who applies for an adoption subsidy after the adoption has been finalized.
 - Who alleges that the adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child’s case.
 - Who has not been referred to community care as provided in rule 441—186.2(234).
 - Who has been referred to community care as provided in rule 441—186.2(234) and has exhausted the community care provider’s dispute resolution process.
 - Who has been referred to aftercare services under 441—Chapter 187 and has exhausted the aftercare provider’s dispute resolution process.
5. For child support recovery, a person:
- Who is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.13(17A), or whose dispute based on the date of collection has not been acted on in a timely manner.
 - Who is contesting a claim or offset as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by alleging a mistake of fact. “Mistake of fact” means a mistake in the identity of the obligor or whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.
 - Whose name has been certified for passport sanction as provided in Iowa Code section 252B.5.
 - Who has been notified that there will be a termination in services as provided in rule 441—95.14(252B).
6. For PROMISE JOBS, a person:
- Whose claim for participation allowances has been denied, reduced, or canceled.
 - Who claims that the contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.
 - Who is dissatisfied with the results of informal grievance resolution procedures, or who fails or refuses to receive informal grievance resolution procedures.
 - Who has been notified that PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.
 - Who has been notified that an overpayment of benefits has been established and repayment is requested.
 - Who alleges acts of discrimination on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief.
 - Who claims displacement by a PROMISE JOBS participant.

7. For providers, a person or entity:
 - Whose license, certification, registration, approval, or accreditation has been denied or revoked or has not been acted on in a timely manner.
 - Whose claim for payment or request for prior authorization of payment has been denied in whole or in part and who states that the denial was not made according to department policy. Providers of Medicaid services must accept reimbursement based on the department's methodology.
 - Whose contract as a Medicaid patient manager has been terminated.
 - Who has been subject to the withholding of a payment to recover a prior overpayment or who has received an order to repay an overpayment pursuant to 441—subrule 79.4(7).
 - Who has been notified that the managed care reconsideration process has been exhausted and who remains dissatisfied with the outcome.
 - Whose application for child care quality rating has not been acted upon in a timely fashion, who disagrees with the department's quality rating decision, or whose certificate of quality rating has been revoked.
8. For the child or dependent adult abuse registry, juvenile sex offender registry or criminal record check evaluation, a person:
 - Who has requested correction of child abuse or dependent adult abuse information.
 - Who has been restricted from or denied employment in a health care facility, state institution, or other facility based on a record check. "Employment" includes, but is not limited to, service as an employee, a volunteer, a provider, or a contractor. "Facilities" include, but are not limited to, county or multicounty juvenile detention homes and juvenile shelter care homes, child-placing agencies, substance abuse treatment programs, group living foster care facilities, child development homes, child care centers, state resource centers, mental health institutes, and state training schools.
 - Who is contesting a risk assessment decision as provided in rule 441—103.34(692A) by alleging that the risk assessment factors have not been properly applied, the information relied upon to support the assessment findings is inaccurate, or the procedures were not correctly followed.
9. For mental health and developmental disabilities, a person:
 - Whose application for state community mental health or mental retardation service funds has been denied or has not been acted upon in a timely manner.
 - Who has been notified that there will be a reduction or cancellation of state community mental health or mental retardation service funds.
10. For HIPAA (Health Insurance Portability and Accountability Act) decisions, a current or former applicant or recipient of Medicaid or HAWK-I, or a person currently or previously in a department facility whose request:
 - To restrict use or disclosure of protected health information was denied.
 - To change how protected health information is provided was denied.
 - For access to protected health information was denied. When the denial is subject to reconsideration under 441—paragraph 9.9(1) "i," persons denied access due to a licensed health care professional's opinion that the information would constitute a danger to that person or another person must first exhaust the reconsideration process.
 - To amend protected health information was denied.
 - For an accounting of disclosures was denied.
11. For drug manufacturers, a manufacturer that has received a notice of decision regarding disputed drug rebates pursuant to the dispute resolution procedures of a national drug rebate agreement or an Iowa Medicaid supplemental drug rebate agreement.
12. Individuals and providers that are not listed in paragraphs "1" to "11" may meet the definition of an aggrieved person if the department has taken an adverse action against that individual or provider.

"Appeal" denotes a review and hearing request made by a person who is affected by a decision made by the agency or its designee. An appeal shall be considered a contested case within the meaning of Iowa Code chapter 17A.

"Appeals advisory committee" means a committee consisting of central office staff who represent the department in the screening of proposed decisions for the director.

“Appeals section” means the unit within the department of human services that receives appeal requests, certifies requests for hearing, and issues final appeal decisions.

“Appellant” denotes the person who claims or asserts a right or demand or the party who takes an appeal from a hearing to an Iowa district court.

“Attribution appeal” means an appeal to determine if additional resources can be allocated for the community spouse when the other spouse has entered a medical institution or is applying for home-and community-based waiver services. The result of the attribution appeal may affect Medicaid eligibility. An appellant may elect to have an attribution appeal held by administrative hearing.

“Contested case” means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a “no factual dispute” contested case under Iowa Code section 17A.10A.

“Department” means the Iowa department of human services.

“Department of inspections and appeals” means the state agency which contracts with the department to conduct appeal hearings.

“Due process” denotes the right of a person affected by an agency decision to receive a notice of decision and an opportunity to be heard at an appeal hearing and to present an effective defense.

“Ex parte communication” means written, oral, or other forms of communication between a party to the appeal and the presiding officer while an appeal is pending when all parties were not given the opportunity to participate.

“Food assistance administrative disqualification hearing” means a type of hearing used to determine if an individual fraudulently received benefits for which the individual was not eligible. A presiding officer shall determine if the individual will be banned from participating in the food assistance program for a period of time.

“In person or face-to-face hearing” means an appeal hearing conducted by an administrative law judge who is physically present in the same location as the appellant.

“Intentional program violation” means deliberately making a false or misleading statement; or misrepresenting, concealing, or withholding facts; or committing any act that is a violation of the Food and Nutrition Act of 2008, food assistance program regulations, or any state law relating to the use, presentation, transfer, acquisition, receipt, possession, or trafficking of an electronic benefit transfer (EBT) card. An intentional program violation is determined through a food assistance administrative disqualification hearing. The hearing may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

“Issues of fact or judgment” denotes disputed issues of facts or of the application of state or federal law or policy to the facts of the individual’s personal situation.

“Issues of policy” denotes issues of the legality, fairness, equity, or constitutionality of state or federal law or agency policy where the facts and applicability of the law or policy are undisputed.

“Joint or group hearings” denotes an opportunity for several persons to present their case jointly when all have the same complaint against agency policy.

“Local office” means the county, institution or district office of the department of human services.

“Presiding officer” means an administrative law judge employed by the department of inspections and appeals. The presiding officer may also be the department’s director or the director’s designee. The presiding officer has the authority to conduct appeal hearings and render proposed and final decisions.

“Presumption” denotes an inference as to the existence of a fact not known or drawn from facts that are known.

“PROMISE JOBS discrimination complaint” means any written complaint filed in accordance with the provisions of rule 441—7.8(17A) by a PROMISE JOBS participant or the participant’s representative which alleges that an adverse action was taken against the participant on the basis of race, creed, color, sex, national origin, religion, age, physical or mental disability, or political belief.

“PROMISE JOBS displacement grievance” means any written complaint filed with a PROMISE JOBS contractee by regular employees or their representatives which alleges that the work assignment of an individual under the PROMISE JOBS program violates any of the prohibitions against displacement of regular workers described in rule 441—93.17(239B).

“Reconsideration” means a review process that must be exhausted before an appeal hearing is granted. Such review processes include, but are not limited to, a reconsideration request through the Iowa Medicaid enterprise or its subcontractors, Magellan Behavioral Health Care, a health maintenance organization, a prepaid health plan, medical assistance patient management services, the managed health care review committee, a division or bureau within the department, the mental health, mental retardation, developmental disabilities, and brain injury commission, or a licensed health care professional as specified in 441—paragraph 9.9(1) *“i.”* Once the reconsideration process is complete, a notice of decision will be issued with appeal rights.

“Teleconference hearing” means an appeal hearing conducted by an administrative law judge over the telephone.

“Timely notice period” is the time from the date a notice is mailed to the effective date of action. That period of time shall be at least ten calendar days, except in the case of probable fraud of the appellant. When probable fraud of the appellant exists, *“timely notice period”* shall be at least five calendar days from the date a notice is sent by certified mail.

“Vendor” means a provider of health care under the medical assistance program or a provider of services under a service program.

[ARC 8003B, IAB 7/29/09, effective 9/2/09]

441—7.2(17A) Application of rules. Rescinded IAB 7/29/09, effective 9/2/09.

441—7.3(17A) Presiding officer. Appeal hearings shall be conducted by a presiding officer appointed by the department of inspections and appeals pursuant to Iowa Code section 10A.801. The presiding officer shall not be connected in any way with the previous actions or decisions on which the appeal is made. Nor shall the presiding officer be subject to the authority, direction, or discretion of any person who has prosecuted or advocated in connection with that case, the specific controversy underlying that case, or any pending factually related contested case or controversy involving the same parties.

441—7.4(17A) Notification of hearing procedures. Hearing procedures shall be published in the form of rules and shall be made available to all applicants, recipients, appellants, and other interested groups and individuals. Procedures for hearings shall be identified in the notice of hearing issued to all parties as provided in subrule 7.10(7).

441—7.5(17A) The right to appeal. Any person or group of persons may file an appeal with the department concerning any issue. The department shall determine whether a hearing shall be granted.

7.5(1) When a hearing is granted. A hearing shall be granted to any appellant when the right to a hearing is granted by state or federal law or Constitution, except as limited in subrules 7.5(2) and 7.5(4).

7.5(2) When a hearing is not granted. A hearing shall not be granted when:

- a. One of the following issues is appealed:
 - (1) The service is no longer available through the department.
 - (2) Repayment of food assistance benefits as a result of trafficking has been requested on Form 470-4179, Notice of Food Assistance Trafficking Debt.
 - (3) Payment for a medical claim has been made in accordance with the Medicaid payment schedule for the service billed.
 - (4) Children have been removed from or placed in a specific foster care setting.
 - (5) Children have not been placed with or have been removed from a preadoptive family.
 - (6) A qualified provider or qualified entity has denied a person presumptive eligibility for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44).
 - (7) A qualified provider or qualified entity has determined a person to be presumptively eligible for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44), but presumptive eligibility ends due to the person’s failure to file an application.
 - (8) Notice has been issued from the treasury offset program for a food assistance overpayment.
 - (9) A rate determination has been reviewed under rule 441—152.3(234).

(10) The maximum provider rate ceiling has been contested for child care assistance under 441—subrule 170.4(7).

(11) The risk pool board has accepted or rejected an application for assistance from the risk pool fund or the tobacco settlement fund risk pool fund in whole or in part under rules 441—25.66(426B) and 441—25.77(78GA,ch1221).

(12) The appellant has a complaint about child support recovery matters other than those described in numbered paragraph “5” of the definition of an aggrieved person in rule 441—7.1(17A). This includes collection of an annual fee for child support services as specified in Iowa Code chapter 252B.

(13) The appellant has a complaint about a local office employee (when this is the only issue of the appeal).

(14) A request for an exception to policy under 441—subrule 1.8(1) has been denied.

(15) A final decision from a previous hearing with a presiding officer has been implemented.

(16) The issue appealed is not eligible for further hearing based on the doctrine of issue preclusion.

(17) The appeal involves patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders.

b. Either state or federal law requires automatic grant adjustment for classes of recipients. The director of the department shall decide whether to grant a hearing in these cases. When the reason for an individual appeal is incorrect grant computation in the application of these automatic adjustments, a hearing may be granted.

c. State or federal law or regulation provides for a different forum for appeals.

d. The appeal is filed prematurely as:

(1) There is no adverse action by the department, or

(2) The appellant has not exhausted the reconsideration process.

e. Upon review, it is determined that the appellant does not meet the criteria of an aggrieved person as defined in rule 441—7.1(17A).

f. The sole basis for denying, terminating or limiting assistance under 441—Chapter 47 or 441—Chapter 58 is that funds for the respective programs have been reduced, exhausted, eliminated or otherwise encumbered.

g. The appellant is an “aggrieved party” as defined in rule 441—22.1(225C) and is eligible for a compliance hearing with the mental health, mental retardation, developmental disabilities, and brain injury commission in accordance with rule 441—22.5(225C).

h. The issue appealed is moot.

i. The issue appealed has previously been determined in another appeal by the same appellant.

7.5(3) Group hearings. The department may respond to a series of individual requests for hearings by requesting the department of inspections and appeals to conduct a single group hearing in cases in which the sole issue involved is one of state or federal law or policy or change in state or federal law or policy. An appellant scheduled for a group hearing may withdraw and request an individual hearing.

7.5(4) Time limit for granting hearing to an appeal. Subject to the provisions of subrule 7.5(1), when an appeal is made, the granting of a hearing to that appeal shall be governed by the following timeliness standards:

a. General standards. In general, a hearing shall be held if the appeal is made within 30 days after official notification of an action or before the effective date of action. When the appeal is made more than 30 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant’s family.

2. There was a family emergency or household disaster, such as a fire, flood, or tornado.

3. The appellant offers a good cause beyond the appellant’s control, which can be substantiated.

4. There was a failure to receive the department’s notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an agency action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is mailed is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

b. Food assistance standard. For appeals regarding food assistance, a hearing shall be held if the appeal is made within 90 days after official notification of an action.

c. Offset standards. For appeals regarding state or federal tax or debtor offsets, a hearing shall be held if the appeal is made within 15 days after official notification of the action. Counties have 30 days to appeal offsets, as provided in 441—paragraph 14.4(1)“e.” When the appeal is made more than 15 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant’s family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The appellant offers a good cause beyond the appellant’s control, which can be substantiated.
4. There was a failure to receive the department’s notification for a reason not attributable to the appellant.

Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an offset action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is mailed is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

d. Abuse standard. For appeals regarding child and dependent adult abuse, a hearing shall be held if the appeal is made within six months after official notification of the action as provided in Iowa Code section 235A.19. The day after the official notice is mailed is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

e. Displacement and discrimination standard. PROMISE JOBS displacement and discrimination appeals shall be granted hearing on the following basis:

(1) An appeal of an informal grievance resolution on a PROMISE JOBS displacement grievance shall be made in writing within 10 days of issuance (i.e., mailing) of the resolution decision or within 24 days of the filing of the displacement grievance, whichever is the shorter time period, unless good cause for late filing as described in subparagraph 7.5(4)“a”(1) is found.

(2) An appeal of a PROMISE JOBS discrimination complaint shall be made within the time frames provided in paragraph 7.5(4)“a” in relation to the action alleged to have involved discrimination.

f. Risk assessment standard. An appeal of a sex offender risk assessment shall be made in writing within 14 calendar days of issuance of the notice.

7.5(5) Informal settlements. The time limit for submitting an appeal is not extended while attempts at informal settlement are in progress. Prehearing conferences are provided for at subrules 7.7(4) and 7.8(4).

7.5(6) Appeals of family investment program (FIP), refugee cash assistance (RCA), and PROMISE JOBS overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence, computation, and amount of a FIP, RCA, or PROMISE JOBS overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

1. Form 470-2616, Demand Letter for FIP/RCA Agency Error Overissuance;
2. Form 470-3490, Demand Letter for FIP/RCA Client Error Overissuance;
3. Form 470-3990, Demand Letter for PROMISE JOBS Agency Error Overissuance;
4. Form 470-3991, Demand Letter for PROMISE JOBS Client Error Overissuance; or
5. Form 470-3992, Demand Letter for PROMISE JOBS Provider Error Overissuance.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph “*a.*”

c. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the recovery of an overpayment through benefit reduction, as described at rule 441—46.25(239B), but not the existence, computation, or amount of an overpayment, begins when the person receives Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), Notice of Decision, informing the person that benefits will be reduced to recover a FIP or RCA overpayment.

7.5(7) Appeals of Medicaid, state supplementary assistance (SSA), and HAWK-I program overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence and amount of a medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) program overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

- (1) Form 470-2891, Notice of Medical Assistance Overpayment; or
- (2) Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph “*a.*”

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

7.5(9) Appeals of child care assistance benefit overissuances or overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence, computation, and amount of a child care assistance benefit overissuance or overpayment begins when the department sends the first notice informing the person of the child care assistance overpayment. The notice shall be sent on Form 470-4530, Notice of Child Care Assistance Overpayment.

b. A hearing shall not be held if an appeal is filed in response to a second or subsequent notice about the same overpayment.

7.5(10) Appeals of food assistance overpayments.

a. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence, computation, and amount of a food assistance overpayment begins when the department sends the first notice informing the person of the food assistance overpayment. The notice shall be sent on:

- (1) Form 470-0338, Demand Letter for Food Assistance Agency Error Overissuance;
- (2) Form 470-3486, Demand Letter for Food Assistance Intentional Program Violation Overissuance; or
- (3) Form 470-3487, Demand Letter for Food Assistance Inadvertent Household Error Overissuance.

b. Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the recovery of an overpayment through benefit reduction, but not the existence, computation, or amount of an overpayment, begins when the person receives Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), Notice of Decision, informing the person that benefits will be reduced to recover a food assistance overpayment.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 8439B, IAB 1/13/10, effective 3/1/10]

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

7.6(1) Written and oral notification. The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person’s status.

a. Written notification of the following shall be given at the time of application and at the time of any agency action affecting the claim for assistance:

- (1) The right to request a hearing.
- (2) The procedure for requesting a hearing.

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

(4) Provisions, if any, for payment of legal fees by the department.

b. Written notification shall be given on the application form and on all notices of decisions. Oral explanation shall also be given regarding the policy on appeals during the application process and at the time of any contemplated action by the agency when the need for an explanation is indicated.

c. Persons not familiar with English shall be provided a translation into the language understood by them in written form or orally. Appellants are entitled to have an interpreter present during appeal hearings. In all cases when a person is illiterate or semiliterate, the person shall be advised of each right to the satisfaction of the person's understanding.

7.6(2) Representation. All persons shall be advised that they may be represented at hearings by others, including legal counsel, relatives, friends, or any other spokesperson of choice, unless otherwise specified by statute or federal regulations. The department shall advise the persons of any legal services which may be available and that the person may be represented by counsel at the person's own expense. [ARC 8003B, IAB 7/29/09, effective 9/2/09]

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

7.7(1) Notification.

a. Whenever the department proposes to cancel or reduce assistance or services or to revoke a license, certification, approval, registration, or accreditation, it shall give timely and adequate notice of the pending action, except:

(1) When a service is deleted from the state's comprehensive annual service plan in the social services block grant program at the onset of a new program year, or

(2) As provided in subrule 7.7(2).

b. For the purpose of this subrule, "assistance" includes food assistance, medical assistance, the family investment program, refugee cash assistance, child care assistance, emergency assistance, family or community self-sufficiency grant, PROMISE JOBS, state supplementary assistance, healthy and well kids in Iowa (HAWK-I) program, foster care, adoption, aftercare services, or other programs or services provided by the department.

c. The department shall give adequate notice of the approval or denial of assistance or services; the approval or denial of a license, certification, approval, registration, or accreditation; and pending action for a state or federal tax or debtor offset.

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

e. "Adequate" means a written notice that includes:

(1) A statement of what action is being taken,

(2) The reasons for the intended action,

(3) The manual chapter number and subheading supporting the action and the corresponding rule reference,

(4) An explanation of the appellant's right to appeal, and

(5) The circumstances under which assistance is continued when an appeal is filed.

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

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

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

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

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

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

f. The agency establishes that the recipient has been accepted for assistance in another state.

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

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

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

j. Rescinded, effective 2/1/84.

k. The department terminates or reduces benefits or makes changes based on a completed Form 470-2881, 470-2881(S), 470-2881(M), or 470-4083(MS), Review/Recertification Eligibility Document, as described at 441—paragraph 40.27(1)“*b*” or rule 441—75.52(249A).

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

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

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

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

7.7(4) *Conference during the timely notice period.* During the timely notice period, the appellant may have a conference to discuss the situation and the agency shall provide a full explanation of the reasons for the pending action and give the recipient an opportunity to offer facts to support the contention that the pending action is not warranted. The appellant may be accompanied by a representative, legal counsel, friend or other person and this person may represent the appellant when the appellant is not able to be present unless otherwise specified by statute or federal regulation.

7.7(5) *Notification not required.* Notification is not required in the following instances:

a. When services in the social service block grant preexpenditure report are changed from one plan year to the next, or when the plan is amended because funds are no longer available.

b. When service has been time-limited in the social service block grant preexpenditure report, and as a result the service is no longer available.

c. When the placement of a person(s) in foster care is changed.

d. When payment has been in accordance with the Medicaid payment schedule for the service billed because there is no adverse action.

e. When services of the community self-sufficiency grant project are available to all PROMISE JOBS participants as specified in 441—subrule 47.46(1).

7.7(6) *Reinstatement.*

a. Whenever the department determines that a previously canceled case must remain canceled for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

b. Whenever the department determines that a previously canceled case is eligible for reinstatement at a lower level of benefits, for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

c. Food assistance cases are eligible for reinstatement only in circumstances found in rule 441—65.44(234) . FIP cases are eligible for reinstatement only in circumstances found in 441—subrule 40.22(5).

[ARC 8003B, IAB 7/29/09, effective 9/2/09]

441—7.8(17A) Opportunity for hearing.

7.8(1) *Initiating an appeal.* To initiate an appeal, a person or the person's authorized representative must state in writing that the person disagrees with a decision, action, or failure to act on the person's case.

a. All appeals shall be made in writing, except for food assistance appeals, which may be made orally.

b. The written request may be sent or delivered by any means to the appeals section, to the local office, or to the office that took the adverse action.

c. The oral request may be made to the appeals section or to the department office that took the adverse action.

7.8(2) *Filing the appeal.* The appellant shall be encouraged, but not required, to make written appeal on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and the worker shall provide any instructions or assistance required in completing the form. When the appellant is unwilling to complete or sign this form, nothing in this rule shall be construed to preclude the right to perfect the appeal, as long as the appeal is in writing (except for food assistance appeals) and has been communicated to the department by the appellant or appellant's representative.

A written appeal is filed on the date postmarked on the envelope sent to the department, or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

7.8(3) Rescinded IAB 12/13/89, effective 2/1/90.

7.8(4) *Prehearing conference.* When desired by the appellant, a prehearing conference with a representative of the local office or the office which took the action appealed shall be held as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the conference, unless precluded by federal rule or state statute.

The purpose of the prehearing conference is to provide information as to the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse action, to provide an opportunity for the appellant to explain the appellant's action or position, and to provide an opportunity for the appellant to examine the contents of the case record plus all documents and records to be used by the department at the hearing in accordance with 441—Chapter 9. A conference need not be requested for the appellant to have access to the records as provided in subrule 7.13(1) and 441—Chapter 9.

7.8(5) *Interference.* The prehearing conference shall not be used to discourage appellants from proceeding with their appeals. The right of appeal shall not be limited or interfered with in any way, even though the person's complaint may be without basis in fact, or because of the person's own misinterpretation of law, agency policy, or methods of implementing policy.

7.8(6) *Right of the department to deny or dismiss an appeal.* The department or the department of inspections and appeals has the right to deny or dismiss the appeal when:

a. It has been withdrawn by the appellant in writing.

b. The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.

c. It has been abandoned.

d. The agency, by written notice, withdraws the action appealed and restores the appellant's status which existed before the action appealed was taken.

e. The agency implements action and issues a notice of decision to correct an error made by the agency which resulted in the appeal.

Abandonment may be deemed to have occurred when the appellant, or the appellant's authorized representative fails, without good cause, to appear at the hearing.

7.8(7) Denial of due process. Facts of harassing, threats of prosecution, denial of pertinent information needed by the appellant in preparing the appeal, as a result of the appellant's communicated desire to proceed with the appeal shall be taken into consideration by the administrative law judge in reaching a proposed decision.

7.8(8) Withdrawal. When the appellant desires to voluntarily withdraw an appeal, the worker, the presiding officer, or the appeals section shall request a clear, written statement from the appellant to withdraw the appeal. The appellant may use Form 470-0492 or 470-0492(S), Request for Withdrawal of Appeal, for this purpose.

7.8(9) Department's responsibilities. Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:

a. Within one working day of receipt, complete the worker information section of Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and forward that form, the written appeal, the postmarked envelope, if there is one, and a copy of the notification of the proposed adverse action to the appeals section.

b. Forward a summary and supporting documentation of the worker's factual basis for the proposed action to the appeals section within ten days of the receipt of the appeal.

c. Provide the appellant and the appellant's representative copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal at the same time as the materials are sent to the appeals section or the presiding officer.

[ARC 8003B, IAB 7/29/09, effective 9/2/09]

441—7.9(17A) Continuation of assistance pending a final decision on appeal.

7.9(1) When assistance continues. Assistance shall not be suspended, reduced, restricted, or canceled, nor shall a license, registration, certification, approval, or accreditation be revoked, or other proposed adverse action be taken pending a final decision on an appeal when:

a. An appeal is filed within the timely notice period.

b. The appellant requests a hearing within ten days from the date adequate notice is issued for cancellation or reduction of food assistance, family investment program, or medical assistance benefits, based on the completed report form, including:

(1) Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-4083(MS).

(2) Transitional Medicaid Notice of Decision/Quarterly Income Report, Form 470-2663, 470-2663(S), 470-2663(M), or 470-2663(MS).

c. If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.

7.9(2) When assistance does not continue. The adverse action appealed to suspend, reduce, restrict, or cancel assistance; revoke a license, registration, certification, approval, or accreditation; or take other proposed action may be implemented pending a final decision on appeal when:

a. An appeal is not filed within the timely notice period.

b. The appellant does not request a hearing within ten days from the date adequate notice is issued based on the completed monthly report.

c. Benefits or services were time limited through a certification period or prior authorization for which notice was given when established or for which adequate notice was provided.

d. and *e.* Rescinded IAB 4/30/03, effective 7/1/03.

f. The appellant directs the worker in writing to proceed with the intended action.

7.9(3) Recovery of excess assistance paid pending a final decision on appeal. Continued assistance is subject to recovery by the department if its action is affirmed, except as specified at subrule 7.9(5).

When the department action is sustained, excess assistance paid pending a hearing decision shall be recovered to the date of the decision. This recovery is not an appealable issue. However, appeals may be heard on the computation of excess assistance paid pending a hearing decision.

7.9(4) Recovery of excess assistance paid when the appellant's benefits are changed prior to a final decision. Recovery of excess assistance paid will be made to the date of change which affects the

improper payment. The recovery shall be made when the appellant's benefits are changed due to one of the following reasons:

a. A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law or policy and not one of incorrect grant computation, and the grant is adjusted.

b. A change affecting the appellant's grant occurs while the hearing decision is pending and the appellant fails to request a hearing after notice of the change.

7.9(5) *Recovery of assistance when a new limited benefit plan is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new limited benefit plan period is established. A new limited benefit plan period shall be established when the department is affirmed in a timely appeal of the establishment of the limited benefit plan. All of the following conditions shall exist:

a. The appeal is filed within the timely notice period of the notice of decision establishing the beginning date of the LBP.

b. Assistance is continued pending the final decision of the appeal.

c. The department's action is affirmed.

[ARC 8003B, IAB 7/29/09, effective 9/2/09]

441—7.10(17A) Procedural considerations. Upon receipt of the notice of appeal, the department shall:

7.10(1) *Registration.* Register the appeal.

7.10(2) *Acknowledgment.* Send an acknowledgment of receipt of the appeal to the appellant, representative, or both.

A copy of the acknowledgment of receipt of appeal will be sent to the appropriate departmental office.

7.10(3) *Granting a hearing.* The department shall determine whether an appellant may be granted a hearing and the issues to be discussed at that hearing in accordance with the applicable rules, state statutes, or federal regulations.

a. The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The department shall indicate at the time of certification the issues to be discussed at that hearing.

b. The appeals of those appellants who are denied a hearing shall not be closed until issuance of a letter to the appellant and the appellant's representative, advising of the denial of hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial of hearing may present additional information relative to the reason for denial and request reconsideration by the department or a hearing over the denial.

7.10(4) *Hearing scheduled.* For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in department of inspections and appeals rules 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

a. In cases involving individual appellants, the hearing shall be held by teleconference call or in the appropriate department office.

b. In cases of appeals by vendors or agencies, the hearing shall be scheduled by teleconference call or at the most appropriate department office.

c. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

d. In cases involving an appeal of a sex offender risk assessment, the hearing shall be held within 30 days of the date of the appeal request.

e. Emergency assistance appeals shall be expedited.

7.10(5) *Method of hearing.* The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the

same rights during a teleconference hearing as specified in 441—7.13(17A). The appellant may request to have a presiding officer render a decision for attribution appeals through an administrative hearing.

7.10(6) Reschedule requests. Requests by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals directly except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals.

a. The appellant may request that the teleconference hearing be rescheduled as an in-person hearing. All requests made to the department or to the department of inspections and appeals for a teleconference hearing to be rescheduled as an in-person hearing shall be granted. Any appellant request for an in-person hearing made to the department shall be communicated to the department of inspections and appeals immediately.

b. All other requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.10(7) Notification. For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice, as prescribed in Iowa Code section 17A.12(2), shall set forth:

(1) The date, time, method and place of the hearing;

(2) That evidence may be presented orally or documented to establish pertinent facts; and

(3) That the appellant may question or refute any testimony, may bring witnesses of the appellant's choice and may be represented by others, including an attorney, subject to federal law and state statute. The department will not pay for the cost of legal representation.

b. A copy of this notice shall be forwarded to the department employee who took the action and to other persons when circumstances peculiar to the case indicate that the notification may be desirable.

c. Notices of hearing regarding an intentional program violation shall be served upon the appellant both by certified mail, return receipt requested, and by first-class mail, postage prepaid, addressed to the appellant at the last-known address. All other notices of hearing shall be mailed by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

[ARC 8003B, IAB 7/29/09, effective 9/2/09]

441—7.11(17A) Information and referral for legal services. The local office shall advise persons appealing any agency decision of legal services in the community that are willing to assist them.

441—7.12(17A) Subpoenas. The department shall have all subpoena power conferred upon it by statute. Departmental subpoenas shall be issued to a party on request or will be served by the department when requested at least one week in advance of the hearing date.

441—7.13(17A) Rights of appellants during hearings.

7.13(1) Examination of the evidence. The department shall provide the appellant, or representative, opportunity prior to, as well as during, the hearing, to examine all materials permitted under rule 9.1(17A,22) or to be offered as evidence. Off the record, or confidential information which the appellant or representative does not have the opportunity to examine shall not be included in the record of the proceedings or considered in reaching a decision.

7.13(2) Conduct of hearing. The hearing shall be conducted by an administrative law judge designated by the department of inspections and appeals. It shall be an informal rather than a formal judicial procedure, and shall be designed to serve the best interest of the appellant. The appellant shall have the right to introduce any evidence on points at issue believed necessary, and to challenge and cross-examine any statement made by others, and to present evidence in rebuttal. A verbatim record shall be kept of the evidence presented.

7.13(3) Opportunity for response. Opportunity shall be afforded all parties to respond and present evidence and arguments on all issues involved and to be represented by counsel at their own expense.

7.13(4) Default. If a party to the appeal fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default

decision or proceed with the hearing pursuant to subrules 7.13(1), 7.13(2) and 7.13(3) and render a proposed decision on the merits in the absence of the defaulting party.

a. Where appropriate and not contrary to law, any party may move for a default decision or for a hearing and a proposed decision on the merits in the absence of a defaulting party.

b. A default decision or a proposed decision on the merits in the absence of the defaulting party may award any relief against the defaulting party consistent with the relief requested prior to the default, but the relief awarded against the defaulting party may not exceed the requested relief prior to the default.

c. Proceedings after a default decision are specified in subrule 7.13(5).

d. Proceedings after a hearing and a proposed decision on the merits in the absence of a defaulting party are specified in subrule 7.13(6).

7.13(5) Proceedings after default decision.

a. Default decisions become final agency action unless a motion to vacate the decision is filed within the time allowed for an appeal of a proposed decision by subrule 7.16(5).

b. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding and must be filed with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

c. Timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

d. "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

e. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

f. Upon a final decision granting a motion to vacate, the contested case hearing shall proceed accordingly, after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

g. Upon a final decision denying a motion to vacate, the default decision becomes final agency action.

7.13(6) Proceedings after hearing and proposed decision on the merits in the absence of a defaulting party.

a. Proposed decisions on the merits after a party has failed to appear or participate in a contested case become final agency action unless:

(1) A motion to vacate the proposed decision is filed by the defaulting party based on good cause for the failure to appear or participate, within the time allowed for an appeal of a proposed decision by subrule 7.16(5); or

(2) Any party requests review on the merits by the director pursuant to rule 441—7.16(17A).

b. If a motion to vacate and a request for review on the merits are both made in a timely manner after a proposed decision on the merits in the absence of a defaulting party, the review by the director on the merits of the appeal shall be stayed pending the outcome of the motion to vacate.

c. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding and must be filed with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the department to respond to the motion to vacate. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the department.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

d. Timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

e. "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

f. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

g. Upon a final decision granting a motion to vacate, a new contested case hearing shall be held after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

h. Upon a final decision denying a motion to vacate, the proposed decision on the merits in the absence of a defaulting party becomes final unless there is request for review on the merits by the director made pursuant to paragraph 7.13(6) "a" or "j."

i. Any review on the merits by the director requested pursuant to paragraph 7.13(6) "a" and stayed pursuant to paragraph 7.13(6) "b" pending a decision on a motion to vacate shall be conducted upon a final decision denying the motion to vacate.

j. Upon a final decision denying a motion to vacate a proposed decision issued in the absence of a defaulting party, any party to the contested case proceeding may request a review on the merits by the director pursuant to rule 441—7.16(17A), treating the date that the denial of the motion to vacate became final as the date of the proposed decision.

[ARC 8003B, IAB 7/29/09, effective 9/2/09]

441—7.14(17A) Limitation of persons attending. The hearing shall be limited in attendance to the following persons, unless otherwise specified by statute or federal regulations: appellant, appellant's representative, agency employees, agency's legal representatives, other persons present for the purpose of offering testimony pertinent to the issues in controversy, and others upon mutual agreement of the parties. The administrative law judge may sequester witnesses during the hearing.

Nothing in this rule shall be construed to allow members of the press, news media, or any other citizens' group to attend the hearing without the written consent of the appellant.

441—7.15(17A) Medical examination. When the hearing involves medical issues, a medical assessment or examination by a person or physician other than the one involved in the decision under question shall be obtained and the report made a part of the hearing record when the administrative law judge or appellant considers it necessary. Any medical examination required shall be performed by a physician satisfactory to the appellant and the department at agency expense.

Forms 470-0502, Authorization for Examination and Claim for Payment, and 470-0447, Report on Incapacity, shall be utilized in obtaining medical information to be used in the appeal and to authorize payment for the examination.

441—7.16(17A) The appeal decision.

7.16(1) Record. The record in a contested case shall include, in addition to those materials specified in Iowa Code section 17A.12(6):

a. The notice of appeal.

b. All evidence received or considered and all other submissions, including the verbatim record of the hearing.

7.16(2) Findings of fact. Any party may submit proposed findings of fact. The presiding officer will rule on the proposed findings of fact. Findings of fact shall be based solely on the evidence in the record and on matters officially noticed in the record. The findings of fact and conclusions of law in the proposed or final decision shall be limited to contested issues of fact, policy, or law.

7.16(3) Proposed decision. Following the reception of evidence, the presiding officer shall issue a proposed decision, consisting of the issues of the appeal, the decision, the findings of fact and the conclusions of law. Each item shall be separately stated under individual headings. The proposed decision shall be mailed by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

7.16(4) Appeal of the proposed decision. After issuing a proposed decision the administrative law judge shall submit it to the department with copies to the appeals advisory committee.

The appellant, appellant's representative, or the department may appeal for the director's review of the proposed decision.

When the appellant or the department has not appealed the proposed decision or an appeal for the director's review of the proposed decision is not granted, the proposed decision shall become the final decision.

The director's review on appeal of the proposed decision shall be on the basis of the record as defined in subrule 7.16(1), except that the director need not listen to the verbatim record of the hearing in a review or appeal. The review or appeal shall be limited to issues raised prior to that time and specified by the party requesting the appeal or review. The director may designate another to act on the director's behalf in making final decisions.

7.16(5) Time limit for appeal of a proposed decision. Appeal for the director's review of the proposed decision must be made in writing to the director and postmarked or date-stamped within ten calendar days of the date on which the proposed decision was signed and mailed. The day after the proposed decision is mailed is the first day of the time period within which a request for review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(6) Appeal of the proposed decision by the department. The appeals advisory committee acts as an initial screening device for the director and may recommend that the director review a proposed decision. That recommendation is not binding upon the director, and the director may decide to review a proposed decision without that committee's recommendation.

When the director grants a review of a proposed decision on the department's request the appeals section shall notify all other parties to the appeal of the review and send a copy of the request to all other parties. All other parties shall be provided ten calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

The day after the notification is mailed is the first day of the time period within which a response to the department's request for review must be filed. When the time limit for responding falls on a holiday or a weekend, the time will be extended to the next workday.

7.16(7) Appeal of the proposed decision by the appellant. When the director grants a review of a proposed decision all other parties shall be so notified.

7.16(8) Opportunity for oral presentation of appeal of the proposed decision. In cases where there is an appeal of a proposed decision each party shall be afforded an opportunity to present oral arguments with the consent of the director. Any party wishing oral argument shall specifically request it. When granted, all parties shall be notified of the time and place.

7.16(9) Time limits. A final decision on the appeal shall be issued within 90 days from the date of the appeal on all decisions except food assistance and vendors. Food assistance-only decisions shall be rendered in 60 days. PROMISE JOBS displacement grievance decisions shall be rendered within 90 days from the date the displacement grievance was filed with the PROMISE JOBS contractee. Failure to reach a decision within these time frames shall not affect the merits of the appellant's appeal.

a. Time frames may be extended based on continuances or additional time frames as approved by the presiding officer. Should the appellant request a delay in the hearing in order to prepare the case

or for other essential reasons, reasonable time, not to exceed 30 days except with the approval of the administrative law judge, shall be granted and the extra time shall be added to the maximum for final administrative action.

b. The department shall take prompt, definite and final administrative action to carry out the decision rendered within 7 calendar days of receipt of a copy of the final decision. When the final decision is favorable to the appellant, or when the department decides in favor of the appellant before the hearing, the department shall make any additional corrective payments due, retroactive to the date of the incorrect action.

7.16(10) Final decision. The department shall mail the final decision to the appellant at the appellant's last-known address by first-class mail, postage prepaid.

[ARC 8003B, IAB 7/29/09, effective 9/2/09]

441—7.17(17A) Exhausting administrative remedies. To have exhausted all adequate administrative remedies, a party need not request a rehearing under Iowa Code section 17A.16(2) where the party accepts the findings of fact as prepared by the administrative law judge, but wishes to challenge the conclusions of law, or departmental policy.

441—7.18(17A) Ex parte communication.

7.18(1) Prohibited communication. There shall be no written, oral, or other type of communication between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in the case while an appeal is pending, without all parties being notified of an opportunity to participate, unless specifically authorized by statute or rule.

a. This provision does not prevent the presiding officer from communicating with members of the agency or seeking the advice or help of persons other than those defined in paragraph “c.”

b. Persons described in paragraph “c” shall not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

c. For purposes of this rule:

(1) People with a direct or indirect interest in a case include any member of the appeals advisory committee and any person engaged in personally investigating, prosecuting, or advocating in either the case under appeal or a pending factually related case involving the same parties.

(2) The term “personally investigating” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case.

7.18(2) Commencement of prohibition. Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

7.18(3) When communication is ex parte. Rescinded IAB 4/30/03, effective 7/1/03.

7.18(4) Avoidance of ex parte communication. To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Written communications shall be provided to all parties to the appeal.

7.18(5) Communications not prohibited. Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines.

7.18(6) Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified from the case. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written

communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be disclosed. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of communication.

7.18(7) *Disclosure of prior receipt of information through ex parte communication.* Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

7.18(8) *Imposition of sanctions.* The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by department personnel shall be reported to the department for possible sanctions, including censure, suspension, dismissal, or other disciplinary action.

441—7.19(17A) Accessibility of hearing decisions. Summary reports of all hearing decisions shall be made available to local offices and the public. The information shall be presented in a manner consistent with requirements for safeguarding personal information concerning applicants and recipients.

441—7.20(17A) Right of judicial review and stays of agency action.

7.20(1) *Right of judicial review.* If a director's review is requested, the final decision shall advise the appellant or the appellant's representative of the right to judicial review by the district court. When the appellant or the appellant's representative is dissatisfied with the final decision and requests judicial review of the decision to the district court, the department shall furnish copies of the documents or supporting papers to district court, including a written transcript of the hearing. An appeal of the final decision to district court does not itself stay execution or enforcement of an agency action.

7.20(2) *Stays of agency action.*

a. Any party to a contested case proceeding may petition the director for a stay or other temporary remedies pending judicial review, of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

b. In determining whether to grant a stay pending judicial review, the director shall consider the factors listed in Iowa Code section 17A.19(5) "c."

c. A stay may be vacated by the director pending judicial review upon application of the department or any other party.

441—7.21(17A) Food assistance hearings and appeals.

7.21(1) *Appeal hearings.* All appeal hearings in the food assistance program shall be conducted in accordance with federal regulation, Title 7, Section 273.15, as amended to January 1, 2008.

7.21(2) *Food assistance administrative disqualification hearings.* All food assistance administrative disqualification hearings shall be conducted in accordance with federal regulation, Title 7, Section 273.16, as amended to January 1, 2008.

7.21(3) *Conduct of a food assistance administrative disqualification hearing.* Hearings over disqualification of a household member for an intentional program violation shall be conducted by a presiding officer.

a. The department of inspections and appeals shall serve an Intentional Program Violation Hearing Notice upon the household member both by certified mail, return receipt requested, and by first-class

mail, postage prepaid, addressed to household member at the last-known address 30 calendar days before the initial hearing date.

b. The household member or that person's representative may request to postpone the hearing for up to 30 days, provided the request is made at least 10 calendar days before the scheduled hearing date.

c. At the hearing, the presiding officer shall advise the household member or that person's representative that the household member has the right to refuse to answer questions during the hearing and that the state or federal government may use the information in a civil or criminal action.

7.21(4) Consolidating hearings. Appeal hearings and food assistance administrative disqualification hearings may be consolidated if the issues arise out of the same or related circumstances, and the household member has been provided with notice of the consolidation by the department of inspections and appeals.

a. If the hearings are combined, the time frames for conducting a food assistance administrative disqualification hearing shall apply.

b. If the hearings are combined for the purpose of setting the amount of the overpayment at the same time as determining whether or not an intentional program violation has occurred, the household shall lose its right to a subsequent hearing on the amount of the overpayment.

7.21(5) Attendance at hearing. The household member shall be allowed 10 days from the scheduled hearing to present reasons indicating good cause for not attending the hearing.

a. The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists for the default as specified in subrule 7.13(5). Timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

b. Unless good cause is determined, when the household member or that person's representative cannot be located or fails to appear at the scheduled hearing, the hearing shall be conducted without that person. In that instance, the presiding officer shall consider the evidence and determine if the evidence is clear and convincing that an intentional program violation was committed.

c. If the household member who failed to appear at the hearing is found to have committed an intentional program violation, but the presiding officer later determines that this person or the person's representative had good cause for not appearing, the previous hearing decision shall no longer be valid. A new hearing shall be conducted.

7.21(6) Food assistance administrative disqualification hearing decisions. The presiding officer shall base the determination of an intentional program violation on clear and convincing evidence that demonstrates the person committed, and intended to commit, an intentional program violation.

a. The proposed and final hearing decisions shall be made in accordance with rule 7.16(17A) unless otherwise specified.

b. The appeals section shall notify the household member and the local office of the final decision within 90 days of the date the household member is notified in writing that the hearing has been scheduled. If the hearing was postponed pursuant to subrule 7.21(3), paragraph "b," the 90 days for notifying the household member of the final decision shall be extended for as many days as the hearing is postponed.

c. The department shall take no action to disqualify a person from receiving food assistance before receiving the final appeal decision finding that the person has committed an intentional program violation.

d. No further administrative appeal procedure shall exist after the final decision is issued. The determination of an intentional program violation shall not be reversed by a subsequent hearing decision. However, the person may appeal the case to the Iowa district court.

e. When a court decision reverses a determination of an intentional program violation, the appeals section shall notify the local office of the specifics of the court decision.

[ARC 8003B, IAB 7/29/09, effective 9/2/09]

441—7.22(17A) FIP disqualification hearings. Rescinded IAB 4/30/03, effective 7/1/03.

441—7.23(17A) Contested cases with no factual dispute. If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall jointly submit a schedule for submission of the record, briefs and oral arguments to the presiding officer for approval.

441—7.24(17A) Emergency adjudicative proceedings.

7.24(1) Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the United States Constitution and the Iowa Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

- a. Whether there has been sufficient factual investigation to ensure that the agency is proceeding on the basis of reliable information.
- b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing.
- c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare.
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare.
- e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.

7.24(2) Issuance of order.

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger and the department's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by using one or more of the following procedures:

- (1) Personal delivery.
- (2) Certified mail, return receipt requested, to the last address on file with the department.
- (3) Certified mail to the last address on file with the department.
- (4) First-class mail to the last address on file with the department.
- (5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that department orders be sent by fax and has provided a fax number for that purpose.

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

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

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

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

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◊ Two or more ARCs

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.

\$743	Care allowance
\$ 93	Personal allowance
<hr/>	
\$836	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 \$1018
- b. Aged or disabled client, eligible spouse, and a dependent relative \$1355
- c. Blind client and a dependent relative \$1040
- d. Blind client, aged or disabled spouse, and a dependent relative \$1377
- e. Blind client, blind spouse, and a dependent relative \$1399

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 \$28.14. 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 allowance of \$93 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.

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TITLE VIII
MEDICAL ASSISTANCE
CHAPTER 75
CONDITIONS OF ELIGIBILITY
[Ch 75, 1973 IDR, renumbered as Ch 90]
[Prior to 7/1/83, Social Services[770] Ch 75]
[Prior to 2/11/87, Human Services[498]]

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

441—75.1(249A) Persons covered.

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

- a. Persons denied RCA because the amount of payment would be less than \$10.
- b. Rescinded IAB 7/30/08, effective 10/1/08.
- c. Persons who are eligible in every respect for refugee cash assistance (RCA) as provided in 441—Chapter 60, but who do not receive RCA because they did not make application for the assistance.

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

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

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

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

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

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

- a. Subject to paragraphs “b” and “c” below, Medicaid shall be available to persons who:
 - (1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).
 - (2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.
 - (3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.
 - (4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.
- b. For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

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

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

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

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

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

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

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

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

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

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

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

(1) Failure to provide information, or

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

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

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Another state is currently paying an adoption subsidy for the child.

d. The state paying the adoption subsidy:

(1) Is a member of the interstate compact on adoption and medical assistance (ICAMA); and

(2) Provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

75.1(17) *Persons who meet the income and resource requirements of the cash assistance programs.* Medicaid shall be available to the following persons who meet the income and resource guidelines of supplemental security income or refugee cash assistance, but who are not receiving cash assistance:

a. Aged and blind persons, as defined at subrule 75.13(2).

b. Disabled persons, as defined at rule 441—75.20(249A).

In establishing eligibility for children for this coverage group based on eligibility for SSI, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2) or as under refugee cash assistance.

75.1(18) *Persons eligible for waiver services.* Medicaid shall be available to recipients of waiver services as defined in 441—Chapter 83.

75.1(19) *Persons and families terminated from aid to dependent children (ADC) prior to April 1, 1990, due to discontinuance of the \$30 or the \$30 and one-third earned income disregards.* Rescinded IAB 6/12/91, effective 8/1/91.

75.1(20) *Newborn children.* Medicaid shall be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for three-day emergency services for labor and delivery for the child's birth. Effective April 1, 2009, eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department shall accept any written or verbal statement as verification of the newborn's birth date unless the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility shall be completed.

75.1(21) *Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support.* Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/11/95, effective 10/1/95.

75.1(22) *Refugee spenddown participants.* Rescinded IAB 10/11/95, effective 10/1/95.

75.1(23) *Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow's or widower's disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow's or widower's benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form 470-0442, Application for Medical Assistance or State Supplementary Assistance.

75.1(24) *Postpartum eligibility for pregnant women.* Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

75.1(25) *Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child's social security benefits based on disability.* Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent's account.

75.1(26) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(27) *Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits.* Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

c. Rescinded IAB 5/1/91, effective 4/11/91.

d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

75.1(28) *Pregnant women, infants and children (Mothers and Children (MAC))*. Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 300 percent of the federal poverty level for pregnant women and for infants (under one year of age). Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. "Family income" is the income remaining after disregards and deductions have been applied as provided in rule 441—75.57(249A).

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8) "b" and "c," shall be treated in accordance with paragraphs 75.57(9) "b" and "c."

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent's home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person's parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed \$10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

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

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.

f. An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

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

h. When determining eligibility under this coverage group, living with a specified relative as specified at subrule 75.54(2) and the student provisions specified in subrule 75.54(1) do not apply.

i. A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

j. If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

75.1(29) *Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program).* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

a. The person's monthly income does not exceed 100 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(1) The amount of income shall be determined as under the federal Supplemental Security Income (SSI) program.

(2) Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits. The amount of resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4).

c. The effective date of eligibility is the first of the month after the month of decision.

75.1(30) *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. Eligibility shall continue until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either before the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. A pregnant woman who files a Medicaid application but withdraws that application before eligibility is determined has not been determined ineligible for Medicaid. The pregnant woman shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Presumptive Medicaid Income Calculation, in order to establish that the pregnant woman's family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision of ineligibility is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.

a. A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

(1) Provides one or more of the following services:

1. Outpatient hospital services.

2. Rural health clinic services (if contained in the state plan).

3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

(2) Has been specifically designated by the department in writing as a qualified provider for the purposes of determining presumptive eligibility on the basis of the department's determination that the provider is capable of making a presumptive eligibility determination based on family income.

(3) Meets one of the following:

1. Receives funds under the Migrant Health Centers or Community Health Centers (subsection 329 or subsection 330 of the Public Health Service Act) or the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act) or the Health Services for Urban Indians Program (Title V of the Indian Health Care Improvement Act).

2. Participates in the program established under the Special Supplemental Food Program for Women, Infants, and Children (subsection 17 of the Child Nutrition Act of 1966) or the Commodity Supplemental Food Program (subsection 4(a) of the Agriculture and Consumer Protection Act of 1973).

3. Participates in a state perinatal program.

4. Is an Indian health service office or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

b. The provider shall complete Form 470-2579, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, and submit it to the department for approval in order to become certified as a provider qualified to make presumptive eligibility determinations. Once the provider has been approved as a provider qualified to make presumptive Medicaid eligibility determinations, Form 470-2582, Memorandum of Understanding Between the Iowa Department of Human Services and a Qualified Provider, shall be signed by the provider and the department.

c. Once the qualified provider has made a presumptive eligibility determination for a pregnant woman, the provider shall:

(1) Contact the department to obtain a state identification number for the pregnant woman who has been determined presumptively eligible.

(2) Notify the department in writing of the determination within five working days after the date the presumptive determination is made. A copy of the Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), shall be used for this purpose.

(3) Inform the pregnant woman in writing, at the time the determination is made, that if she chose not to apply for Medicaid on the Health Services Application, Form 470-2927 or 470-2927(S), she has until the last day of the month following the month of the preliminary determination to file an application with the department. A Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, shall be issued by the qualified provider for this purpose.

(4) Forward copies of the Health Services Application, Form 470-2927 or 470-2927(S), to the appropriate offices for eligibility determinations if the pregnant woman indicated on the application that she was applying for any of the other programs listed on the application. These copies shall be forwarded within two working days from the date of the presumptive determination.

d. In the event that a pregnant woman needing prenatal care does not appear to be presumptively eligible, the qualified provider shall inform the pregnant woman that she may file an application at the local department office if she wishes to have a formal determination made.

e. Presumptive eligibility shall end under any of the following conditions:

(1) The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

(2) The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and has been found ineligible for Medicaid.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

f. The adequate and timely notice requirements and appeal rights associated with an application that is filed pursuant to rule 441—76.1(249A) shall apply to an eligibility determination made on the Medicaid application. However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

(1) Issued a presumptive eligibility decision by a qualified provider.

(2) Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the initial presumptive eligibility determination.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

g. A woman shall not be determined to be presumptively eligible for Medicaid more than once per pregnancy.

75.1(31) *Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of the specified relative in the eligible group.* Medicaid shall be available for a period of up to 12 additional months to families who are canceled from FMAP as provided in subrule 75.1(14) because the specified relative of a dependent child receives increased income from employment.

For the purposes of this subrule, "family" shall mean individuals living in the household whose needs and income were included in determining the FMAP eligibility of the household members at the time that the FMAP benefits were terminated. "Family" also includes those individuals whose needs and income would be taken into account in determining the FMAP eligibility of household members if the household were applying in the current month.

a. Increased income from employment includes:

- (1) Beginning employment.
- (2) Increased rate of pay.
- (3) Increased hours of employment.

b. In order to receive transitional Medicaid coverage under these provisions, an FMAP family must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. The 12 months' Medicaid transitional coverage begins the day following termination of FMAP eligibility.

d. When ineligibility is determined to occur retroactively, the transitional Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted, unless the provisions of paragraph "f" below apply.

e. Rescinded IAB 8/12/98, effective 10/1/98.

f. Transitional Medicaid shall not be allowed under these provisions when it has been determined that the member received FMAP in any of the six months immediately preceding the month of cancellation as the result of fraud. Fraud shall be defined in accordance with Iowa Code Supplement section 239B.14.

g. During the transitional Medicaid period, assistance shall be terminated at the end of the first month in which the eligible group ceases to include a child, as defined by the family medical assistance program.

h. If the family receives transitional Medicaid coverage during the entire initial six-month period and the department has received, by the twenty-first day of the fourth month, a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), Medicaid shall continue for an additional six months, subject to paragraphs "g" and "i" of this subrule.

(1) If the department does not receive a completed form by the twenty-first day of the fourth month, assistance shall be canceled.

(2) A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)"f" and 75.57(2)"l."

i. Medicaid shall end at the close of the first or fourth month of the additional six-month period if any of the following conditions exists:

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional six-month period as required in paragraph 75.1(31)"h," unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.

3. The family offers a good cause beyond the family's control.
4. There was a failure to receive the department's notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

(2) The specified relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or there were instances when problems could negatively impact the client's achievement of self-sufficiency as described at 441—subrule 93.133(4).

(3) It is determined that the family's average gross earned income, minus child care expenses for the children in the eligible group necessary for the employment of the specified relative, during the immediately preceding three-month period exceeds 185 percent of the federal poverty level as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

j. These provisions apply to specified relatives defined at paragraph 75.55(1) "a," including:

(1) Any parent who is in the home. This includes parents who are included in the eligible group as well as those who are not.

(2) A stepparent who is included in the eligible group and who has assumed the role of the caretaker relative due to the absence or incapacity of the parent.

(3) A needy specified relative who is included in the eligible group.

k. The timely notice requirements as provided in 441—subrule 76.4(1) shall not apply when it is determined that the family failed to meet the eligibility criteria specified in paragraph "g" or "i" above. Transitional Medicaid shall be terminated beginning with the first month following the month in which the family no longer met the eligibility criteria. An adequate notice shall be provided to the family when any adverse action is taken.

75.1(32) *Persons and families terminated from refugee cash assistance (RCA) because of income earned from employment.* Refugee medical assistance (RMA) shall be available as long as the eight-month limit for the refugee program is not exceeded to persons who are receiving RMA and who are canceled from the RCA program solely because a member of the eligible group receives income from employment.

a. An RCA recipient shall not be required to meet any minimum program participation time frames in order to receive RMA coverage under these provisions.

b. A person who returns to the home after the family became ineligible for RCA may be included in the eligible group for RMA coverage if the person was included on the assistance grant the month the family became ineligible for RCA.

75.1(33) *Qualified disabled and working persons.* Medicaid shall be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

a. Qualified disabled and working persons are persons who meet the following requirements:

(1) The person's monthly income does not exceed 200 percent of the federal poverty level applicable to the family size involved.

(2) The person's resources do not exceed twice the maximum amount allowed under the supplemental security income (SSI) program.

(3) The person is not eligible for any other Medicaid benefits.

(4) The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Social Security Act (as added by Section 6012 of OBRA 1989).

b. The amount of the person's income and resources shall be determined as under the SSI program.

75.1(34) *Specified low-income Medicare beneficiaries.* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

a. The person's monthly income exceeds 100 percent of the federal poverty level but is less than 120 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

c. The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(35) Medically needy persons.

a. *Coverage groups.* Subject to other requirements of this chapter, Medicaid shall be available to the following persons:

(1) Pregnant women. Pregnant women who would be eligible for FMAP-related coverage groups except for excess income or resources. For FMAP-related programs, pregnant women shall have the unborn child or children counted in the household size as if the child or children were born and living with them.

(2) FMAP-related persons under the age of 19. Persons under the age of 19 who would be eligible for an FMAP-related coverage group except for excess income.

(3) CMAP-related persons under the age of 21. Persons under the age of 21 who would be eligible in accordance with subrule 75.1(15) except for excess income.

(4) SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

(5) FMAP-specified relatives. Persons whose income or resources exceed the family medical assistance program's limit and who are a specified relative as defined at subrule 75.55(1) living with a child who is determined dependent.

b. *Resources and income of all persons considered.*

(1) Resources of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35)“b”(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility of adults. Resources of all specified relatives and of all potentially eligible individuals living together shall be disregarded in determining eligibility of children. Income of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35)“b”(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility.

(2) The amount of income of the responsible relative that has been counted as available to an FMAP household or SSI individual shall not be considered in determining the countable income for the medically needy eligible group.

(3) The resource determination shall be according to subrules 75.5(3) and 75.5(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

c. *Resources.*

(1) The resource limit for adults in SSI-related households shall be \$10,000 per household.

(2) Disposal of resources for less than fair market value by SSI-related applicants or members shall be treated according to policies specified in rule 441—75.23(249A).

(3) The resource limit for FMAP- or CMAP-related adults shall be \$10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered according to department of public health 641—subrule 75.4(2).

(4) The resources of SSI-related persons shall be treated according to SSI policies.

(5) When a resource is jointly owned by SSI-related persons and FMAP-related persons, the resource shall be treated according to SSI policies for the SSI-related person and according to FMAP policies for the FMAP-related persons.

d. *Income.* All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted shall be considered in determining initial and continuing eligibility.

(1) Income policies specified in subrules 75.57(1) through 75.57(8) and paragraphs 75.57(9) “b,” “c,” “g,” “h,” and “i” regarding treatment of earned and unearned income are applied to FMAP-related and CMAP-related persons when determining initial eligibility and for determining continuing eligibility unless otherwise specified. The three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply to medically needy persons.

(2) Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

(3) The monthly income shall be determined prospectively unless actual income is available.

(4) The income for the certification period shall be determined by adding both months’ net income together to arrive at a total.

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

e. Medically needy income level (MNIL).

(1) The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided in subrule 75.58(2), with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	\$483	\$483	\$566	\$666	\$733	\$816	\$891	\$975	\$1058	\$1158

Each additional person \$116

(2) When determining household size for the MNIL, all potential eligibles and all individuals whose income is considered as specified in paragraph 75.1(35) “b” shall be included unless the person has been excluded according to the provisions of rule 441—75.59(249A).

(3) The MNIL for the certification period shall be determined by adding both months’ MNIL to arrive at a total.

The MNIL for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

(4) The total net countable income for the certification period shall be compared to the total MNIL for the certification period based on family size as specified in subparagraph (2).

If the total countable net income is equal to or less than the total MNIL, the medically needy individuals shall be eligible for Medicaid.

If the total countable net income exceeds the total MNIL, the medically needy individuals shall not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

f. Verification of medical expenses to be used in spenddown calculation. The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the provider of the applicant’s or member’s spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that

period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

g. Spenddown calculation.

(1) Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.
2. Are not Medicaid-payable in a previous certification period or the retroactive certification period.
3. Are not incurred during any prior certification period with the exception of the retroactive period in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs "1" through "3" above, paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

(2) Order of deduction. Spenddown shall be adjusted when a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met, the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility shall be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed in the Compilation of Various Costs and Statistical Data (Category: All; Type of Care: Residential Care Facility; Location: All; Type of Control: All). The average statewide standard deduction for personal care services used in the medically needy program shall be updated and effective the first day of the first month beginning two full months after the release of the Compilation of Various Costs and Statistical Data for the previous fiscal year.

3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

4. Medical expenses for acupuncture, chronologically by date of submission.

5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

(3) When incurred medical expenses have reduced income to the applicable MNIL, the individuals shall be eligible for Medicaid.

(4) Medical expenses reimbursed by a public program other than Medicaid prior to the certification period shall not be considered a medical deduction.

h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

- (1) Care in a nursing facility or an intermediate care facility for the mentally retarded.
- (2) Care in an institution for mental disease.
- (3) Care in a Medicare-certified skilled nursing facility.

i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the review process when requested to do so by the department.

j. Redetermination. When an SSI-related, CMAP-related, or FMAP-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466(Spanish), shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on redeterminations of eligibility.

k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medicaid Review, Form 470-3118 or 470-3118(S), to be recertified.

l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

(3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in subparagraph (2).

75.1(36) Expanded specified low-income Medicare beneficiaries. As long as 100 percent federal funding is available under the federal Qualified Individuals (QI) Program, Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

- a. The person is not otherwise eligible for Medicaid.
- b. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.
- c. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.
- d. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.
- e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) Home health specified low-income Medicare beneficiaries. Rescinded IAB 10/30/02, effective 1/1/03.

75.1(38) Continued Medicaid for disabled children from August 22, 1996. Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

75.1(39) Working persons with disabilities.

- a. Medical assistance shall be available to all persons who meet all of the following conditions:
 - (1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.
 - (2) They are less than 65 years of age.
 - (3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards.
 - (4) They receive earned income from employment or self-employment or are eligible under paragraph "c."
 - (5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to \$10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph (1) above.
 - (6) They have paid any premium assessed under paragraph "b" below.

- b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

- (1) Beginning with the month of application, the monthly premium amount shall be established for a 12-month period based on projected average monthly income for the 12-month period. The monthly premium established shall not be increased for any reason during the 12-month period. The premium shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively during the 12-month period if a reduction in projected average monthly income is verified.

(2) Eligible persons are required to complete and return Form 470-3118 or 470-3118(S), Medicaid Review, with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	\$25
180% of Federal Poverty Level	\$40
220% of Federal Poverty Level	\$55
250% of Federal Poverty Level	\$70
280% of Federal Poverty Level	\$85
310% of Federal Poverty Level	\$100
340% of Federal Poverty Level	\$120
370% of Federal Poverty Level	\$140
400% of Federal Poverty Level	\$165
430% of Federal Poverty Level	\$190
460% of Federal Poverty Level	\$220
490% of Federal Poverty Level	\$255
530% of Federal Poverty Level	\$295
575% of Federal Poverty Level	\$340
620% of Federal Poverty Level	\$390
670% of Federal Poverty Level	\$452

(4) Eligibility is contingent upon the payment of any assessed premiums. Medical assistance eligibility shall not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(5) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover. EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility shall be canceled.

(6) Payments received shall be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments shall be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess shall be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs "1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account shall be refunded to the client after two calendar months of inactivity or of a zero premium or upon request from the client.

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the premium must be paid in full within the calendar month following the month the payment was due for reopening.

(8) Premiums may be submitted in the form of cash, money orders, or personal checks to the department at the following address: Department of Human Services, Supply Unit A-Level, Room 77, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319.

(9) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(10) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will include reopening provisions that apply if payment is received and appeal rights.

(11) Form 470-3694, Billing Statement, shall be used for billing and collection.

c. Persons receiving assistance under this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule.

d. For purposes of this subrule, the following definitions apply:

"Assistive technology" is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

"Assistive technology accounts" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

"Assistive technology device" is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

"Family," if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, "family" includes the individual's spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual's family. An individual living alone or with others not listed above shall be considered to be a family of one.

"Medical savings account" means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

"Retirement account" means any retirement or pension fund or account, listed in Iowa Code section 627.6(8) "f" as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.1(40) *People who have been screened and found to need treatment for breast or cervical cancer:*

a. Medical assistance shall be available to people who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

b. Eligibility established under paragraph “a” continues until the person is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

c. Presumptive eligibility. A person who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph “a” shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The person shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a person under this paragraph is not dependent upon a finding of Medicaid eligibility for the person.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and

2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or

- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3864, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider’s application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for People with Breast or Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a person, the provider shall:

1. Contact the department to obtain a state identification number for the person who has been determined presumptively eligible.

2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

3. Inform the person in writing, at the time the determination is made, that if the person has not applied for Medicaid on Form 470-2927 or 470-2927(S), Health Services Application, the person has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

4. Forward copies of Form 470-2927 or 470-2927(S), Health Services Application, to the appropriate department office for eligibility determination if the person indicated on the application that the person was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.

(4) In the event that a person needing care does not appear to be presumptively eligible, the qualified provider shall inform the person that the person may file an application at the county department office if the person wishes to have an eligibility determination made by the department.

(5) Presumptive eligibility shall end under either of the following conditions:

1. The person fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

2. The person files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.

(6) Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a person who is:

1. Denied presumptive eligibility by a qualified provider.

2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the person fails to file an application by the last day of the month following the month of the presumptive eligibility determination.

(7) A new period of presumptive eligibility shall begin each time a person is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to need treatment for breast or cervical cancer, and files Form 470-2927 or 470-2927(S), Health Services Application, with a qualified provider.

75.1(41) *Women eligible for family planning services under demonstration waiver.* Medical assistance for family planning services only shall be available to women as provided in this subrule.

a. Eligibility. The following are eligible for assistance under this coverage group:

(1) Women who were Medicaid members when their pregnancy ended and who are capable of bearing children but are not pregnant. Eligibility for these women extends for 12 consecutive months after the month when their 60-day postpartum period ends.

(2) Women who are of childbearing age, are capable of bearing children but are not pregnant, and have income that does not exceed 200 percent of the federal poverty level, as determined according to paragraph 75.1(41)“c.”

b. Application.

(1) Women eligible under subparagraph 75.1(41)“a”(1) are not required to file an application for assistance under this coverage group. The department will automatically redetermine eligibility pursuant to rule 441—76.11(249A) upon loss of other Medicaid eligibility within 12 months after the month when the 60-day postpartum period ends.

(2) Women requesting assistance based on subparagraph 75.1(41)“a”(2) shall file an application as required in rule 441—76.1(249A).

c. Determining income eligibility. The department shall determine the countable income of a woman applying under subparagraph 75.1(41)“a”(2) as follows:

(1) Household size. The household size shall include the applicant or member, any dependent children as defined in 441—subrule 75.54(1) living in the same home as the applicant or member, and any spouse living in the same home as the applicant or member, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act.

(2) Earned income. All earned income as defined in 441—subrule 75.57(2) that is received by a member of the household shall be counted except for the earnings of a child who is a full-time student as defined in 441—paragraph 75.54(1)“b.”

(3) Unearned income. The following unearned income of all household members shall be counted:

1. Unemployment compensation.
2. Child support.
3. Alimony.
4. Social security and railroad retirement benefits.
5. Worker’s compensation and disability payments.
6. Benefits paid by the Department of Veterans Affairs to disabled members of the armed forces or survivors of deceased veterans.

(4) Deductions. Deductions from income shall be made for any payments made by household members for court-ordered child support, alimony, or spousal support to non-household members and as provided in 441—subrule 75.57(2).

(5) Disregard of changes. A woman found to be income-eligible upon application or annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

d. Effective date. Assistance for family planning services under this coverage group shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. Notwithstanding 441—subrule 76.5(1), assistance shall not be available under this coverage group for any months preceding the month of application.

75.1(42) Medicaid for independent young adults. Medical assistance shall be available, as assistance related to the family medical assistance program, to a person who left a foster care placement on or after May 1, 2006, and meets all of the following conditions:

- a. The person is at least 18 years of age and under 21 years of age.
- b. On the person’s eighteenth birthday, the person resided in foster care and Iowa was responsible for the foster care payment pursuant to Iowa Code section 234.35.
- c. The person is not a mandatory household member or receiving Medicaid benefits under another coverage group.
- d. The person has income below 200 percent of the most recently revised federal poverty level for the person’s household size.

(1) “Household” shall mean the person and any of the following people who are living with the person and are not active on another Medicaid case:

1. The person’s own children;
2. The person’s spouse; and
3. Any children of the person’s spouse who are under the age of 18 and unmarried.

No one else shall be considered a member of the person’s household. A person who lives alone or with others not listed above, including the person’s parents, shall be considered a household of one.

(2) The department shall determine the household’s countable income pursuant to rule 75.57(249A). Twenty percent of earned income shall be disregarded.

(3) A person found to be income-eligible upon application or upon annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

75.1(43) Medicaid for children with disabilities. Medical assistance shall be available to children who meet all of the following conditions on or after January 1, 2009:

- a. The child is under 19 years of age.

b. The child is disabled as determined pursuant to rule 441—75.20(249A) based on the disability standards for children used for Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, but without regard to any income or asset eligibility requirements of the SSI program.

c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.

d. The child's household has income at or below 300 percent of the federal poverty level applicable to a family of that size.

(1) For this purpose, the child's household shall include any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph (1) shall be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs or family planning services only is not considered to be "receiving Medicaid" for the purposes of subparagraph (1). A child who lives alone or with persons not identified in subparagraph (1) shall be considered as having a household of one.

(3) For this purpose, the income of all persons included in the child's household shall be determined as provided for SSI-related groups under subrule 75.13(2).

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

75.1(44) Presumptive eligibility for children. Medical assistance shall be available to children under the age of 19 who are determined by a qualified entity to be presumptively eligible for medical assistance pursuant to this subrule.

a. *Qualified entity.* A "qualified entity" is an entity described in paragraphs (1) through (10) of the definition of the term at 42 CFR 435.1101, as amended to October 1, 2008, that:

(1) Has been determined by the department to be capable of making presumptive determinations of eligibility, and

(2) Has signed an agreement with the department as a qualified entity.

b. *Application process.* Families requesting assistance for children under this subrule shall apply with a qualified entity using the form specified in 441—paragraph 76.1(1) "f." The qualified entity shall use the department's Web-based system to make the presumptive eligibility determination, based on the information provided in the application.

(1) All presumptive eligibility applications shall be forwarded to the department for a full Medicaid or HAWK-I eligibility determination, regardless of the child's presumptive eligibility status.

(2) The date a valid application was received by the qualified entity establishes the date of application for purposes of determining the effective date of Medicaid or HAWK-I eligibility unless the qualified entity received the application on a weekend or state holiday. Applications received by the qualified entity on a weekend or a state holiday shall be considered to be received on the first business day following the weekend or state holiday.

(3) The qualified entity shall issue Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, to inform the applicant of the decision on the application as soon as possible but no later than within two working days after the date the determination is made.

(4) Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

c. *Eligibility requirements.* To be determined presumptively eligible for medical assistance, a child shall meet the following eligibility requirements.

(1) Age. The child must be under the age of 19.

(2) Household income. Household income must be less than 300 percent of the federal poverty level for a household of the same size. For this purpose, the household shall include the applicant child and any sibling (of whole or half blood, or adoptive), spouse, parent, or stepparent living with the applicant child. This determination shall be based on the household's gross income, with no deductions, diversions, or disregards.

(3) Citizenship or qualified alien status. The child must be a citizen of the United States or a qualified alien as defined in subrule 75.11(2).

(4) Iowa residency. The child must be a resident of Iowa.

(5) Prior presumptive eligibility. A child shall not be determined presumptively eligible more than once in a 12-month period. The first month of the 12-month period begins with the month the application is received by the qualified entity.

d. Period of presumptive eligibility. Presumptive eligibility shall begin with the date that presumptive eligibility is determined and shall continue until the earliest of the following dates:

(1) The last day of the next calendar month;

(2) The day the child is determined eligible for Medicaid;

(3) The last day of the month that the child is determined eligible for HAWK-I; or

(4) The day the child is determined ineligible for Medicaid and HAWK-I. Withdrawal of the Medicaid or HAWK-I application before eligibility is determined shall not affect the child's eligibility during the presumptive period.

e. Services covered. Children determined presumptively eligible under this subrule shall be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services. Payment of claims for Medicaid services provided to a child during the presumptive eligibility period, including EPSDT services, is not dependent upon a determination of Medicaid or HAWK-I eligibility by the department.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7833B, IAB 6/3/09, effective 8/1/09; ARC 7929B, IAB 7/1/09, effective 7/1/09; ARC 7931B, IAB 7/1/09, effective 7/1/09; ARC 8095B, IAB 9/9/09, effective 10/14/09; ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8261B, IAB 11/4/09, effective 10/15/09; ARC 8439B, IAB 1/13/10, effective 3/1/10]

441—75.2(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare), and other resources for meeting the cost of medical care which may be available to the member. These resources must be used when reasonably available.

75.2(1) The department shall approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable.

a. Persons who have been approved by the Social Security Administration for supplemental security income shall complete Form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information, and return it to the department.

b. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information.

75.2(2) As a condition of eligibility for medical assistance, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department any rights to payments of medical care from any third party to the extent that payment has been made under the medical assistance program. The applicant's signature on any form listed in 441—subrule 76.1(1) shall constitute agreement to the assignment. The assignment shall be effective for the entire period for which medical assistance is paid.

b. Cooperate with the department in obtaining third-party payments. The member or one acting on the member's behalf shall:

(1) File a claim or submit an application for any reasonably available medical resource, and

(2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

75.2(3) Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the member, or one acting on behalf of a minor, or of a legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

a. Physical or emotional harm to the member for whom medical resources are being sought.

b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult member, for whom medical resources are being sought.

75.2(4) Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the determination of good cause based on information and evidence provided by the member or by one acting on the member's behalf.

a. The medical assistance benefits of a minor or a legally incompetent adult member shall not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

75.2(5) When the department receives information through a cross-match with Iowa workforce development department and child support recovery files which indicates the absent parent of a Medicaid-eligible child is employed, the department shall send Form 470-0413, Obligor Insurance Questionnaire, to the absent parent in order to obtain health insurance coverage information. If the absent parent does not respond within 15 days from the date Form 470-0413 is sent, the department shall send Form 470-2240, Employer Insurance Questionnaire, to the employer in order to obtain the health insurance coverage information.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.
[ARC 7546B, IAB 2/11/09, effective 4/1/09]

441—75.3(249A) Acceptance of other financial benefits. An applicant or member shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or member may qualify, unless the applicant or member can show an incapacity to do so. Sources of benefits may be, but are not limited to, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

75.3(1) When it is determined that the supplemental security income (SSI)-related applicant or member may be entitled to other cash benefits, the department shall send a Notice Regarding Acceptance of Other Benefits, Form 470-0383, to the applicant or member.

75.3(2) The SSI-related applicant or member must express an intent to apply or refuse to apply for other benefits within ten calendar days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or member is mentally or physically incapable of filing the claim for other cash benefits.

75.3(3) When the SSI-related applicant or member is physically or mentally incapable of filing the claim for other cash benefits, the department shall request the person acting on behalf of the member to pursue the potential benefits.

75.3(4) The SSI-related applicant or member shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or member shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.4(249A) Medical assistance lien.

75.4(1) When payment is made by the department for medical care or expenses through the medical assistance program on behalf of a member, the department shall have a lien, to the extent of those payments, to all monetary claims which the member may have against third parties.

a. A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

b. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including, but not limited to, notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

c. All notifications to the department required by law shall be directed to the Iowa Medicaid Enterprise, Revenue Collection Unit, P.O. Box 36475, Des Moines, Iowa 50315. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.4(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the member. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.4(3) In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or one acting on the member's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult member shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

a. The client, or one acting on the client's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. Rescinded IAB 9/4/91, effective 11/1/91.

c. The client or person acting on the client's behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or one acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or one acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The member may report the change in person, by telephone, by mail or by using the Ten-Day Report of Change, Form 470-0499 or 470-0499(S), which is mailed with the Family Investment Program warrants and is issued to the client when Medicaid applications are approved, when annual reviews are completed, when a completed Ten-Day Report of Change is submitted, and when the client requests a form.

d. The member, or one acting on the member's behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

e. When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee shall be terminated. When a parent or payee fails to cooperate in completing or returning the Priority Leads Letter, Form 470-0398, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

f. The member, or one acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

75.4(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on the Health Insurance Claim, Form CMS-1500, that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for medical assistance or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

75.4(5) Department's lien.

a. The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be

construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

c. When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department shall issue notice to the insurer of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

d. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

75.4(6) For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for medical assistance or a past or present Medicaid member.

75.4(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.

441—75.5(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

75.5(1) Determining income from property.

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income shall be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest shall be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

75.5(2) Division of income between married people for SSI-related coverage groups.

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

75.5(3) Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When determined. The department shall determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3) "a" live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

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

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

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

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

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

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

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

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

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

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

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than \$24,000, then \$24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

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

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

(1) That the attribution is incorrect, or

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

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

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

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2) "d" shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

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

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

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater

than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

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

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

75.5(4) Consideration of resources of married people.

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

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

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

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

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

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

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the

seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

a. Eligibility. A person may be eligible for medical assistance under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the “asset adjustment” provided in this subrule.

b. Definition. “Asset adjustment” shall mean a \$1 disregard of resources for each \$1 that has been paid out under the person’s qualified or approved long-term care insurance policy.

c. Estate recovery. An amount equal to the benefits paid out under a member’s qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member’s spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35 and chapter 514H.

[ARC 8443B, IAB 1/13/10, effective 3/1/10]

441—75.6(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual’s Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual’s other resources or income be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the community.

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

441—75.7(249A) Furnishing of social security number. As a condition of eligibility, a person for whom Medicaid is being requested or received must furnish a social security account number or must furnish proof of application for the number if the social security number has not been issued or is not known and provide the number upon receipt. This requirement does not apply if the person

refuses to obtain a social security number because of well-established religious objections. The term “well-established religious objections” means that the person is a member of a recognized religious sect or a division of a recognized religious sect and adheres to the tenets or teachings of the sect or division, and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(1) Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

75.7(2) The mother of a newborn child shall have until the second month following the mother’s discharge from the hospital to apply for a social security account number for the child.

75.7(3) Social security account numbers may be requested for people in the eligible group for whom Medicaid is not being requested or received, but provision of the number shall not be a condition of eligibility for the people in the eligible group for whom Medicaid is being requested or received.

This rule is intended to implement Iowa Code section 249A.3.

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient’s behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person’s spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) Definitions.

“*Incapable of expressing intent*” shall mean that the person meets one or more of the following conditions:

1. Has an IQ of 49 or less or has a mental age of seven or less.
2. Is judged legally incompetent.
3. Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other person licensed by the state in the field of mental retardation.

“*Institution*” shall mean an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. Foster care facilities are included.

75.10(2) Determining residency. Residency is determined according to the following criteria:

a. Persons aged 21 and over.

(1) For any person not residing in an institution the state of residence is the state where the person is:

1. Living with the intention to remain there permanently or for an indefinite period (or, if incapable of expressing intent, where the person is living), or
2. Living and which the person entered with a job commitment or seeking employment (whether or not currently employed).

(2) For any institutionalized person who became incapable of indicating intent before age 21, the person’s state of residence is:

1. That of the parent applying for Medicaid on the person’s behalf, if the parents reside in separate states. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent’s.
2. The parent’s or legal guardian’s state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent’s.
3. The current state of residence of the parent or legal guardian who files the application if the person is institutionalized in the state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent’s.
4. The state of residence of the person who has been abandoned by the person’s parents and does not have a legal guardian is the state in which the person is institutionalized.

(3) For any institutionalized person who became incapable of expressing intent at or after age 21, the state of residence is the state in which the person is physically present, except where another state makes a placement.

(4) For any other institutionalized person the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

b. Persons under age 21.

(1) For any person who is emancipated from the person’s parents or who is married and capable of expressing intent, the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

(2) For any person not residing in an institution or foster home whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the person is living.

(3) For any other person not in an institution or foster home and not subject to subparagraph (1) or (2) above, the state of residence is determined in accordance with rule 441—75.53(249A).

(4) For any person in an institution or foster home who is neither married nor emancipated, the state of residence is:

1. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

2. The current state of residence of the parent or legal guardian who files the application if the person is institutionalized or in foster care in that state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

3. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized or in foster care.

c. Persons placed by a state in an out-of-state foster home or institution. A state arranging or actually making the placement of a person in an institution or foster home in another state is considered the person's state of residence. However, a Title IV-E eligible child placed out of state by the department is eligible for Medicaid from the other state. Therefore, the Title IV-E eligible child shall only receive Iowa Medicaid until the receiving state provides coverage. A Title IV-E eligible child placed in Iowa by another state shall be considered eligible for Iowa Medicaid.

d. Medicaid-eligible persons receiving Medicaid from another state and gaining Iowa residency. These persons shall be granted Medicaid beginning with the month of residency in Iowa if the person is otherwise eligible and surrenders the other state's medical card. Good cause for not surrendering the other state's medical card shall exist when:

(1) The other state does not issue medical cards.

(2) The other state's medical card is a magnetic stripe or a computer chip card that contains more than Medicaid-related information.

(3) The other state's medical card: was left with Medicaid-eligible members of the person's household in the other state who did not move to Iowa with the person; was lost, mutilated, or destroyed; was not kept by the person upon the person's move to Iowa; or was previously surrendered to the other state.

In addition to surrendering the other state's medical card or establishing good cause, the cancellation of Medicaid in the other state shall be verified.

This rule is intended to implement Iowa Code section 249A.3.

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) Definitions.

"Care and services necessary for the treatment of an emergency medical condition" shall mean services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

"Emergency medical condition" shall mean a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. Placing the patient's health in serious jeopardy.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

"Federal means-tested program" means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.

2. Short-term, non-cash, in-kind emergency disaster relief.

3. Assistance or benefits under the National School Lunch Act.

4. Assistance or benefits under the Child Nutrition Act of 1966.

5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.

6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to have payments made on the child's behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).

7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;

- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and

- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965.

10. Benefits under the Head Start Act.

11. Benefits funded through an employment and training program of the U.S. Department of Labor.

"*Qualified alien*" means an alien who is:

1. Lawfully admitted for permanent residence under the Immigration and Nationality Act;

2. Granted asylum under Section 208 of the Immigration and Nationality Act;

3. A refugee and who is admitted to the United States under Section 207 of the Immigration and Nationality Act;

4. Paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least one year;

5. An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act; or

6. Granted conditional entry pursuant to Section 203(a)(7) of the Immigration and Nationality Act, as in effect prior to April 1, 1980.

"*Qualifying quarters*" includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) *Citizenship and alienage.*

a. To be eligible for Medicaid a person must be one of the following:

- (1) A citizen or national of the United States.

- (2) A qualified alien residing in the United States before August 22, 1996.

- (3) An alien child under the age of 19 who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

- (4) A refugee who is admitted to the United States under Section 207 of the Immigration and Nationality Act.

- (5) An alien who has been granted asylum under Section 208 of the Immigration and Nationality Act.

- (6) An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act.

- (7) A qualified alien veteran who has an honorable discharge that is not due to alienage.

(8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.

(9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.

(10) A qualified alien who has resided in the United States for a period of at least five years.

b. As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship status by signing the application form which contains a similar declaration at time of review.

c. Except as provided in paragraph "f," applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph "b" shall present satisfactory documentation of citizenship or nationality as defined in paragraph "d" or "e." An applicant or member shall have a reasonable period to obtain and provide proof of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request to obtain and provide proof is issued to an applicant or member and continues to the date when the proof is provided or the date when the department establishes that the applicant or member is no longer making a good-faith effort to obtain the proof, whichever is earlier.

(2) Medicaid eligibility shall continue for members during the reasonable period. Medicaid shall not be approved for applicants until acceptable documentary evidence is provided.

(3) A reference to a form in paragraph "d" or "e" includes any successor form.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph “*b*” is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is eligible for child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is eligible for adoption or foster care assistance funded under Part E of Title IV of the federal Social Security Act; or

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

g. If no other identity documentation allowed by subparagraph 75.11(2)“*e*”(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child’s parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2)“*e*”(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

75.11(3) Deeming of sponsor’s income and resources.

a. In determining the eligibility and amount of benefits of an alien, the income and resources of the alien shall be deemed to include the following:

(1) The income and resources of any person who executed an affidavit of support pursuant to Section 213A of the Immigration and Nationality Act (as implemented by the Personal Responsibility and Work Reconciliation Act of 1996) on behalf of the alien.

(2) The income and resources of the spouse of the person who executed the affidavit of support.

b. When an alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act or has worked 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with qualifying quarters as defined at subrule 75.11(1) and,

in the case of any qualifying quarter creditable for any period beginning after December 31, 1996, did not receive any federal means-tested public benefits, as defined in subrule 75.11(1), during any period, deeming of the sponsor's income and resources no longer applies.

75.11(4) Eligibility for payment of emergency medical services. Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

a. The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

b. The medical provider who treated the emergency medical condition or the provider's designee must submit verification of the existence of the emergency medical condition on either:

- (1) Form 470-4299, Verification of Emergency Health Care Services; or
- (2) A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7932B, IAB 7/1/09, effective 7/1/09; ARC 8096B, IAB 9/9/09, effective 10/14/09]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, the phrase “inmate of a public institution” is defined by 42 CFR Section 435.1009, as amended on November 10, 1994.

This rule is intended to implement Iowa Code section 249A.3.

441—75.13(249A) Categorical relatedness.

75.13(1) FMAP-related Medicaid eligibility. Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) SSI-related Medicaid. Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

a. SSI policy reference. The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

b. Income considered. For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

c. Trust contributions. Income that a person contributes to a trust as specified at 75.24(3) “b” shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

d. Conditional eligibility. For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

e. Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all

remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.13(3) *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for each applicant or member as well as for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when good cause as defined in subrule 75.14(8) for refusal to cooperate is established.

a. The applicant or member shall cooperate in the following:

- (1) Identifying and locating the parent of the child for whom Medicaid is requested.
- (2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.
- (3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.

(4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the applicant or member:

(1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. The applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. The applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The income maintenance unit shall make the determination of whether or not the applicant or member has cooperated.

75.14(2) Failure of the applicant or member to cooperate shall result in denial or cancellation of the person's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2) "a," "b," and "c" shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Referrals to the child support recovery unit for Medicaid applicants or members. The department shall provide prompt notice to the child support recovery unit whenever assistance is

furnished with respect to a child with a parent who is absent from the home or when any member of the eligible group is entitled to support payments.

a. A referral to the child support recovery unit shall not be made when a parent's absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. "Prompt notice" means within two working days of the date assistance is approved.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) and 75.14(5) which require the applicant or member to assign any rights to medical support and payments for medical care and to be referred to the child support recovery unit.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- (1) Physical or emotional harm to the child for whom support is to be sought; or
- (2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.
- (3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or
- (4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

- (1) The child was conceived as the result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.
- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

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

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

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

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

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

(5) Advise the applicant or member that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

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

(2) Informs the applicant or member that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or member that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the income maintenance unit shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

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

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

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

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

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

(2) Corroborate the good cause circumstances.

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

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

- (1) Be in writing.
- (2) Contain the income maintenance unit's findings and basis for determination.
- (3) Be entered in the case record.

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

- (1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or
- (2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

c. When the income maintenance unit determines that good cause does not exist:

- (1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and
- (2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

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

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

- (1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and
- (2) Consider any recommendation from the child support recovery unit.

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

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

h. The income maintenance unit shall:

- (1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.
- (2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence:

- (1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.
- (2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.
- (3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.
- (4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from

a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

- (1) Promptly notify the applicant or member that additional corroborative evidence is needed, and
- (2) Specify the type of document which is needed.

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

- (1) Advise the applicant or member how to obtain the necessary documents, and
- (2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds \$500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

- a. The individual's spouse; or
- b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. *FMAP-related clients.* The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

- (1) The client has a parent or child at home.
- (2) The family's income is considered together in determining eligibility.

b. *SSI-related clients who are employed.* If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. *SSI-related clients returning home within three months.* If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. *Married couples.*

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. *State supplementary assistance recipients.* The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. *Foster care recipients.* The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. *Clients receiving a VA pension.* The amount of \$90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

- (1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or
- (2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

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

a. Ongoing personal needs allowance. All clients shall retain \$50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed \$10 per month except with court approval.

(2) If the client has earned income, an additional \$65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. Personal needs in the month of entry.

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

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

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

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

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

d. Maintenance needs of spouse and other dependents.

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

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

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

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

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

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

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

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

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

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 8444B, IAB 1/13/10, effective 3/1/10]

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) Multiple pregnancy. If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) Cost of examination. When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

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

This rule is intended to implement Iowa Code section 249A.3.

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) Exceptions to coverage. This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

75.19(2) *Duration of coverage.* Coverage under this rule shall extend through the earliest of the following months:

- a. The month of the household's annual eligibility review;
- b. The month when the child reaches the age of 19; or
- c. The month when the child moves out of Iowa.

75.19(3) *Assignment of review date.* Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) *Applicants receiving federal benefits.* An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Redeterminations of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's medical condition will

be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2) "b."

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

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

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid. Payment shall include only the cost to the Medicaid member or household.

75.21(1) *Condition of eligibility for group plans.* The Medicaid member or a person acting on the member's behalf shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of a group health plan. When the department has determined that a group health plan is cost-effective, enrollment in the plan is a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid members through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

a. When a parent fails to provide information necessary to determine availability and cost-effectiveness of a group health plan, fails to enroll in a group health plan that has been determined cost-effective, or disenrolls from a group health plan that has been determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established.

b. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

- (1) There was a serious illness or death of the parent or a member of the parent's family.
- (2) There was a family emergency or household disaster, such as a fire, flood, or tornado.
- (3) The parent offers a good cause beyond the parent's control.
- (4) There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

c. Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of a spouse who cannot enroll in the plan independently of the other spouse shall not be terminated due to the other spouse's failure to cooperate.

d. The presence of good cause does not relieve the parent of the requirement to cooperate. When necessary, the parent may be given additional time to cooperate when good cause is determined to exist.

75.21(2) *Individual health plans.* Participation in an individual health plan is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

- a.* A household member is currently enrolled in the plan; and
- b.* The health plan is cost-effective as defined in subrule 75.21(3).

75.21(3) *Cost-effectiveness.* Cost-effectiveness for both group and individual health plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under the health plan for those services. When determining the cost-effectiveness of the health plan, the following data shall be considered:

a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

b. The scope of services covered under the health plan, including but not limited to exclusions for preexisting conditions.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for members covered under the health plan.

d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

(1) If the member is currently covered by the health plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

e. Annual administrative expenditures of \$50 per Medicaid member covered under the health plan.

f. Whether the estimated savings to Medicaid for members covered under the health insurance plan are at least \$5 per month per household.

75.21(4) Coverage of non-Medicaid-eligible family members.

a. When a group health plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However:

(1) The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

b. When an individual health plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

75.21(5) Exceptions to payment. Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., \$50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.

d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34) or the IowaCare program in accordance with the provisions of 441—Chapter 92. Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. Insurance coverage is being provided through the Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

k. The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

l. The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

m. The health plan pays secondary to another plan.

n. The only Medicaid members covered by the health plan are currently in foster care.

o. All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

75.21(6) Duplicate policies. When more than one cost-effective health plan is available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) Discontinuation of premium payments.

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(8) Effective date of premium payment. The effective date of premium payments for a cost-effective health plan shall be determined as follows:

a. Premium payments shall begin no earlier than the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the health plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income when determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage for individual health plans or for group health plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(9) Method of premium payment. Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

- (1) Information cannot be obtained for direct payment, or
- (2) The department pays for only part of the total premium.

75.21(10) Payment of claims. Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(11) Reviews of cost-effectiveness and eligibility. Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the health plan contract renewal date. The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, for the review.

b. For individual health plans, the client shall complete HIPP Individual Policy Review, Form 470-3017, for the review.

c. Failure of the household to cooperate in the review process shall result in cancellation of premium payment and may result in Medicaid ineligibility as provided in subrule 75.21(1).

d. Redeterminations shall be completed whenever:

- (1) A premium rate, deductible, or coinsurance changes,
- (2) A person covered under the policy loses full Medicaid eligibility,
- (3) Changes in employment or hours of employment affect the availability of health insurance,
- (4) The insurance carrier changes,
- (5) The policyholder leaves the Medicaid home, or
- (6) There is a decrease in the services covered under the policy.

e. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person. The department sends a HIPP Change Report, Form 470-3007, with all premium payments.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(16) "a," shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for Medicaid members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(12) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(8)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.*

a. An adequate notice shall be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The health plan is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the health plan is no longer cost-effective, or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(14) *Rate refund.* The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(15) *Reinstatement of eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(16) *Amount of premium paid.*

a. For group health plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(17) *Reporting changes.* Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

This rule is intended to implement Iowa Code section 249A.3.
[ARC 7935B, IAB 7/1/09, effective 9/1/09]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, “AIDS” and “HIV” are defined in accordance with Iowa Code section 141A.1.

75.22(1) Conditions of eligibility. The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician’s statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician’s statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person’s current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician’s Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed \$10,000 per household. The following are examples of countable resources:

- (1) Unobligated cash.
- (2) Bank accounts.
- (3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) Application process.

a. *Application.* Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant’s name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. *Time limit for decision.* Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the

control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. Eligible on the day of decision. No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. Waiting list. After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) Presumed eligibility The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) Family coverage. When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) Method of premium payment. Premiums shall be paid in accordance with the provisions of subrule 75.21(9).

75.22(6) Effective date of premium payment. Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) Reviews. The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) Termination of assistance. Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) Notices.

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) Confidentiality. The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) Ineligibility for services. When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. Institutionalized individual. When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

75.23(2) Look-back date.

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) Period of ineligibility. The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2009, through June 30, 2010, this average statewide cost shall be \$4,598.61 per month or \$151.27 per day.

75.23(4) Reduction of period of ineligibility. The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) Exceptions. An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

2. Household goods.

3. A vehicle required by the client for transportation.

4. Funds for burial of \$4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"*Assets*" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.

2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"*Income*" shall be defined by 42 U.S.C. Section 1382a.

“*Institutionalized individual*” shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

“*Resources*” shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

“*Transfer or disposal of assets*” means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2) “b”(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11) “c”);
5. Failure to take a share of an estate as a surviving spouse (also known as “taking against a will”) on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11) “d”); or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) Purchase of annuities.

a. The entire amount used to purchase an annuity on or after February 8, 2006, shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in subparagraphs (1) through (3) of this paragraph and also meets the condition described in subparagraph (4).

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;
2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or
3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;
2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and
3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(4) Iowa is named as the remainder beneficiary either:

1. In the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or
2. In the second position after the community spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

b. Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in 75.23(9) “a” were met.

75.23(10) Purchase of promissory notes, loans, or mortgages.

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual’s application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9)“a” were met.

75.23(11) Purchase of life estates.

a. The entire amount used to purchase a life estate in another individual’s home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual’s home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The life estate was purchased before February 8, 2006; or

(2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8444B, IAB 1/13/10, effective 3/1/10]

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual’s eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) Establishment of trust.

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual’s spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual’s spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual’s spouse.

b. The term “assets,” with respect to an individual, includes all income and resources of the individual and of the individual’s spouse, including any income or resources which the individual or the individual’s spouse is entitled to but does not receive because of action by the individual or the individual’s spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual’s spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual’s spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distribution may be made for the trust.

(4) Any restriction on the use of distributions from the trust.

e. The term “trust” includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) *Treatment of revocable and irrevocable trusts.*

a. In the case of a revocable trust:

- (1) The principal of the trust shall be considered an available resource.
- (2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.
- (3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

- (1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.
- (2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) *Exceptions.* This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual.

For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates for the period from July 1, 2009, to June 30, 2010, shall be as follows:

- (1) The average statewide charge to a private-pay resident of a nursing facility is \$4,189 per month.
- (2) and (3) Rescinded IAB 7/7/04, effective 7/1/04.
- (4) The maximum statewide Medicaid rate for a resident of an intermediate care facility for the mentally retarded is \$20,960 per month.
- (5) The average statewide charge to a resident of a mental health institute is \$17,758 per month.
- (6) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is \$5,044 per month.
- (7) The average statewide charge to a home- and community-based waiver applicant or recipient shall be consistent with the level of care determination and correspond with the average charges and rates set forth in this paragraph.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

- (1) The trust is established and managed by a nonprofit association.
- (2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
- (3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 7834B, IAB 6/3/09, effective 7/8/09]

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

“*Aged*” shall mean a person 65 years of age or older.

“*Applicant*” shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“*Blind*” shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

“*Break in assistance*” for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

“*Central office*” shall mean the state administrative office of the department of human services.

“*Certification period*” for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

“*Client*” shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

“*CMAP-related medically needy*” shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

“*Community spouse*” shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Conditionally eligible*” shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

“*Coverage group*” shall mean a group of persons who meet certain common eligibility requirements.

“*Department*” shall mean the Iowa department of human services.

“*Disabled*” shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

“*FMAP-related medically needy*” shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

“*Health insurance*” shall mean protection which provides payment of benefits for covered sickness or injury.

“*Incurred medical expenses*” for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

“*Institutionalized person*” shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

“Institutionalized spouse” shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“Local office” shall mean the county office of the department of human services or the mental health institute or hospital school.

“Medically needy income level (MNIL)” shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

“Member” shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, “member” shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. “Member” may be used interchangeably with “recipient.” This definition does not apply to the phrase “household member.”

“Necessary medical and remedial services” for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

“Noncovered Medicaid services” for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

“Nursing facility services” shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

“Obligated medical expense” for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

“Ongoing eligibility” for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

“Pay and chase” shall mean that the state pays the total amount allowed under the agency’s payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

“Payee” refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

“Recertification” in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

“Recipient” shall mean a person who is receiving assistance including receiving assistance for another person.

“Responsible relative” for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

“Retroactive certification period” for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

“Retroactive period” shall mean the three calendar months immediately preceding the month in which an application is filed.

“Spenddown” shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

“SSI-related” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

“SSI-related medically needy” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

“Supply” shall mean the requested information is received by the department by the specified due date.

“Transfer of assets” shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include

establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

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

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[ARC 7935B, IAB 7/1/09, effective 9/1/09]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) Class settlement payments. Payments made from any fund established pursuant to a class settlement in the case of *Susan Walker v. Bayer Corporation, et al.*, 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) Other settlement payments. Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.28 to 75.49 Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

“Applicant” shall mean a person who is requesting assistance on the person’s own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“Application period” means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

“Assistance unit” includes any person whose income is considered when determining eligibility.

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

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

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

“Change in work expenses” means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

“Department” shall mean the Iowa department of human services.

“Dependent” means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

“Dependent child” or *“dependent children”* means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

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

“Initial two months” means the first two consecutive months for which eligibility is granted.

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

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

“*Needy specified relative*” means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

“*Nonrecurring lump sum unearned income*” means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers’ compensation.

“*Parent*” means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

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

“*Recipient*” means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

“*Schedule of needs*” means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

“*Stepparent*” means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent by ceremonial or common-law marriage.

“*Unborn child*” shall include an unborn child during the entire term of the pregnancy.

“*Uniformed service*” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Eligibility for the family medical assistance program (FMAP) and FMAP-related programs shall be reinstated without a new application when all necessary information is provided at least three working days before the effective date of cancellation and eligibility can be reestablished, except as provided in the transitional Medicaid program in accordance with subparagraph 75.1(31)“j”(2).

75.51(1) Exception to time limit. Assistance may be reinstated without a new application when all necessary information is provided after the third working day but before the effective date of cancellation and eligibility can be reestablished before the effective date of cancellation.

75.51(2) Cancellation for failure to return review form. When all eligibility factors are met, assistance shall be reinstated when a completed Review/Recertification Eligibility Document (RRED), Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), is received by the department within ten days of the date a cancellation notice is sent to the member because the form was incomplete or not returned.

441—75.52(249A) Continuing eligibility.

75.52(1) Reviews. Eligibility factors shall be reviewed at least annually for the FMAP-related programs.

a. Reviews shall be conducted using information contained in and verification supplied with Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), Review/Recertification Eligibility Document.

b. Family medical assistance-related medically needy recertifications shall be conducted using information contained in and verification supplied with Form 470-3118 or 470-3118(S), Medicaid Review.

75.52(2) Additional reviews. A redetermination of specific eligibility factors shall be made when:

a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

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

75.52(3) Forms. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), Review/Recertification Eligibility Document (RRED), with the following exceptions:

a. When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the semiannual or annual review.

b. Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

75.52(4) Client responsibilities. For the purposes of this subrule, "clients" shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete Form 470-2881, 470-2881(M), 470-4083(Spanish), or 470-4083(M), Review/Recertification Eligibility Document (RRED), or Form 470-3118 or 470-3118(S), Medicaid Review, when requested by the department in accordance with these rules. The department shall supply the form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the form is issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the review month.

(2) When the form is not issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date it is mailed by the department.

(3) If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1) "f" and 75.57(2) "l."

(4) A copy of a form received by fax or electronically shall have the same effect as an original form.

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

(1) Income from all sources, including any change in care expenses.

(2) Resources.

(3) Members of the household.

(4) School attendance.

(5) A stepparent recovering from an incapacity.

(6) Change of mailing or living address.

(7) Payment of child support.

(8) Receipt of a social security number.

(9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8) "b."

(10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

(1) Members of the household.

(2) Change of mailing or living address.

(3) Sources of income.

- (4) Health insurance premiums or coverage.
- e.* Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.
- f.* A report shall be considered timely when made within ten days from the date:
- (1) A person enters or leaves the household.
 - (2) The mailing or living address changes.
 - (3) A source of income changes.
 - (4) A health insurance premium or coverage change is effective.
 - (5) Of any change in income.
 - (6) Of any change in care expenses.
- g.* When a change is not reported as required in paragraphs 75.52(4) “c” through “e,” any excess Medicaid paid shall be subject to recovery.
- h.* When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4) “c” through “e.”
- 75.52(5) Effective date.** After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.
- a.* When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).
- b.* Rescinded IAB 10/4/00, effective 10/1/00.
- c.* When an individual included in the eligible group becomes ineligible, that individual’s Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).
[ARC 8260B, IAB 11/4/09, effective 1/1/10]

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) Definition of resident. A resident of Iowa is one:

- a.* Who is living in Iowa voluntarily with the intention of making that person’s home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or
- b.* Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

75.53(2) Retention of residence. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) Suitability of home. The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) Absence from the home.

- a.* An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph “b.”
- (1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year from the date of entry into the medical institution will result in the individual's needs being removed from the eligible group.

(2) An individual is out of the home to secure education or training as defined for children in paragraph 75.54(1) "b" as long as the child remains a dependent and as defined for adults in 441—subrule 93.114(1), first sentence.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

441—75.54(249A) Eligibility factors specific to child.

75.54(1) Age. Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

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

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

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

75.54(2) Residing with a relative. The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

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

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

75.54(3) Deprivation of parental care and support. Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) Continuous eligibility for children. Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.**75.55(1) Specified relationship.**

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

Father or adoptive father.

Mother or adoptive mother.

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

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

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

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

75.55(2) Liability of relatives. All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts shall be made by the child support recovery unit.

b. When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

441—75.56(249A) Resources.

75.56(1) Limitation. Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1) "n" or "o," the net market value of any other real property shall be considered with personal property.

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

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

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of \$3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of \$3,000 shall be counted toward the resource limit in paragraph 75.56(1)“*e.*” When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

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

e. A reserve of other property, real or personal, not to exceed \$2,000 for applicant assistance units and \$5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the \$5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9)“*c*”reserved for the current or future month’s income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

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

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

j. Settlements for payment of medical expenses.

k. Life estates.

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

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

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

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

o. Nonhomestead property that produces income consistent with the property’s fair market value.
75.56(2) Persons considered.

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

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

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

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine

the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

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

75.56(3) Homestead defined. The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) Liquidation. When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

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

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

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1) "d" and 75.57(7) "ag." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) Net market value defined. Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) Availability.

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

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

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

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

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

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

75.56(7) Damage judgments and insurance settlements.

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

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

75.56(8) Conservatorships.

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

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

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1) “*e*” and 75.24(2) “*b*.”

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month’s needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3). The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3). Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1) “*e*,” 75.57(6) “*u*,” and 75.57(7) “*o*.” Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided. The department shall return all verification to the applicant or member.

75.57(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income, from investment and nonrecurring lump sum payments, shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

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

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

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

d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

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

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

75.57(2) Earned income. Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

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

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)“*b*” and self-supporting parents on underage parent cases as described at paragraph 75.57(8)“*c*” shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed \$175 per month, or \$200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual’s employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) The expense shall be verified by a receipt or a statement from the provider of care and shall be allowed when paid to any person except a parent or legal guardian of the child or another member of the eligible group, or to any person whose needs are met by diversion of income from any person in the eligible group.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)“*a*” and “*b*” and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)“*a*”(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

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

e. A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person’s own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) \$41 plus an amount equivalent to the monthly maximum food stamp allotment in the food stamp program for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or \$41 for a roomer, or an amount equivalent to the monthly maximum food stamp allotment in the food stamp program for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2) "j."

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

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

l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) Shared living arrangements. When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic

needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

75.57(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8) "b."

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

75.57(5) *Income of unmarried specified relatives under the age of 19.*

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8) "c."

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

b. The value of the coupon allotment in the food stamp program.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Subsidized guardianship program payments.

t. Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.

u. The first \$50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed \$50 per month per eligible group.

v. Bona fide loans. Evidence of a bona fide loan may include any of the following:

(1) The loan is obtained from an institution or person engaged in the business of making loans.

(2) There is a written agreement to repay the money within a specified time.

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month

following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2) "a," "b," and "c" shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) Exempt as income. The following are exempt as income.

- a. Reimbursements from a third party.
- b. Reimbursement from the employer for a job-related expense.
- c. The following nonrecurring lump sum payments:
 - (1) Income tax refund.
 - (2) Retroactive supplemental security income benefits.
 - (3) Settlements for the payment of medical expenses.
 - (4) Refunds of security deposits on rental property or utilities.
 - (5) That part of a lump sum received and expended for funeral and burial expenses.
 - (6) That part of a lump sum both received and expended for the repair or replacement of resources.
- d. Payments received by the family for providing foster care when the family is operating a licensed foster home.
- e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.

When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.
- f. Federal or state earned income tax credit.
- g. Supplementation from county funds, providing:
 - (1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or
 - (2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.
- h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.
- i. A retroactive corrective family investment program (FIP) payment.
- j. The training allowance issued by the division of vocational rehabilitation, department of education.
- k. Payments from the PROMISE JOBS program.
- l. The training allowance issued by the department for the blind.
- m. Payments from passengers in a car pool.
- n. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.
- o. Rescinded IAB 10/4/00, effective 10/1/00.
- p. Rescinded IAB 10/4/00, effective 10/1/00.
- q. Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.
- r. Rescinded IAB 10/4/00, effective 10/1/00.
- s. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.
- t. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

u. Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1) “*b*”(1) and (2). The exemption applies through the entire month of the person’s twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

v. Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8) “*c*” effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

w. Incentive payments received from participation in the adolescent pregnancy prevention programs.

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

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

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3) “*b*” shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than \$1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the \$1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than \$1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4) "b" and 75.57(1) "d."

ah. All census earnings received by temporary workers from the Bureau of the Census.

ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases. A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2) "a," "b," and "c," and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

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

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

(2) The stepparent's monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent's ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2) "b"(1) through (5).

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

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

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8) "b"(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8) "b"(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9) "a"(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5)

shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1)“f.”

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent’s dependents living in the home who are not eligible for FMAP-related Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent’s dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent’s own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)“b”(1) through (7). Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the self-supporting parent’s ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)“b”(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)“b”(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)“b”(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse’s ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) Budgeting process.

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group during the 30 days before the application date to project future income. EXCEPTION: If the applicant provides verification that the 30-day period specified above is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified at paragraph 75.57(2)“c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)“c” shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

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

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4)“d” and “e” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4)“c” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)“i.”

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8)“b” and “c,” shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers’ compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly

amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or
2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2) “*b*,” shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual’s needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

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

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

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

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the

same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

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

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

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

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

75.57(10) *Restriction on diversion of income.* Rescinded IAB 7/11/01, effective 9/1/01.

75.57(11) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

441—75.58(249A) Need standards.

75.58(1) *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

- (1) All dependent children who are siblings of whole or half blood or adoptive.
- (2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

- (1) The needy specified relative who assumes the role of parent.
- (2) The needy specified relative who acts as caretaker when the parent is in the home but is unable

to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

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

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

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

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

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

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

75.58(2) Schedule of needs. The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
 - (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.
 - (3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.
 - (4) Food: Including school lunches.
 - (5) Clothing: Including layette, laundry, dry cleaning.
 - (6) Personal care and supplies: Including regular school supplies.
 - (7) Medicine chest items.
 - (8) Communications: Telephone, newspapers, magazines.
 - (9) Transportation: Including bus fares.
- b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) Exclusions from the eligible group. In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

- a. Siblings (of whole or half blood, or adoptive) of eligible children.
- b. Self-supporting parents of minor unmarried parents.
- c. Stepparents of eligible children.

d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) Needs, income, and resource exclusions. The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

75.59(3) Medicaid entitlement. Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

75.59(4) Situations where parent's needs are excluded. In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2) "a," "b," and "c."

75.59(5) Situations where child's needs, income, and resources are excluded. In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) Pending SSI approval. When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

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CHAPTER 76
APPLICATION AND INVESTIGATION

[Ch 76, 1973 IDR, renumbered as Ch 911]

[Prior to 7/1/83, Social Services[770] Ch 76]

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

441—76.1(249A) Application. Each person wishing to do so shall have the opportunity to apply for assistance without delay.

76.1(1) Application forms. The applicant shall immediately be given an application form to complete. When the applicant requests that the form be mailed, the department shall send the necessary form in the next outgoing mail.

a. An application for family medical assistance-related Medicaid programs shall be submitted on the Health and Financial Support Application, Form 470-0462 or Form 470-0466 (Spanish); the Health Services Application, Form 470-2927 or Form 470-2927(S); the HAWK-I Application, Comm. 156; or the HAWK-I Electronic Application Summary and Signature Page, Form 470-4016.

b. An application for SSI-related Medicaid shall be submitted on the Health Services Application, Form 470-2927 or Form 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466 (Spanish).

c. A person who is a recipient of supplemental security income (SSI) benefits shall not be required to complete a separate Medicaid application. If the department does not have all information necessary to establish that an SSI recipient meets all Medicaid eligibility requirements, the SSI recipient may be required to complete Form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information, and may be required to attend an interview to clarify information on this form.

d. An application for Medicaid for persons in foster care shall be submitted on Form 470-2927 or Form 470-2927(S), Health Services Application.

e. The department shall initiate a medical assistance application for a person whose application data is received from the federal Social Security Administration pursuant to 42 U.S.C. 1320b-14(c)(3).

(1) The Social Security Administration transmits data from Form SSA 1020B-OCR-SM, Application for Extra Help with Medicare Prescription Drug Plan Costs, to the department. The date that the Social Security Administration transmits its application data to the department shall be treated as the date of application for medical assistance.

(2) The department shall mail Form 470-4846, Medicare Savings Program and Food Assistance Application, to the person whose data was transmitted to gather the rest of the information needed to determine eligibility.

f. An application for presumptive eligibility for children shall be submitted on Form 470-4855 or 470-4855(S), Application: Presumptive Health Care Coverage for Children.

76.1(2) Place of filing. An application may be filed over the Internet or in any local office of the department or in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided. The hospital, health center, or facility shall forward the application to the department office responsible for completing the eligibility determination.

a. The Health Services Application, Form 470-2927 or Form 470-2927(S), may also be filed at the office of a qualified provider of presumptive Medicaid eligibility, a WIC office, a maternal health clinic, or a well child clinic. The office or clinic shall forward the application within two working days to the department office responsible for completing the eligibility determination.

b. The HAWK-I Application, Comm. 156, and the HAWK-I Electronic Application Summary and Signature Page, Form 470-4016, shall be filed with the third-party administrator as provided at 441—subrule 86.3(3). If it appears that the family is Medicaid-eligible, the third-party administrator shall forward the application to the department office responsible for determining Medicaid eligibility.

c. Those persons eligible for supplemental security income and those who would be eligible if living outside a medical institution may make application at the social security district office.

d. Women applying for medical assistance for family planning services under 441—subrule 75.1(41) or 441—Chapter 87 may also apply at any family planning agency as defined in rule 441—87.1(82GA,ch1187).

e. Persons applying for presumptive eligibility for children shall submit the application to a qualified entity as described under 441—subrule 75.1(44).

76.1(3) *Date and method of filing application.* An application is considered filed on the date an identifiable application, Form 470-0462, 470-0466 (Spanish), 470-2927, or 470-2927(S), is received and date-stamped in any place of filing specified in subrule 76.1(2).

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

b. An identifiable application, Form 470-2927 or 470-2927(S), which is filed to apply for FMAP or FMAP-related Medicaid at a WIC office, well child health clinic, maternal health clinic, or the office of a qualified provider for presumptive eligibility, shall be considered filed on the date received and date-stamped in one of these offices.

c. When a HAWK-I Application, Comm. 156, or HAWK-I Electronic Application Summary and Signature Page, Form 470-4016, is filed with the third-party administrator and subsequently referred to the department for a Medicaid eligibility determination, the date the application is received and date-stamped by the third-party administrator shall be the filing date.

d. A copy of an application received by fax or electronically at one of the places described above shall have the same effect as an original application.

e. An identifiable application is an application containing a legible name, address, and signature.

f. If an authorized representative signed the application on behalf of an applicant, the signature of the applicant or the responsible person must be on the application before the application can be approved. For FMAP and FMAP-related Medicaid, the signature of a parent or stepparent in the home must be on the application before the application can be approved.

76.1(4) *Applicant cooperation.* An applicant must cooperate with the department in the application process, which may include providing information or verification, attending a scheduled face-to-face interview, or signing documents. Failure to cooperate in the application process shall serve as a basis for rejection of an application.

76.1(5) *Application not required.* For family medical assistance-related programs, a new application is not required when an eligible person is added to an existing Medicaid eligible group or when a responsible relative becomes a member of a Medicaid eligible household. This person is considered to be included in the application that established the existing eligible group. However, in these instances the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date of entry or the date of report, whichever is later.

a. In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing paternity as described at 441—subrule 75.14(2) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by cooperating in obtaining medical support or establishing paternity.

b. In those instances where a person previously ineligible for Medicaid for failure to provide a social security number or proof of application for a social security number as described at rule 441—75.7(249A) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by providing a social security number or proof of application for a social security number.

c. In those instances where a person who has been voluntarily excluded from the eligible group in accordance with the provisions of rule 441—75.59(249A) is being added to the eligible group, the person shall be added effective the first of the month after the month in which the household requests that the person no longer be voluntarily excluded.

76.1(6) *Right to withdraw the application.* After an application has been filed, the applicant may withdraw the application at any time before the eligibility determination. The applicant may request that the application be withdrawn entirely or may, before the date the application is processed, request withdrawal for any month covered by the application process except as provided in the medically needy program in accordance with the provisions of 441—subrule 75.1(35). Requests for voluntary withdrawal

of the application shall be documented in the case record and a Notice of Decision, Form 470-0485, 470-0486, 470-0486(S), or 470-0490, shall be sent to the applicant confirming the request.

76.1(7) Responsible persons and authorized representatives.

a. Responsible person. If the applicant or member is unable to act on the applicant's or member's behalf because the applicant or member is incompetent, physically incapacitated, or deceased, a responsible person may act responsibly for the applicant or member. The responsible person shall be a family member, friend or other person who has knowledge of the applicant's or member's financial affairs and circumstances and a personal interest in the applicant's or member's welfare or a legal representative such as a conservator, guardian, executor or someone with power of attorney. The responsible person shall assume the applicant's or member's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an authorized representative as provided for in paragraph 76.1(7)"b" to represent the incompetent, physically incapacitated, or deceased applicant's or member's position and responsibilities during the application process or for ongoing eligibility. This authorization does not relieve the responsible person from assuming the incompetent, physically incapacitated, or deceased applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

(1) When there is no person as described above to act on the incompetent, physically incapacitated, or deceased applicant's or member's behalf, any individual or organization shall be allowed to act as the responsible person if the individual or organization conducts a diligent search and completes Form 470-3356, Inability to Find a Responsible Person, attesting to the inability to find a responsible person to act on behalf of the incompetent, physically incapacitated, or deceased applicant or member.

(2) The department may require verification of incompetence or death and the person's relationship to the applicant or member or the legal representative status.

(3) Copies of all department correspondence that would normally be provided to the applicant or member shall be provided to the responsible person and the representative if one has been authorized by the responsible person.

b. Authorized representative. A competent applicant or member or a responsible person as described in paragraph 76.1(7)"a" may authorize any individual or organization to represent the applicant or member in the application process or for ongoing eligibility.

(1) The authorization must be in writing, and signed and dated by the applicant or member or a responsible person before the department shall recognize the authorized representative.

(2) If the authorization indicates the time period or dates of medical services it is to cover, this stated period or dates of medical services shall be honored and may include subsequent applications, if necessary, that relate to the time period or dates of medical services indicated on the authorization. If the authorization does not indicate the time period or dates of medical services it is to cover, the authorization shall be valid for any applications filed within 120 days from the date the authorization was signed and all subsequent actions pertaining to the applications filed within the 120-day period.

(3) Anytime an applicant or member or a responsible person notifies the department in writing that the applicant or member or a responsible person no longer wants an authorized representative to act on the applicant's or member's behalf, the department shall no longer recognize that person or organization as the applicant's or member's representative.

(4) Designation of an authorized representative does not relieve a competent applicant or member or a responsible person as defined in 76.1(7)"a" of the primary responsibility to cooperate with the department in the determination of initial and ongoing eligibility, which may include providing information or verification, attending a scheduled face-to-face interview, or signing documents on which the authorized representative's signature would be inadequate.

(5) Copies of all departmental correspondence shall be provided to the client and the representative if one has been authorized by the applicant or member.

[ARC 7544B, IAB 2/11/09, effective 1/14/09; ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8439B, IAB 1/13/10, effective 3/1/10]

441—76.2(249A) Information and verification procedure. The decision with respect to eligibility shall be based primarily on information and verification furnished by the applicant or member. The

department shall notify the applicant or member in writing of additional information or verification that is required to establish eligibility. This notice shall be provided to the applicant or member personally, or by mail or facsimile. Applicants for whom eligibility is determined in whole or in part by the Social Security Administration (SSA) shall make application to the SSA within five working days of referral by the department. If, by the due date, the department does not receive the information or verification requested, an authorization to obtain the specific information or verification requested, or a request for an extension of the due date, the application shall be denied or assistance canceled. Signing a general authorization for release of information to the department does not meet this responsibility. Five working days shall be allowed for the applicant or member to supply and the department to receive the information or verification requested. The department may extend the deadline for a reasonable period of time when the applicant or member is making every effort but is unable to secure the required information or verification from a third party.

76.2(1) Interviews.

a. In processing applications for Medicaid for adults, the department may require a face-to-face or telephone interview upon written notice to the applicant. An interview is not required as a condition of eligibility for children.

b. For SSI-related Medicaid for adults, the department may require a face-to-face or telephone interview at the time of review.

c. The department shall notify the applicant in writing of the date, time and method of an interview. This notice shall be provided to the applicant personally or by mail or facsimile. Interviews that are rescheduled at the request of the applicant or authorized representative may be agreed upon verbally; a written confirmation is not required.

d. Failure of the applicant or member to attend a scheduled interview shall serve as a basis for rejection of an application or cancellation of assistance for adults. Failure of the applicant or member to attend an interview shall not serve as a basis for rejection of an application or cancellation of assistance for children.

76.2(2) Choice of coverage groups. An applicant who meets the eligibility requirements of more than one coverage group shall be given the choice of coverage group under which eligibility shall be determined.

76.2(3) Conditional benefits granted previous to October 1, 1993. When the client is receiving Medicaid under the conditional benefit policy of the SSI program pursuant to subrule 75.13(2), the client shall be required to describe the efforts that are made to sell the property on Form 470-2908, Description of Efforts to Sell Property, as requested by the department. The department shall request that the form be completed no more often than specified. For personal property being sold Form 470-2908 shall be completed no more often than every 30 days during the conditional benefit period. For real property being sold Form 470-2908 shall be completed beginning 35 days after conditional benefits are granted and no more often than every 60 days thereafter for nine months. If eligibility continues and the real property is not sold, the form shall be completed no more often than every 90 days.

76.2(4) Monthly reporting. Rescinded IAB 10/4/00, effective 10/1/00.

76.2(5) Reporting of changes. The applicant shall report any change as defined at 441—paragraph 75.52(4)“c” which occurs during the application process within five working days of the change. Changes that occur after approval for benefits shall be reported in accordance with paragraph 75.52(4)“c.”

[ARC 7740B, IAB 5/6/09, effective 6/10/09]

441—76.3(249A) Time limit for decision. Applications shall be investigated by the county department of human services. A determination of approval, conditional eligibility, or denial shall be made as soon as possible, but no later than 30 days following the date of filing the application unless one or more of the following conditions exist.

76.3(1) The application is being processed for eligibility under the medically needy coverage group as defined in 441—subrule 75.1(35). Applicants for medically needy shall receive a written notice of

approval, conditional eligibility, or denial as soon as possible, but no later than 45 days from the date the application was filed.

76.3(2) An application on the client's behalf for supplemental security income benefits is pending.

76.3(3) The application is pending due to completion of the requirement in 441—subrule 75.1(7).

76.3(4) The application is pending due to nonreceipt of information which is beyond the control of the applicant or department. It is the responsibility of the applicant to provide information to the department timely or to ask for an extension of time before the due date when additional time is needed to secure the information or verification.

76.3(5) The application is pending due to the disability determination process performed through the department.

76.3(6) Unusual circumstances exist which prevent a decision from being made within the specified time limit. Unusual circumstances include those situations where the department and the applicant have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit has expired or because of emergency situations such as fire, flood, or other conditions beyond the administrative control of the department.

441—76.4(249A) Notification of decision. The applicant or member will be notified in writing of the decision of the department regarding the applicant's or member's eligibility for Medicaid. If the applicant or member has been determined to be ineligible an explanation of the reason will be provided.

76.4(1) The member shall be given a timely and adequate written notice as provided in 441—subrule 7.7(1) when any decision or action is being taken by the department which adversely affects Medicaid eligibility or the amount of benefits.

76.4(2) Timely notice may be dispensed with but adequate notice shall be sent, no later than the effective date of action, when one or more of the conditions in 441—subrule 7.7(2) are met.

76.4(3) A written notice of decision shall be issued to the applicant the next working day following a determination of eligibility, conditional eligibility or ineligibility.

441—76.5(249A) Effective date.

76.5(1) *Three-month retroactive eligibility.*

a. Medical assistance benefits shall be available for all or any of the three months preceding the month in which the application is filed to persons who meet both of the following conditions:

(1) Have medical bills for covered services which were received during the three-month retroactive period.

(2) Would have been eligible for medical assistance benefits in the month services were received, if application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance benefits shall be made available when an application has been made on behalf of a deceased person if the conditions in paragraph "a" are met.

d. Persons receiving only supplemental security income benefits who wish to make application for Medicaid benefits for three months preceding the month of application shall complete Form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information.

e. Rescinded IAB 10/8/97, effective 12/1/97.

76.5(2) *First day of month.*

a. For persons approved for the family medical assistance-related programs, medical assistance benefits shall be effective on the first day of a month when eligibility was established anytime during the month.

b. For persons approved for supplemental security income, programs related to supplemental security income, or state supplementary assistance, medical assistance benefits shall be effective on the first day of a month when the individual was resource eligible as of the first moment of the first day of the month and met all other eligibility criteria at any time during the month.

c. When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first of the month in which the request was made.

d. When a request is made to add a person to the eligible group who previously was excluded, in accordance with the provisions of rule 441—75.59(249A), assistance shall be effective no earlier than the first of the month following the month in which the request was made.

76.5(3) Care prior to approval. No payment shall be made for medical care received prior to the effective date of approval.

441—76.6(249A) Certification for services. The department of human services shall issue a Medical Assistance Eligibility Card, Form 470-1911, to persons who have been determined to be eligible for the benefits provided under the Medicaid program unless one of the following situations exists:

76.6(1) Pregnant woman. The eligible person is a pregnant woman determined presumptively eligible in accordance with 441—subrule 75.1(30). These persons shall be issued a Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), by the provider.

76.6(2) IowaCare. A person who is enrolled in the IowaCare program shall be issued an IowaCare Medical Card, Form 470-4164.

76.6(3) Breast and cervical cancer. The eligible person is one who has been determined presumptively eligible for treatment of breast or cervical cancer or a precancerous condition in accordance with 441—paragraph 75.1(40)“c.” These persons shall be issued a Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), by the provider.

441—76.7(249A) Reinvestigation. Reinvestigation shall be made as often as circumstances indicate but in no instance shall the period of time between reinvestigations exceed 12 months.

76.7(1) The member shall supply, insofar as the member is able, additional information needed to establish eligibility within five working days from the date a written request is issued.

a. The member shall give written permission for the release of information when the member is unable to furnish information needed to establish eligibility.

b. Failure to supply the information or verification requested or refusal to request assistance and authorize the department to secure the requested information from other sources shall serve as a basis for cancellation of Medicaid. Signing a general authorization for release of information to the department does not meet this responsibility.

76.7(2) Eligibility criteria for persons whose eligibility for Medicaid is related to the family medical assistance program shall be reviewed according to policies found in rule 441—75.52(249A).

76.7(3) Persons whose eligibility for Medicaid is related to supplemental security income shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the reinvestigation process when requested to do so by the department.

76.7(4) The review for foster children or children in subsidized adoption or subsidized guardianship shall be completed on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review, according to the schedule of the family medical assistance program or supplemental security income program for disabled children, as applicable.

76.7(5) Women eligible for family planning services only shall complete Form 470-4071, Family Planning Medicaid Review, as part of the reinvestigation process. Form 470-4071 shall be issued at least 30 days before the end of the eligibility period. The woman must submit the completed review form before the end of the eligibility period to any location specified in paragraph 76.1(2)“d.” Women who fail to submit Form 470-4071 before the end of the eligibility period must reapply as directed in rule 441—76.1(249A).

[ARC 7740B, IAB 5/6/09, effective 6/10/09; ARC 8260B, IAB 11/4/09, effective 1/1/10]

441—76.8(249A) Investigation by quality control or the department of inspections and appeals. The client shall cooperate with the department when the client's case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical

assistance eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to do so shall serve as a basis for cancellation of assistance unless the Medicaid eligibility is determined by the Social Security Administration. Once a person's eligibility is denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

441—76.9(249A) Member lock-in. In order to promote high quality health care and to prevent harmful practices such as duplication of medical services, drug abuse or overuse, and possible drug interactions, recipients that utilize medical assistance services or items at a frequency or in an amount which is considered to be overuse of services as defined in subrule 76.9(7) may be restricted (locked-in) to receive services from a designated provider(s).

76.9(1) A lock-in or restriction shall be imposed for a minimum of 24 months with longer restrictions determined on an individual basis.

76.9(2) Provider selection. The member may select the provider(s) from which services will be received. The designated providers will be identified on the department's eligibility verification system (ELVS). Only prescriptions written or approved by the designated primary physician(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 76.9(3).

76.9(3) Payment will be made to provider(s) other than the designated (lock-in) provider(s) in the following instances:

a. Emergency care is required and the designated provider is not available. Emergency care is defined as care necessary to sustain life or prevent a condition which could cause physical disability.

b. The designated provider requires consultation with another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

c. The designated provider refers the recipient to another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

76.9(4) When the recipient fails to choose a provider(s) within 30 days of the request, the division of medical services will select the provider(s) based on previously utilized provider(s) and reasonable access for the recipient.

76.9(5) Recipients may change designated provider(s) when a change is warranted, such as when the recipient has moved, the provider no longer participates, or the provider refuses to see the patient. The worker for the recipient shall make the determination when the recipient has demonstrated that a change is warranted. Recipients may add additional providers to the original designation with approval of a health professional employed by the department for this purpose.

76.9(6) When lock-in is imposed on a recipient, timely and adequate notice shall be sent and an opportunity for a hearing given in accordance with 441—Chapter 7.

76.9(7) Overuse of services is defined as receipt of treatments, drugs, medical supplies or other Medicaid benefits from one or multiple providers of service in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient.

a. Determination of overuse of service shall be based on utilization data generated by the Surveillance and Utilization Review Subsystem of the Medicaid Management Information System. The system employs an exception reporting technique to identify the recipients most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average.

b. In addition to referrals from the Surveillance and Utilization Review Subsystem described in paragraph "a," referrals for utilization review shall be made when utilization data generated by the Medicaid Management Information System reflects that utilization of Medicaid recipient outpatient visits to physicians, advanced registered nurse practitioners, federally qualified health centers, rural health centers, other clinics, and emergency rooms exceeds 24 visits in any 12-month period. This utilization review shall not apply to Medicaid recipients who are enrolled in the MediPASS program or a health maintenance organization, or who are children under 21 years of age or residents of a nursing facility. For the purposes of this paragraph, the term "physician" does not include a psychiatrist.

c. An investigation process of Medicaid recipients determined in paragraphs “*a*” or “*b*” to be subject to a review of overutilization shall be conducted to determine if actual overutilization exists by verifying that the information reported by the computer system is valid and is also unusual based on professional medical judgment. Medical judgments shall be made by physicians, pharmacists, nurses and other health professionals either employed by, under contract to, or consultants for the department. These medical judgments shall be made by the health professionals on the basis of the body of knowledge each has acquired which meets the standards necessary for licensure or certification under the Iowa licensing statutes for the particular health discipline.

441—76.10(249A) Client responsibilities.

76.10(1) In coverage groups for which Medicaid eligibility is determined using income and resource policies related to the supplemental security income (SSI) program, clients shall timely report any changes in the following circumstances to the department. EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless they have a trust or are applying for or receiving home- and community-based waiver services.

- a.* Income from all sources.
- b.* Resources.
- c.* Membership of the household.
- d.* Recovery from disability.
- e.* Mailing or living address.
- f.* Health insurance premiums or coverage.
- g.* Medicare premiums or coverage.
- h.* Receipt of social security number.
- i.* Gross income of the community spouse or dependent children, parents or siblings of the institutionalized or community spouse living with a community spouse when a diversion is made to the community spouse or family. (See definitions in rule 441—75.25(249A).)
- j.* Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.
- k.* Residence in a medical institution for other than respite care for more than 15 days for home and community-based recipients.

76.10(2) In coverage groups for which Medicaid eligibility is determined using the family medical assistance program (FMAP) income and resource policies, clients shall report changes in accordance with 441—paragraphs 75.52(4) “*c*” through “*e*.” After assistance has been approved, changes occurring during the month are effective the first day of the next calendar month, provided the notification requirements at rule 441—76.4(249A) can be met.

76.10(3) A report shall be considered timely when received by the department:

- a.* Within ten days from the date the change is known to the member or authorized representative;
- or
- b.* Within five days from the date the change is known to the applicant or authorized representative.

76.10(4) When a change is not timely reported, any incorrect program expenditures shall be subject to recovery from the client.

76.10(5) Effective date of change. When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first day of the month in which the request was made unless otherwise specified at rule 441—76.5(249A). After assistance has been approved, changes reported during the month shall be effective the first day of the next calendar month, unless:

- a.* Timely notice of adverse action is required as specified in 441—subrule 7.7(1).
- b.* The certification has expired for persons receiving assistance under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).
- c.* Rescinded IAB 10/31/01, effective 1/1/02.

441—76.11(249A) Automatic redetermination. Whenever a Medicaid member no longer meets the eligibility requirements of the current coverage group, an automatic redetermination of eligibility for other Medicaid coverage groups shall be made. If the reason for ineligibility under the initial coverage group pertained to a condition of eligibility which applies to all coverage groups, such as failure to cooperate, no further redetermination shall be required. When the redetermination is completed, the member shall be notified of the decision in writing. The redetermination process shall be completed as follows:

76.11(1) Information received by the tenth of the month. If information that creates ineligibility under the current coverage group is received in the department by the tenth of the month, the redetermination process shall be completed by the end of that month unless the provisions of subrule 76.11(3) apply. The effective date of cancellation for the current coverage group shall be the first day of the month following the month the information is received.

76.11(2) Information received after the tenth of the month. If information that creates ineligibility under the current coverage group is received in the department after the tenth of the month, the redetermination process shall be completed by the end of the following month unless the provisions of subrule 76.11(3) apply. The effective date of cancellation for the current coverage group shall be the first day of the second month following the month the information is received.

76.11(3) Change in federal law. If a change in federal law affects the eligibility of large numbers of Medicaid members and the Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR Sec. 435.1003 as amended to January 13, 1997, the redetermination process shall be completed within the extended time limit and the effective date of cancellation for the current coverage group shall be no later than the first day of the month following the month in which the extended time limit expires.

76.11(4) Referral for HAWK-I program. When the only coverage group under which a child will qualify for Medicaid is the medically needy program with a spenddown as provided in 441—subrule 75.1(35), a referral to the Hawk-I program shall be made in accordance with 441—subrule 86.4(4) as part of the automatic redetermination process when it appears the child is otherwise eligible.

441—76.12(249A) Recovery.

76.12(1) Definitions.

“Administrative overpayment” means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

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

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make prompt revisions in medical payment following changes in policies requiring the changes as of a specific date.

“Client” means a current or former Medicaid member.

“Client error” means medical assistance incorrectly paid to or for the client because the client or client’s representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client’s income, resources, or other eligibility and benefit factors. 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.

76.12(2) Amount subject to recovery. The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client. The incorrect expenditures may result from client or agency error, or administrative overpayment.

76.12(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; and the reason for the incorrect expenditure.

76.12(4) Source of recovery. Recovery shall be made from the client or from parents of children under age 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

76.12(5) Repayment. The repayment of incorrectly expended Medicaid funds shall be made to the department.

However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an intermediate care facility for the mentally retarded, or mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department shall then recover the funds from the facility through a vendor adjustment.

76.12(6) Appeals. The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

76.12(7) Estate recovery. Medical assistance is subject to recovery from the estate of a Medicaid member, the estate of the member's surviving spouse, or the estate of the member's surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Social Security Act is not subject to recovery. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.5(2) "d." The classification of the debt is defined at Iowa Code section 633.425(7).

a. Definition of estate. For the purpose of this subrule, the "estate" of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes, but is not limited to, interest in jointly held property, retained life estates, and interests in trusts.

b. Debt due for member 55 years of age or older. Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994.

c. Debt due for member under the age of 55 in a medical institution.

(1) Receipt of medical assistance creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994, when the member:

1. Is under the age of 55; and

2. Is a resident of a nursing facility, an intermediate care facility for the mentally retarded, or a mental health institute; and

3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member's behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department shall presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due shall be established. The department shall notify the member of the presumption and the establishment of a debt due.

d. Request for a determination of ability to return home. Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member

or someone acting on the member's behalf may request that the department determine whether the member can or could reasonably have been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due shall be established until the department has made a decision on the member's ability to return home. If the determination is that there is or was no ability to return home, a debt due shall be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

e. Determination of ability to return home. When the member or someone acting on the member's behalf requests that the department determine if the member can or could have returned home, the determination shall be made by the Iowa Medicaid enterprise (IME) medical services unit.

(1) The IME medical services unit cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The IME medical services unit will notify the member or the member's representative and the department of the determination.

(2) If the determination is that the member can or could return home, the IME medical services unit shall establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member's representative asks for a reconsideration of the decision. The IME medical services unit will notify the member or the member's representative and the department of the reconsideration decision.

(4) If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 7. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

f. Debt collection.

(1) A nursing facility participating in the medical assistance program shall notify the IME revenue collection unit upon the death of a member residing in the facility by submitting Form 470-4331, Estate Recovery Program Nursing Home Referral.

(2) Upon receipt of Form 470-4331 or a report of a member's death through other means, the IME revenue collection unit will use Form 470-4339, Medical Assistance Debt Response, to request a statement of the member's assets from the member's personal representative. The representative shall sign and return Form 470-4339 indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist. EXCEPTION: The procedures in this subparagraph are not necessary when a probate estate has been opened, because probate procedures provide for an inventory, an accounting, and a final report of the estate.

g. Waiving the collection of the debt.

(1) The department shall waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. Reduction in the amount received from the member's estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member's death.

2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed \$10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, "income" and "resources" shall be defined as under the family medical assistance program.

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 633.425.

(3) The department shall determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

h. Amount waived. If collection of all or part of a debt is waived pursuant to paragraph “g,” to the extent that the person received the member’s estate, the amount waived shall be a debt due from the following:

- (1) The estate of the member’s surviving spouse, upon the death of the spouse.
- (2) The estate of the member’s surviving child who is blind or has a disability, upon the death of the child.
- (3) A surviving child who was under 21 years of age at the time of the member’s death, when the child reaches the age of 21.
- (4) The estate of a surviving child who was under 21 years of age at the time of the member’s death, if the child dies before reaching the age of 21.
- (5) The hardship waiver recipient, when the hardship no longer exists.
- (6) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

i. Impact of asset disregard on debt due. The estate of a member who is eligible for medical assistance under 441—subrule 75.5(5) shall not be subject to a claim for medical assistance paid on the member’s behalf up to the amount of the assets disregarded by asset disregard. Medical assistance paid on behalf of the member before these conditions shall be recovered from the estate, regardless of the member’s having purchased precertified or approved insurance.

j. Interest on debt. Interest shall accrue on a debt due under this subrule at the rate provided pursuant to Iowa Code section 535.3, beginning six months after the death of a Medicaid member, the surviving spouse, or the surviving child, or upon the child’s reaching the age of 21.

k. Reimbursement to county. If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code Supplement chapter 633C, the department shall reimburse the county on a proportionate basis.

[ARC 8343B, IAB 12/2/09, effective 1/6/10]

441—76.13(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state’s medical assistance state plan to determine (1) during what period the individual or the individual’s spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406), service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

76.13(1) Agreement required. The parties shall sign a data use agreement for the purposes of this rule. The agreement shall prescribe the manner in which information shall be provided to the department of human services and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department to match covered persons and identify third-party payers for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

76.13(2) Agreement form.

a. An agreement with the department shall be in substantially the same form as Form 470-4415, Agreement for Use of Data.

b. An agreement with the department's designee shall be in a form approved by the designee, which shall include privacy protections equivalent to those provided in Form 470-4415, Agreement for Use of Data.

76.13(3) Confidentiality of data. The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164.

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These rules are intended to implement Iowa Code sections 249.3, 249.4, 249A.4 and 249A.5.

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CHAPTER 81
NURSING FACILITIES

[Prior to 7/1/83 Social Services[770] Ch 81]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL POLICIES

441—81.1(249A) Definitions.

“*Abuse*” means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident’s physical or financial resources for one’s own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident’s life or health.

“*Advance directive*” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the resident is incapacitated.

“*Allowable costs*” means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm’s-length transaction, not to exceed the limitations set out in rules.

“*Beginning eligibility date*” means date of an individual’s admission to the facility or date of eligibility for medical assistance, whichever is the later date.

“*Case mix*” means a measure of the intensity of care and services used by similar residents in a facility.

“*Case-mix index*” means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

“*Civil penalty*” shall mean a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

“*Clinical experience*” means application or learned skills for direct resident care in a nursing facility.

“*Complete replacement*” means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

“*Cost normalization*” refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility’s per diem direct care component costs by the facility cost report period case-mix index.

“*Denial of critical care*” is a pattern of care in which the resident’s basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident’s serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

“*Department*” means the Iowa department of human services.

“*Department’s accounting firm*” means the firm on contract with the department to calculate nursing facility rates and provide other accounting services as requested.

“Direct care component” means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.

“Discharged resident” means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form 470-0042, Case Activity Report.

“Facility” means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

“Facility-based nurse aide training program” means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

“Facility cost report period case-mix index” is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

“Facilitywide average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

“Informed consent” means a resident’s agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

“Iowa Medicaid enterprise” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

“Laboratory experience” means practicing care-giving skills prior to contact in the clinical setting.

“Major renovations” means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds \$1.5 million. The \$1.5 million threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility’s financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the \$1.5 million threshold.

“Medicaid average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

“Minimum data set” or *“MDS”* refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility’s case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.6(16)“b,” for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.6(16)“c” and “e,” the excess payment allowance pursuant to paragraph 81.6(16)“d,” and the limits on reimbursement components pursuant to paragraph 81.6(16)“f.” MDS is described in subrule 81.13(9).

“Minimum food, shelter, clothing, supervision, physical or mental health care, or other care” means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

“Mistreatment” means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

“*New construction*” means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

“*Non-direct care component*” means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

“*Non-facility-based nurse aide training program*” means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

“*Nurse aide*” means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

“*Nurse aide registry*” means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

“*Nurse aide training and competency evaluation programs (NATCEP)*” are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

“*Patient-day-weighted median cost*” means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

“*Physical abuse*” means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

“*Physical injury*” means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage.

“*Poor performing facility (PPF)*” is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)“o.”

“*Primary instructor*” means a registered nurse responsible for teaching a state-approved nurse aide training course.

“*Program coordinator*” means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

“*Rate determination letter*” means the letter that is distributed quarterly by the Iowa Medicaid enterprise to each nursing facility notifying the facility of the facility’s Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

“*Skills performance record*” means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

“*Special population nursing facility*” refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 21 and under and require the skilled level of care.

2. Seventy percent of the residents served require the skilled level of care for neurological disorders.

“*Terminated from the Medicare or Medicaid program*” means a facility has lost the final appeal to which it is entitled.

“*Testing entity*” means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) “a,” and 249A.4.
[ARC 8445B, IAB 1/13/10, effective 12/11/09]

441—81.2 Rescinded, effective 11/21/79.

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

81.3(2) *Skilled nursing care level of need.* Rescinded IAB 7/11/01, effective 7/1/01.

81.3(3) *Screening.* All persons, regardless of the source of payment, seeking admission to a nursing facility shall also be screened by the IME medical services unit to determine if mental illness, mental retardation, or a related condition is present. The Iowa Medicaid program will cover the cost of this screening through the managed mental health contractor.

a. Final approval for initial admissions and continued stay of persons with mental illness, mental retardation, or a related condition is determined by the department of human services, division of mental health and disability services.

b. Nursing facility payment under the Iowa Medicaid program will be made for persons with mental illness, mental retardation, or a related condition only if it is determined by the division of mental health and disability services that the person’s treatment needs will be or are being met.

81.3(4) *Special care level of need.* Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) “a” and 249A.4.
[ARC 8445B, IAB 1/13/10, effective 12/11/09]

441—81.4(249A) Arrangements with residents.

81.4(1) *Resident care agreement.* Rescinded IAB 12/6/95, effective 2/1/96.

81.4(2) *Financial participation by resident.* A resident’s payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident’s client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.4(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident’s personal needs funds. (See subrule 81.13(5) “c.”) The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.6(249A) if the service cannot be obtained free of charge. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged

to the resident's personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department shall turn the funds over to the estate.

81.4(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.

441—81.5(249A) Discharge and transfer. (See subrules 81.13(2) "a" and 81.13(6) "c.")

81.5(1) *Notice.* When a public assistance recipient requests transfer or discharge, or another person requests this for the recipient, the administrator shall promptly notify the local office of the department. This shall be done in sufficient time to permit a social service worker to assist in the planning for the transfer or discharge.

81.5(2) *Case activity report.* A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.5(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.5(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

- c. Transfer orders.
- d. Nursing care plan.
- e. Physician's orders for care.
- f. The resident's personal records.
- g. When applicable, the personal needs fund record.
- h. Resident care review team assessment.

81.5(5) *Unused client participation.* When a resident leaves the facility during the month, any unused portion of the resident's client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.

441—81.6(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the department's accounting firm. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report to the department's accounting firm. Costs for patient care services shall be reported, divided into the subcategories of "Direct Patient Care Costs" and "Support Care Costs." Costs associated with food and dietary wages shall be included in the "Support Care Costs" subcategory. The financial and statistical report shall be submitted in an electronic format approved by the department. These reports shall be based on the following rules.

81.6(1) *Failure to maintain records.* Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in subrule 81.14(1).

81.6(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

81.6(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports to the department's accounting firm no later than three months after the close of the facility's established fiscal year. The Iowa Veterans Home shall submit the report to the department's accounting firm no later than three months after the close of each six-month period of the facility's established fiscal year. Failure to submit a report that meets the requirements of this rule within this time shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the department's accounting firm 60 days prior to the first date of the change.

81.6(4) *Payment at new rate.*

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below shall be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed \$94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.6(16). In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed \$94, times an inflation factor pursuant to subrule 81.6(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.6(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

(4) Aggregate payments to a nursing facility that is owned or operated by state or non-state government shall not exceed the facility's actual medical assistance program costs. Aggregate payments shall include amounts received from the Medicaid program, as well as receipts from patient and other third-party payments up to the Medicaid-allowed amount.

b. The Medicaid payment rate for special population nursing facilities shall be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities shall be updated annually without a quarterly adjustment.

81.6(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.6(6) *Census of public assistance recipients.* Census figures of public assistance recipients shall be obtained on the last day of the month ending the reporting period.

81.6(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.6(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.6(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.6(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services which include room, board, nursing services, and such services as supervision, feeding, incontinency, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.6(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs.
b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.
c. Bad debts are not an allowable expense.
d. Charity allowances and courtesy allowances are not an allowable expense.
e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal costs shall be prorated. Amounts which appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) Each facility which supplies transportation services as defined in Iowa Code section 601J.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 601J and 820—[09,A] chapter 2 of the department of transportation rules at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division shall, result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. It includes salary amounts paid for managerial, administrative, professional, and other services; amounts paid by the facility for the personal benefit of the proprietor or immediate relative;

the cost of assets and services which the proprietor or immediate relative receives from the facility; and deferred compensation.

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$3,296 per month plus \$35.16 per month per licensed bed capacity for each bed over 60, not to exceed \$4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.6(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

i. Management fees shall be limited on the same basis as the owner administrator's salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, 1983 edition, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 81.6(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

m. When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be based on the cost of the facility as identified in subrule 81.6(12), paragraph "a," plus the landlord's other expenses and a reasonable rate of return, not to exceed actual rent payments.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be no more than the amortized cost of the facility as identified in subrule 81.6(12), paragraph "a," plus the landlord's other expenses.

The landlord must be willing to provide documentation of these costs for rental arrangements.

n. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

o. Reasonable legal fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs following the decertification date.

p. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36, Division II, shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.6(21) "a."

81.6(12) Termination or change of owner.

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services 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 facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property 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 annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.6(13) Facility-requested rate adjustment. A facility may request a rate adjustment for a period of time no more than 18 months prior to the facility's rate effective date. The request for adjustment shall be made to the department's accounting firm.

81.6(14) Payment to new facility. The payment to a new facility shall be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.6(16) "c." After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component shall be adjusted by the facility's average Medicaid case-mix index pursuant to subrule 81.6(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility's first fiscal year, rates will be established in accordance with subrule 81.6(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year.

81.6(15) Payment to new owner. An existing facility with a new owner shall continue to be reimbursed using the previous owner's per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility's fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year. The facility shall notify the department's accounting firm of the date its fiscal year will end.

81.6(16) *Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate.* This subrule provides for the establishment of the modified price-based reimbursement rate. The first step in the rate calculation (paragraph “a”) determines the per diem direct care and non-direct care component costs. The second step (paragraph “b”) normalizes the per diem direct care component costs to remove cost variations associated with different levels of resident case mix. The third step (paragraph “c”) calculates the patient-day-weighted medians for the direct care and non-direct care components that are used in subsequent steps to establish rate component limits and excess payment allowances, if any. The fourth step (paragraph “d”) calculates the potential excess payment allowance. The fifth step (paragraph “e”) calculates the reimbursement rate, including any applicable capital cost per diem instant relief add-on described in paragraph “h,” that is further subjected to the rate component limits, including any applicable enhanced non-direct care rate component limit described in paragraph “h,” in step six (paragraph “f”). The seventh step (paragraph “g”) calculates the additional reimbursement based on accountability measures available beginning July 1, 2002.

a. Calculation of per diem cost. For purposes of calculating the non-state-owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs shall be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility’s per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001, July 1, 2003, July 1, 2004, July 1, 2005, and every second year thereafter, total reported allowable costs shall be adjusted using the inflation factor specified in subrule 81.6(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state-owned nursing facilities. Patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 90 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.6(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility’s per diem direct care costs by the facility’s cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.6(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median shall be established for both the non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state-owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.6(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated. The non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.6(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, shall be inflated to July 1, 2004, using the inflation factor specified in subrule 81.6(18).

d. Excess payment allowance.

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

The wage index factor applied July 1, 2001, through June 30, 2002, shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by the Centers for Medicare and Medicaid Services (CMS) each July. The geographic wage index adjustment shall not exceed \$8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16)“a.” In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.6(16)“b” times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16)“a.” In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph “d,” not to exceed the rate component limits determined by the methodology in paragraph “f.”

(1) For non-state-owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.6(19), plus the allowed excess payment allowance as determined by the methodology in paragraph “d.”

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph “d” and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph “h.”

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities shall be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.6(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs “d” and “e,” in no instance shall a rate component exceed the rate component limit defined as follows:

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in

441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph “d” times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

g. Pay-for-performance program. Additional reimbursement based on the nursing facility pay-for-performance program is available for non-state-owned facilities effective July 1, 2009, as provided in this paragraph. The pay-for-performance program provides additional reimbursement based upon a nursing facility’s achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of the state fiscal year (which is referred to in this paragraph as the “payment period”).

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident’s quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility’s achievement of multiple measures suggests that quality is an essential element in the facility’s delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, “direct care staff” is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. “Direct care staff” does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The Iowa Medicaid enterprise shall annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	For SFY 2010, 10/1/09 to 3/31/10; thereafter, July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification

Standard	Measurement Period	Value	Source
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.	Self-certification
Subcategory: Resident Satisfaction			
Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility. To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74% 7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

(6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
<p>Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations.</p> <p>If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to July 30, 1999, the facility shall be deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIA list of facilities meeting the standard
<p>Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points NOTE: A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIA list of facilities meeting the standard
Subcategory: Staffing			
<p>Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities.</p> <p>Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</p>	Facility fiscal year ending on or before December 31 of the payment period	5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation 10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit. The facility cost report period case-mix index shall be used to normalize nursing hours.
<p>Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.</p>	Facility fiscal year ending on or before December 31 of the payment period	5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55% 10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

Standard	Measurement Period	Value	Source
<p>Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.</p>	Calendar year ending December 31 of the payment period	5 points	Self-certification
<p>Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Subcategory: Nationally Reported Quality Measures			
<p>High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.</p>	12-month period ending September 30 of the payment period	<p>3 points if one-half to one standard deviation below the mean percentage of occurrences</p> <p>5 points if one standard deviation or more below the mean percentage of occurrences</p>	IME medical services unit report based on MDS data as reported by CMS
<p>Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.</p>	12-month period ending September 30 of the payment period	5 points	IME medical services unit report based on MDS data as reported by CMS

Standard	Measurement Period	Value	Source
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences 5 points if one standard deviation or more below the mean rate of occurrences	IME medical services unit report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures: The facility received at least 9 points from a combination of the measures listed in this subcategory.	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures 4 points if the facility receives 13 to 15 points in this subcategory	IME medical services unit report based on MDS data as reported by CMS

(7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIA list of facilities meeting the standard
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10% 4 points if Medicaid utilization is more than the median plus 20%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation 4 points if administrative costs percentage is less than the mean less one standard deviation	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data shall be drawn from Form 470-4828, Nursing Facility Medicaid Pay-for-Performance Self-Certification Report, submitted by the facility to IME. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to IME on Form 470-3891, Nursing Facility Opinion Survey Transmittal. The department shall request required source reports from the long-term care ombudsman and the department of inspections and appeals (DIA).

(10) Calculation of potential add-on payment. The number of points awarded shall be determined annually. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, subject to subparagraph (11):

<u>Score</u>	<u>Amount of Add-on Payment</u>
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

91-100 points 5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department shall request the department of inspections and appeals to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program shall be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the Iowa Medicaid enterprise shall:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.6(16) "g"; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, to report the use of any additional payments received for the nursing facility pay-for-performance program. Form 470-4829 is due to the department each year by May 1, beginning May 1, 2011. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department shall publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS) and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph “f.”

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph “f.” The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or
2. Development of home- and community-based waiver program services.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the facility’s most current financial and statistical report.

2. The facility meets the accountability measure criteria set forth in paragraph “g,” subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.
2. Services shall be provided on the direct site of the facility but not as a nursing facility service.
3. Services shall meet all federal and state requirements for Medicaid reimbursement.
4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility’s request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.
 2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).
 3. The period during which the add-on is requested (no more than two years).
 4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)
 5. A copy of the facility's most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.
 6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:
 - The estimated date the assets will be placed into service;
 - The total estimated depreciable value of the assets;
 - The estimated useful life of the assets based upon existing Medicaid and Medicare provisions;and
 - The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.
 7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.
 8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.
 9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.
- (7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:
1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.
 2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).
 3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.
- (8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:
1. The estimated completion date of the project.
 2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.
 3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).
 4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).
- (9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.
1. Total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of

calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 90 percent of the facility's estimated licensed capacity.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. A reconciliation between the estimated amounts and actual amounts shall be completed as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph "f."

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. For purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 90 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.

2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph "f." The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or

2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval shall be terminated

effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the Iowa Medicaid enterprise is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or

2. The facility does not make reasonable progress on any plans required for initial qualification; or

3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership shall continue under the new owner. Future reimbursement rates shall be determined pursuant to subrules 81.6(15) and 81.6(16).

81.6(17) Cost report documentation. All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility's fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility's fiscal year and the midpoint of the facility's fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

b. The starting and average hourly wage for each class of employees for the period of the report.

c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.6(18) Inflation factor. The department shall consider an inflation factor in determining the reimbursement rate. The inflation factor shall be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting shall be used to determine the inflation factor.

81.6(19) Case-mix index calculation.

a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.13(9). Standard Version 5.12b case-mix indices developed by CMS shall be the basis for calculating the average case-mix index and shall be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.6(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph "a." From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors shall be excluded from both average case-mix index calculations.

81.6(20) Medicare crossover claims for nursing facility services.

a. Definitions. For purposes of this subrule:

“*Crossover claim*” means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“*Medicaid-allowed amount*” means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

“*Medicaid reimbursement*” includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

“*Medicare payment amount*” means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Crossover claims. Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim will be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse nursing facilities for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph “*b*” and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph “*b*.” The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year or by a mutually acceptable schedule consistent with Medicare interim payment schedules.

d. Application of savings. Effective May 1, 2003, savings in Medicaid reimbursements attributable to the limits on nursing facility crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

81.6(21) Nursing facility quality assurance payments.

a. Quality assurance assessment pass-through. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance assessment pass-through shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through shall equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. Quality assurance assessment rate add-on. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance add-on of \$10 per patient day shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. Use of the pass-through and add-on. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers determined pursuant to 2009 Iowa Acts, Senate File 476.

(2) No less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to 2009 Iowa Acts, Senate File 476.

d. Effective date. Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, has been approved by the federal Centers for Medicare and Medicaid Services, none of the nursing facility rate-setting methodologies of this subrule shall become effective.

e. End date. If the federal Centers for Medicare and Medicaid Services determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule shall be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department shall:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.2(7), 249A.3(2) “c,” 249A.4, and 249A.16, chapter 249K, and 2009 Iowa Acts, Senate File 476.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8445B, IAB 1/13/10, effective 12/11/09]

441—81.7(249A) Continued review. The IME medical services unit shall review Medicaid members’ need of continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1).

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) “a.”

[ARC 8445B, IAB 1/13/10, effective 12/11/09]

441—81.8(249A) Quality of care review. Rescinded IAB 8/8/90, effective 10/1/90.

441—81.9(249A) Records.

81.9(1) Content. The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Records of all treatments, drugs, and services for which vendors’ payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident’s records which will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility’s most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

- g. Resident accounts.
- h. In-service education program records.
- i. Inspection reports pertaining to conformity with federal, state and local laws.
- j. Residents' personal records.
- k. Residents' medical records.
- l. Disaster preparedness reports.

81.9(2) Retention. Records identified in subrule 81.9(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.9(3) Change of owner. All records shall be retained within the facility upon change of ownership. This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

441—81.10(249A) Payment procedures.

81.10(1) Method of payment. Except for Medicaid accountability measures payment established in paragraph 81.6(16) "g," facilities shall be reimbursed under a modified price-based vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—81.6(249A). Effective July 1, 2002, the per diem rate shall include an amount for Medicaid accountability measures.

81.10(2) Authorization of payment. The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.10(3) Rescinded IAB 8/9/89, effective 10/1/89.

81.10(4) Periods authorized for payment.

a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.

e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for a visit shall be made at 42 percent of the nursing facility's rate. Payment for periods when residents are absent for hospitalization shall:

(1) Be made at 25 percent of the nursing facility's rate if the facility occupancy percentage is 95 percent or greater.

(2) Not be made if a facility's occupancy percentage is less than 95 percent.

(3) Be made at 42 percent of the nursing facility's rate for special population facilities.

g. Payment for residents determined by utilization review to require the residential level of care shall be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.

h. In-state nursing facilities serving Medicaid eligible patients who require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care as

determined by the peer review organization shall receive reimbursement for the care of these patients equal to the sum of the Medicare-certified hospital-based nursing facility direct care rate component limit plus the Medicare-certified hospital-based nursing facility non-direct care rate component limit factor pursuant to subparagraph 81.6(16)“f”(3). Facilities may continue to receive reimbursement at this rate for 30 days for any person weaned from a respirator who continues to reside in the facility and continues to meet skilled care criteria for those 30 days.

81.10(5) Supplementation. Only the amount of client participation may be billed to the resident for the cost of care and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

a. Supplies or services which the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs, medical supplies except for those listed in 441—paragraph 78.10(4)“b,” oxygen except under circumstances specified in 441—paragraph 78.10(2)“a,” and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician except for those specified in 441—78.1(2)“f.”

(5) Fees charged by medical professionals for services requested by the facility which do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for transportation to receive necessary medical services outside the facility. If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation.

c. The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services which meet the Medicare definition of medical necessity and are provided by vendors enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Therapy services.

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances which belong to the resident.

(5) Transportation to receive medical services outside the community subject to limitations specified in rule 441—78.13(249A).

(6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident who is not discharged from the facility spends over 18 days per year on visits (or longer under 81.10(4)“d”) or spends over 10 days per calendar month on a hospital stay. These supplementation payments shall not exceed the amount the department would pay to hold the bed under paragraph 81.10(4)“f.”

When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident's family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

81.10(6) *Payment for out-of-state care.* Rescinded IAB 9/5/90, effective 11/1/90.

81.10(7) *Comparative charges between private pay and Medicaid residents.* Rescinded IAB 2/6/02, effective 4/1/02.

[ARC 8344B, IAB 12/2/09, effective 12/1/09]

441—81.11(249A) Billing procedures.

81.11(1) *Claims.* Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims may be submitted electronically on software provided by the Iowa Medicaid enterprise or in writing on Form 470-0039.

a. When payment is made, the facility will receive a copy of Form 470-0039, Iowa Medicaid Long-Term Care Claim. The white copy of the form shall be signed and returned to the Iowa Medicaid enterprise as a claim for the next month. If the claim is submitted electronically, the facility will receive remittance advice of the claims paid.

b. When there has been a new admission or a discharge, the facility shall submit Form 470-0039 with the changes noted. When a change is necessary to adjust a previously paid claim, the facility shall submit Form 470-0040, Credit/Adjustment Request. Adjustments to electronically submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise. A request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

81.11(2) Reserved.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the local office of the department.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

441—81.13(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

81.13(1) *Procedures for establishing health care facilities as Medicaid facilities.* All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."

a. The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.

d. The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.

e. The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.

f. Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.

g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

k. Rescinded IAB 12/6/95, effective 2/1/96.

81.13(2) Medicaid provider agreements. The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

a. Rescinded IAB 2/3/93, effective 4/1/93.

b. Rescinded IAB 2/3/93, effective 4/1/93.

c. Rescinded IAB 2/3/93, effective 4/1/93.

d. Rescinded IAB 2/3/93, effective 4/1/93.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

f. Rescinded IAB 2/3/93, effective 4/1/93.

81.13(3) Distinct part requirement. All facilities which provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections and appeals.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work regularly therein. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

81.13(4) Civil rights. The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 in all areas of administration including admissions, records, services and physical facilities,

room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.13(5) Resident rights. The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident, including each of the following rights:

a. Exercise of rights.

(1) The resident has the right to exercise rights as a resident of the facility and as a citizen of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

(3) In the case of a resident adjudged incompetent under the laws of a state, by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

b. Notice of rights and services.

(1) The facility shall inform the resident, both orally and in writing in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility shall also provide the resident with the pamphlet "Medicaid for People in Nursing Homes and Other Care Facilities," Comm. 52. This notification shall be made prior to or upon admission and during the resident's stay. Receipt of this information, and any amendments to it, must be acknowledged in writing.

(2) The resident or the resident's legal representative has the right, upon an oral or written request, to access all records pertaining to the resident including clinical records within 24 hours (excluding weekends and holidays); and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days' advance notice to the facility.

(3) The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition.

(4) The resident has the right to refuse treatment and to refuse to participate in experimental research.

(5) The facility shall:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing facility services under the state plan and for which the resident may not be charged and of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in number "1" of this subparagraph.

(6) The facility shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility shall furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds.

2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

3. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

4. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

(8) The facility shall inform each resident of the name, specialty and way of contacting the physician responsible for the resident's care.

(9) The facility shall prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by these benefits.

(10) Notification of changes.

1. A facility shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

2. The facility shall also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

3. The facility shall record and periodically update the address and telephone number of the resident's legal representative or interested family member.

c. Protection of resident funds.

(1) The resident has the right to manage the resident's financial affairs and the facility may not require residents to deposit their personal funds with the facility.

(2) Management of personal funds. Upon written authorization of a resident, the facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified in subparagraphs (3) to (8) of this paragraph.

(3) Deposit of funds. The facility shall deposit any residents' personal funds in excess of \$50 in an interest-bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

The facility shall maintain a resident's personal funds that do not exceed \$50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.

(4) Accounting and records. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record shall be available through quarterly statements and on request to the resident or the resident's legal representative.

(5) Notice of certain balances. The facility shall notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person.

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) Assurance of financial security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the department of inspections and appeals and the department of human services, to ensure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

d. Free choice. The resident has the right to:

- (1) Choose a personal attending physician.
- (2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.
- (3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room.

(2) Except as provided in subparagraph (3) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

(3) The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution or record release is required by law.

f. Grievances. A resident has the right to:

- (1) Voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.
- (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

g. Examination of survey results. A resident has the right to:

- (1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability.
- (2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

h. Work. The resident has the right to:

- (1) Refuse to perform services for the facility.
- (2) Perform services for the facility if the resident chooses, when:
 1. The facility has documented the need or desire for work in the plan of care.
 2. The plan specifies the nature of the services performed and whether the services are voluntary or paid.
 3. Compensation for paid services is at or above prevailing rates.
 4. The resident agrees to the work arrangement described in the plan of care.
 5. Rescinded IAB 3/4/92, effective 4/8/92.

i. Mail. The resident has the right to privacy in written communications, including the right to send and receive mail promptly that is unopened and to have access to stationery, postage and writing implements at the resident's own expense.

j. Access and visitation rights.

(1) The resident has the right and the facility shall provide immediate access to any resident by the following:

1. Any representative of the secretary of the Department of Health and Human Services.
2. Any representative of the state.
3. The resident's individual physician.
4. The state long-term care ombudsman.
5. The agency responsible for the protection and advocacy system for developmentally disabled individuals.
6. The agency responsible for the protection and advocacy system for mentally ill individuals.
7. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time.
8. Others who are visiting with the consent of the resident subject to reasonable restrictions and to the resident's right to deny or withdraw consent at any time.

(2) The facility shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility shall allow representatives of the state ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

k. Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

l. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

m. Married couples. The resident has the right to share a room with the resident's spouse when married residents live in the same facility and both spouses consent to the arrangement.

n. Self-administration of drugs. An individual resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe.

o. Refusal of certain transfers.

(1) A person has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a skilled nursing facility from the distinct part of the institution that is a skilled nursing facility to a part of the institution that is not a skilled nursing facility or, if a resident of a nursing facility, from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a skilled nursing facility.

(2) A resident's exercise of the right to refuse transfer under subparagraph (1) does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

p. Advance directives.

(1) The nursing facility, at the time of admission, shall provide written information to each resident which explains the resident's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives and the nursing facility's policies regarding the implementation of these rights.

(2) The nursing facility shall document in the resident's medical record whether or not the resident has executed an advance directive.

(3) The nursing facility shall not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.

(4) The nursing facility shall ensure compliance with requirements of state law regarding advance directives.

(5) The nursing facility shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this paragraph shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any nursing facility which as a matter of conscience cannot implement an advance directive.

81.13(6) *Admission, transfer and discharge rights.*

a. Transfer and discharge.

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

3. The safety of persons in the facility is endangered.

4. The health of persons in the facility would otherwise be endangered.

5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

6. The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (2), numbers 1 through 5 above, the resident's clinical record shall be documented. The documentation shall be made by:

1. The resident's physician when transfer or discharge is necessary under subparagraph (2), number 1 or 2.

2. A physician when transfer or discharge is necessary under subparagraph (2), number 4.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

2. Record the reasons in the resident's clinical record.

3. Include in the notice the items in subparagraph (6) below.

(5) Timing of the notice. The notice of transfer or discharge shall be made by the facility at least 30 days before the resident is transferred or discharged except that notice shall be made as soon as practicable before transfer or discharge when:

1. The safety of persons in the facility would be endangered.

2. The health of persons in the facility would be endangered.

3. The resident's health improves sufficiently to allow a more immediate transfer or discharge.

4. An immediate transfer or discharge is required by the resident's urgent medical needs.

5. A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice shall include the following:

1. The reason for transfer or discharge.

2. The effective date of transfer or discharge.

3. The location to which the resident is transferred or discharged.

4. A statement that the resident has the right to appeal the action to the department.

5. The name, address, and telephone number of the state long-term care ombudsman.

6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals for residents with developmental disabilities.

7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals for residents who are mentally ill.

(7) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

b. Notice of bed-hold policy and readmission.

(1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility shall provide written information to the resident and a family member or legal representative that specifies:

1. The duration of the bed-hold policy under the state plan during which the resident is permitted to return and resume residence in the facility.

2. The facility's policies regarding bed-hold periods, which shall be consistent with subparagraph (3) below, permitting a resident to return.

(2) Notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility shall provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy described in subparagraph (1) above.

(3) Permitting resident to return to facility. A nursing facility shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

c. Equal access to quality care.

(1) A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all persons regardless of source of payment.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in 81.13(1) "a" (5).

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

d. Admissions policy.

(1) The facility shall not require residents or potential residents to:

1. Waive their rights to Medicare or Medicaid; or

2. Give oral or written assurance that they are not eligible for, or will not apply for, Medicare or Medicaid benefits. However, a continuing care retirement community or a life care community that is licensed, registered, certified, or the equivalent by the state, including a nursing facility that is part of such a community, may require in its contract for admission that before a resident applies for medical assistance, the resources that the resident declared for the purposes of admission must be spent on the resident's care, subject to 441—subrule 75.5(3), 441—paragraph 75.5(4) "a," and 441—subrule 75.16(2).

(2) The facility shall not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require a person who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However:

1. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services.

2. A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

(4) States or political subdivisions may apply stricter admission standards under state or local laws than are specified in these rules, to prohibit discrimination against persons entitled to Medicaid.

81.13(7) Resident behavior and facility practices.

a. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

b. Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

* (1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

*See Objection filed 8/25/92 published herein at end of 441—Chapter 81.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections and appeals) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of inspections and appeals) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.13(8) Quality of life. A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

a. Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.

b. Self-determination and participation. The resident has the right to:

(1) Choose activities, schedules, and health care consistent with the resident's interests, assessments and plans of care.

(2) Interact with members of the community both inside and outside the facility.

(3) Make choices about aspects of life in the facility that are significant to the resident.

c. Participation in resident and family groups.

(1) A resident has the right to organize and participate in resident groups in the facility.

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(3) The facility shall provide a resident or family group, if one exists, with private space.

(4) Staff or visitors may attend meetings at the group's invitation.

(5) The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(6) When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

d. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

e. Accommodation of needs. A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(2) Receive notice before the resident's room or roommate in the facility is changed.

f. Activities.

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program shall be directed by a qualified professional who meets one of the following criteria:

1. Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

2. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting.

3. Is a qualified occupational therapist or occupational therapy assistant.

4. Has completed a training course approved by the state.

g. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is a person who meets both of the following criteria:

1. A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling and psychology.

2. One year of supervised social work experience in a health care setting working directly with individuals.

h. Environment. The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

(3) Clean bed and bath linens that are in good condition.

(4) Private closet space in each resident room.

(5) Adequate and comfortable lighting levels in all areas.

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, shall maintain a temperature range of 71 to 81 degrees Fahrenheit.

(7) For the maintenance of comfortable sound levels.

81.13(9) Resident assessment. The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability.

a. Admission orders. At the time each resident is admitted, the facility shall have physician orders for the resident's immediate care.

b. Comprehensive assessments.

(1) The facility shall make a comprehensive assessment of a resident's needs which is based on the minimum data set (MDS) specified by the department of inspections and appeals, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. The comprehensive assessment shall include at least the following information:

1. Identification and demographic information.

2. Customary routine.

3. Cognitive patterns.

4. Communication.
 5. Vision.
 6. Mood and behavior patterns.
 7. Psychosocial well-being.
 8. Physical functioning and structural problems.
 9. Continence.
 10. Disease diagnoses and health conditions.
 11. Dental and nutritional status.
 12. Skin condition.
 13. Activity pursuit.
 14. Medications.
 15. Special treatments and procedures.
 16. Discharge potential.
 17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
 18. Documentation of participation in assessment.
 19. Additional specification relating to resident status as required in Section S of the MDS.
- (3) Frequency. Assessments shall be conducted:
1. Within 14 calendar days after admission or readmission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. "Readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.
 2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires either interdisciplinary review, revision of the care plan, or both.
 3. In no case less often than once every 12 months.
- (4) Review of assessments. The facility shall examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment.
- (5) Maintenance and use. A facility shall maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results to develop, review and revise the resident's comprehensive plan of care.
- (6) Coordination. The facility shall coordinate assessments with any state-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.
- (7) Automated data processing requirement.
1. Entering data. Within seven days after a facility completes a resident's assessment, a facility shall enter the following information for the resident into a computerized format that meets the specifications defined in numbered paragraphs "2" and "4" below.
 - Admission assessment.
 - Annual assessment updates.
 - Significant change in status assessments.
 - Quarterly review assessments.
 - A subset of items upon a resident's transfer, reentry, discharge, and death.
 - Background (face sheet) information, if there is no admission assessment.
 2. Transmitting data. Within seven days after a facility completes a resident's assessment, a facility shall be capable of transmitting to the state each resident's assessment information contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes edits that ensure accurate and consistent coding of the MDS data as defined by the Centers for Medicare and Medicaid Services (CMS) and the department of human services or the department of inspections and appeals.

3. Monthly transmittal requirements. On at least a monthly basis, a facility shall input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month, including the following:

- Admission assessment.
- Annual assessment.
- Significant correction of prior full assessment.
- Significant correction of prior quarterly assessment.
- Quarterly review.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

4. The facility must transmit MDS data in the ASCII format specified by CMS.

(8) Resident-identifiable information. A facility shall not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

c. Accuracy of assessments. The assessment shall accurately reflect the resident's status.

(1) Coordination. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals. Each assessment shall be conducted or coordinated by a registered nurse.

(2) Certification. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment. A registered nurse shall sign and certify that the assessment is completed.

(3) Penalty for falsification. An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

(4) Use of independent assessors. If the department of human services or the department of inspections and appeals determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subparagraph (3) above, the department of human services or the department of inspections and appeals may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department of human services or the department of inspections and appeals for a period specified by the agency.

d. Comprehensive care plans.

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan shall describe the following:

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under subrule 81.13(10).

2. Any services that would otherwise be required under subrule 81.13(10), but are not provided due to the resident's exercise of rights under subrule 81.13(5), including the right to refuse treatment under subrule 81.13(5), paragraph "b," subparagraph (4).

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident's family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

(3) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care.

e. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary that includes:

(1) A recapitulation of the resident's stay.

(2) A final summary of the resident's status to include items in paragraph "b," subparagraph (2) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

(3) A postdischarge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

f. Preadmission screening for mentally ill individuals and individuals with mental retardation.

(1) A nursing facility shall not admit a new resident with mental illness or mental retardation unless the division of mental health and disability services has approved the admission, based on an independent physical and mental health evaluation. This evaluation shall be reviewed by the IME medical services unit before admission to determine whether the individual requires the level of services provided by the facility because of the physical and mental condition of the individual. If the individual requires nursing facility level of services, the individual shall receive specialized services for mental illness or mental retardation.

(2) Definition. For purposes of this rule:

1. An individual is considered to have "mental illness" if the individual has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

2. An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition as described in 42 CFR 435.1009.

g. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.13(10) Quality of care. Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

a. Activities of daily living. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom; transfer and ambulate; toilet; eat, and to use speech, language or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities specified in subparagraph (1) above.

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

b. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

(1) In making appointments.

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

c. Pressure sores. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

d. Urinary incontinence. Based on the resident's comprehensive assessment, the facility shall ensure that:

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

e. Range of motion. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

f. Mental and psychosocial functioning. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

g. Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable.

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers and to restore, if possible, normal eating skills.

h. Accidents. The facility shall ensure that:

(1) The resident environment remains as free of accident hazards as is possible.

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

i. Nutrition. Based on a resident's comprehensive assessment, the facility shall ensure that a resident:

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

(2) Receives a therapeutic diet when there is a nutritional problem.

j. Hydration. The facility shall provide each resident with sufficient fluid intake to maintain proper hydration and health.

k. Special needs. The facility shall ensure that residents receive proper treatment and care for the following special services:

(1) Injections.

(2) Parenteral and enteral fluids.

(3) Colostomy, ureterostomy or ileostomy care.

(4) Tracheostomy care.

(5) Tracheal suctioning.

(6) Respiratory care.

(7) Foot care.

(8) Prostheses.

l. Unnecessary drugs.

(1) General. Each resident's drug regimen shall be free from unnecessary drugs. An unnecessary drug is any drug when used:

1. In excessive dose including duplicate drug therapy; or
2. For excessive duration; or
3. Without adequate monitoring; or
4. Without adequate indications for its use; or
5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
6. Any combinations of the reasons above.

(2) Antipsychotic drugs. Based on a comprehensive assessment of a resident, the facility shall ensure that:

1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.
2. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

m. Medication errors. The facility shall ensure that:

- (1) It is free of significant medication error rates of 5 percent or greater.
- (2) Residents are free of any significant medication errors.

81.13(11) Nursing services. The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

a. Sufficient staff.

(1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

1. Except when waived under paragraph "c," licensed nurses.
2. Other nursing personnel.

(2) Except when waived under paragraph "c," the facility shall designate a licensed nurse to serve as a charge nurse on each tour of duty.

b. Registered nurse.

(1) Except when waived under paragraph "c," the facility shall use the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(2) Except when waived under paragraph "c," the facility shall designate a registered nurse to serve as the director of nursing on a full-time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

c. Nursing facilities. Waiver of requirement to provide licensed nurses on a 24-hour basis. A facility may request a waiver from either the requirement that a nursing facility provide a registered nurse for at least eight consecutive hours a day, seven days a week, as specified in paragraph "b," or the requirement that a nursing facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in paragraph "a," if the following conditions are met:

(1) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.

(2) The department of inspections and appeals determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.

(3) The department of inspections and appeals finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

(4) A waiver granted under the conditions listed in paragraph "c" is subject to annual department of inspections and appeals review.

(5) In granting or renewing a waiver, a facility may be required by the department of inspections and appeals to use other qualified, licensed personnel.

(6) The department of inspections and appeals shall provide notice of a waiver granted under this paragraph to the state long-term care ombudsman established under Section 307(a)(12) of the Older Americans Act of 1965 and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(7) The nursing facility that is granted a waiver under this paragraph shall notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

81.13(12) Dietary services. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

a. Staffing. The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is licensed by the state according to Iowa Code chapter 152A.

b. Sufficient staff. The facility shall employ sufficient support personnel competent to carry out the functions of the dietary service.

c. Menus and nutritional adequacy. Menus shall:

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(2) Be prepared in advance.

(3) Be followed.

d. Food. Each resident receives and the facility provides:

(1) Food prepared by methods that conserve nutritive value, flavor and appearances.

(2) Food that is palatable, attractive and at the proper temperature.

(3) Food prepared in a form designed to meet individual needs.

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

e. Therapeutic diets. Therapeutic diets shall be prescribed by the attending physician.

f. Frequency of meals.

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There shall be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in subparagraph (4) below.

(3) The facility shall offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

g. Assistive devices. The facility shall provide special eating equipment and utensils for residents who need them.

h. Sanitary conditions. The facility shall:

(1) Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(2) Store, prepare, distribute and serve food under sanitary conditions.

(3) Dispose of garbage and refuse properly.

81.13(13) Physician services. A physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

a. Physician supervision. The facility shall ensure that:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

b. Physician visits. The physician shall:

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph "c" below.

(2) Write, sign and date progress notes at each visit.

(3) Sign and date all orders.

c. Frequency of physician visits.

(1) The resident shall be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(3) Except as provided in paragraph "e," all required physician visits shall be made by the physician personally.

d. Availability of physicians for emergency care. The facility shall provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

e. Performance of physician tasks in nursing facilities. Any required physician task in a nursing facility (including tasks which the rules specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician except where prohibited by state law.

81.13(14) Specialized rehabilitative services.

a. Provision of services. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility shall:

(1) Provide the required services; or

(2) Obtain the required services from an outside provider of specialized rehabilitative services.

b. Qualifications. Specialized rehabilitative services shall be provided under the written order of a physician by qualified personnel.

81.13(15) Dental services. The facility shall assist residents in obtaining routine and 24-hour emergency dental care. The facility shall:

a. Provide or obtain from an outside resource the following dental services to meet the needs of each resident:

(1) Routine dental services to the extent covered under the state plan.

(2) Emergency dental services.

b. If necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office.

c. Promptly refer residents with lost or damaged dentures to a dentist.

81.13(16) Pharmacy services. The facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

a. Procedures. A facility shall provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

b. Service consultation. The facility shall employ or obtain the services of a licensed pharmacist who:

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

c. Drug regimen review.

(1) The drug regimen of each resident shall be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist shall report any irregularities to the attending physician and the director of nursing, and these reports shall be acted upon.

d. Labeling of drugs and biologicals. Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

e. Storage of drugs and biologicals.

(1) In accordance with state and federal laws, the facility shall store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

(2) The facility shall provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

f. Consultant pharmacists. When the facility does not employ a licensed pharmacist, it shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals. The formal arrangements with the licensed pharmacist shall include separate written contracts for pharmaceutical vendor services and consultant pharmacist services. The consultant's visits are scheduled to be of sufficient duration and at a time convenient to work with nursing staff on the resident care plan, consult with the administrator and others on developing and implementing policies and procedures, and planning in-service training and staff development for employees. The consultant shall provide monthly drug regimen review reports. The facility shall provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation shall be available for review in the facility.

81.13(17) Infection control. The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

a. Infection control program. The facility shall establish an infection control program under which it:

- (1) Investigates, controls and prevents infections in the facility.
- (2) Decides what procedures, such as isolation, should be applied to an individual resident.
- (3) Maintains a record of incidents and corrective actions related to infections.

b. Preventing spread of infection.

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility shall isolate the resident.

(2) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility shall require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

c. Linens. Personnel shall handle, store, process, and transport linens so as to prevent the spread of infection.

81.13(18) Physical environment. The facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

a. Life safety from fire. Except as provided in subparagraph (1) or (3) below, the facility shall meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

(1) A facility is considered to be in compliance with this requirement as long as the facility:

1. On November 26, 1982, complied with or without waivers with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the code; or

2. On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continues to remain in compliance with that edition of the Code.

(2) When Medicaid nursing facilities and Medicaid distinct part nursing facility providers request a waiver of Life Safety Code requirements in accordance with Subsection 1919(d)(2)(B)(i) of the Social Security Act, the department of inspections and appeals shall forward the requests to the Centers for Medicare and Medicaid Services Regional Office for review and approval.

(3) The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare and Medicaid Services finds that a fire and safety code imposed by state law adequately protects patients, residents and personnel in long-term care facilities.

b. Emergency power.

(1) An emergency electrical power system shall supply power adequate at least for lighting all entrances and exits, equipment to maintain the fire detection, alarm and extinguishing systems, and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used that have no nonelectrical backup, the facility shall provide emergency electrical power with an emergency generator, as defined in NFPA 99, Health Care Facilities, that is located on the premises.

c. Space and equipment. The facility shall:

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care.

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

d. Resident rooms. Resident rooms shall be designed and equipped for adequate nursing care, comfort and privacy of residents.

(1) Bedrooms shall:

1. Accommodate no more than four residents.

2. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

3. Have direct access to an exit corridor.

4. Be designed or equipped to ensure full visual privacy for each resident.

5. In facilities initially certified after March 31, 1992, except in private rooms, each bed shall have ceiling-suspended curtains, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains.

6. Have at least one window to the outside.

7. Have a floor at or above grade level.

(2) The facility shall provide each resident with:

1. A separate bed of proper size and height for the convenience of the resident.

2. A clean, comfortable mattress.

3. Bedding appropriate to the weather and climate.

4. Functional furniture appropriate to the resident's needs and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(3) The department of inspections and appeals may permit variations in requirements specified in paragraph "d," subparagraph (1), numbers 1 and 2 above relating to rooms in individual cases when the facility demonstrates in writing that the variations are required by the special needs of the residents and will not adversely affect residents' health and safety.

e. Toilet facilities. Each resident room shall be equipped with or located adjacent to toilet facilities unless a waiver is granted by the department of inspections and appeals. Additionally, each resident room shall be equipped with or located adjacent to bathing facilities.

f. Resident call system. The nurse's station shall be equipped to receive resident calls through a communication system from:

(1) Resident rooms.

(2) Toilet and bathing facilities.

g. Dining and resident activities. The facility shall provide one or more rooms designated for resident dining and activities. These rooms shall:

- (1) Be well lighted.
- (2) Be well ventilated, with nonsmoking areas identified.
- (3) Be adequately furnished.
- (4) Have sufficient space to accommodate all activities.

h. Other environmental conditions. The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility shall:

- (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.
- (2) Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.
- (3) Equip corridors with firmly secured handrails on each side.
- (4) Maintain an effective pest control program so that the facility is free of pests and rodents.

81.13(19) Administration. A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

a. Licensure. A facility shall be licensed under applicable state and federal law.

b. Compliance with federal, state and local laws and professional standards. The facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

c. Relationship to other Department of Health and Human Services (HHS) regulations. In addition to compliance with these rules, facilities shall meet the applicable provisions of other HHS regulations, including, but not limited to, those pertaining to nondiscrimination on the basis of race, color, or national origin, nondiscrimination on the basis of handicap, nondiscrimination on the basis of age, protection of human subjects of research, and fraud and abuse. Although these regulations are not in themselves considered requirements under these rules, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with federal funds.

d. Governing body.

- (1) The facility shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.
- (2) The governing body appoints the administrator who is:
 1. Licensed by the state.
 2. Responsible for management of the facility.

e. Required training of nurse aides.

- (1) Definitions.

“*Licensed health professional*” means a physician; physician assistant; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

“*Nurse aide*” means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis, unless:

1. That person is competent to provide nursing and nursing-related services.
2. That person has completed a training and competency evaluation program or a competency evaluation program approved by the department of inspections and appeals; or that person has been deemed or determined competent by the department of inspections and appeals.

(3) Nonpermanent employees. A facility shall not use on a temporary, per diem, leased, or any basis other than a permanent employee any person who does not meet the requirements in subparagraph (2).

(4) Competency. A facility shall not use any person who has worked less than four months as a nurse aide in that facility unless the person:

1. Is a permanent employee and is in a nurse aide training and competency evaluation program approved by the department of inspections and appeals;

2. Has demonstrated competence through satisfactory participation in a nurse aide training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals; or

3. Has been deemed or determined competent by the department of inspections and appeals.

(5) Registry verification. Before allowing a person to serve as a nurse aide, a facility shall receive registry verification that the person has met competency evaluation requirements unless:

1. The person is a permanent employee and is in a training and competency evaluation program approved by the department of inspections and appeals; or

2. The person can prove that the person has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals and has not yet been included in the registry. Facilities shall follow up to ensure that such a person actually becomes registered.

(6) Multistate registry verification. Before allowing a person to serve as a nurse aide, a facility shall seek information from every state registry the facility believes will include information on the person.

(7) Required retraining. If since October 1, 1990, there has been a continuous period of 24 consecutive months during none of which the person provided nursing or nursing-related services for monetary compensation, the person shall complete a new training and competency evaluation program or a new competency evaluation program.

(8) Regular in-service education. The facility shall complete a performance review of every nurse aide at least once every 12 months and shall provide regular in-service education based on the outcome of these reviews. The in-service training shall:

1. Be sufficient to ensure the continuing competencies of nurse aides, but shall be no less than 12 hours per year.

2. Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff.

3. For nurse aides providing services to persons with cognitive impairments, also address the care of the cognitively impaired.

f. Proficiency of nurse aides. The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

g. Staff qualifications.

(1) The facility shall employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation.

(2) Professional staff shall be licensed, certified or registered in accordance with applicable state laws.

h. Use of outside resources.

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in subparagraph (2) below.

(2) Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

i. Medical director.

(1) The facility shall designate a physician to serve as medical director.

(2) The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

j. Laboratory services.

(1) The facility shall provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of the services furnished by laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

2. If the facility provides blood bank and transfusion services, it shall meet the requirements for laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved or licensed to test specimens in the appropriate specialties or subspecialties of service in accordance with 42 CFR Part 493 as amended to October 1, 1990.

4. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services only from a laboratory that meets the requirements of 42 CFR Part 493 as amended to October 1, 1990, or from a physician's office.

(2) The facility shall:

1. Provide or obtain laboratory services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of clinical laboratory services.

k. Radiology and other diagnostic services.

(1) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation for hospitals.

2. If the facility does not provide its own diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(2) The facility shall:

1. Provide or obtain radiology and other diagnostic services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.

l. Clinical records.

(1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.

(2) Clinical records shall be retained for:

1. The period of time required by state law.

2. Five years from the date of discharge when there is no requirement in state law.

3. For a minor, three years after a resident reaches legal age under state law.

(3) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use.

(4) The facility shall keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

1. Transfer to another health care institution.

2. Law.

3. Third-party payment contract.

4. The resident.

(5) The clinical record shall contain:

1. Sufficient information to identify the resident.
2. A record of the resident's assessments.
3. The plan of care and services provided.
4. The results of any preadmission screening conducted by the state.
5. Progress notes.

m. Disaster and emergency preparedness.

(1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.

n. Transfer agreement.

(1) The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably ensures that:

1. Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.

2. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.

(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

o. Quality assessment and assurance.

(1) A facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff.

(2) The quality assessment and assurance committee:

1. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.

2. Develops and implements appropriate plans of action to correct identified quality deficiencies.

(3) The state or the Secretary of the Department of Health and Human Services may not require disclosure of the records of the committee except insofar as the disclosure is related to the compliance of the committee with the requirements of this paragraph.

(4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

p. Disclosure of ownership.

(1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104.

(2) The facility shall provide written notice to the department of inspections and appeals at the time of change, if a change occurs in:

1. Persons with an ownership or control interest.

2. The officers, directors, agents, or managing employees.

3. The corporation, association, or other company responsible for the management of the facility.

4. The facility's administrator or director of nursing.

(3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.
[ARC 8445B, IAB 1/13/10, effective 12/11/09]

441—81.14(249A) Audits.

81.14(1) *Audit of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit,

using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—81.6(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

a. When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the health facility shall be suspended and eventually canceled from the nursing facility program, or

b. When a health facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

81.14(2) *Audit 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 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 81.4(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation 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.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “*a.*” and 249A.4.

441—81.15(249A) Nurse aide training and testing programs. Rescinded IAB 12/9/92, effective 2/1/93.

441—81.16(249A) Nurse aide requirements and training and testing programs.

81.16(1) *Deemed meeting of requirements.* A nurse aide is deemed to satisfy the requirement of completing a training and competency evaluation approved by the department of inspections and appeals if the nurse aide successfully completed a training and competency evaluation program before July 1, 1989. The aide would have satisfied this requirement if:

a. At least 60 hours were substituted for 75 hours; and

b. The aide has made up at least the difference in the number of hours in the program the aide completed and 75 hours in supervised practical nurse aide training or in regular in-service nurse education; or

c. The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 hours' duration; or

d. The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989; or

e. The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections and appeals determines would have met the requirements for approval at the time it was offered.

81.16(2) *State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.*

a. The department of inspections and appeals shall, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of 81.13(19) "e" and 81.16(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections and appeals approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of 81.16(3).

2. A nurse aide competency evaluation program meets the requirements of 81.16(4).

(2) Except as provided by paragraph 81.16(2) "f," the department of inspections and appeals shall not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or

3. Has been assessed a civil money penalty of not less than \$5,000; or

4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

5. Pursuant to state action, was closed or had its residents transferred; or

6. Has been terminated from participation in the Medicaid or Medicare program; or

7. Has been denied payment under subrule 81.40(1) or 81.40(2).

(3) Rescinded IAB 10/7/98, effective 12/1/98.

c. Application process. Applications shall be submitted to the department of inspections and appeals before a new program begins and every two years thereafter on Form 427-0517, Application for Nurse Aide Training. The department of inspections and appeals shall, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections and appeals shall not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections and appeals and the department of inspections and appeals shall review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval.

(1) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in 81.16(2) "b"(2).

(2) The department of inspections and appeals may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the department of inspections and appeals determines that any of the applicable requirements for approval or registry, as set out in subrule 81.16(3) or 81.16(4), are not met.

(3) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the department of inspections and appeals.

(4) If the department of inspections and appeals withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started a training and competency evaluation program from which approval has been withdrawn shall be allowed to complete the course.

f. An exception to subparagraph 81.16(2) “*b*”(2) may be granted by the department of inspections and appeals (DIA) for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted Form 470-3494, Nurse Aide Education Program Waiver Request, to the DIA to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved nurse aide training and competency evaluation program (NATCEP).

(3) No other NATCEP program is offered within 30 minutes’ travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by DIA.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the DIA indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP which shall return the evaluations to DIA.

81.16(3) *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections and appeals to approve required nurse aide training and testing programs. Policies and procedures governing approval of the programs are set forth in these rules.

a. For a nurse aide training and competency evaluation program to be approved by the department of inspections and appeals, it shall, at a minimum:

(1) Consist of no less than 75 clock hours of training.

(2) Include at least the subjects specified in 81.16(3).

(3) Include at least 15 hours of laboratory experience, 30 hours of classroom instruction (the first 16 hours of which must occur before the nurse aide has resident contact) and 30 hours of supervised clinical training. Supervised clinical training means training in a setting in which the trainee demonstrates knowledge while performing tasks on a resident under the general supervision of a registered nurse or licensed practical nurse.

(4) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the instructor. It shall also ensure that students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse.

(5) Meet the following requirements for instructors who train nurse aides:

1. The training of nurse aides shall be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which shall be in the provision of long-term care facility services.

2. Instructors shall be registered nurses and shall have completed a course in teaching adults or have experience teaching adults or supervising nurse aides.

3. In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

4. Other personnel from the health professions may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.

5. The ratio of qualified trainers to students shall not exceed one instructor for every ten students in the clinical setting.

(6) Contain information regarding competency evaluation through written or oral and skills testing.

b. The curriculum of the nurse aide training program shall include:

(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:

1. Communication and interpersonal skills.

2. Infection control.

3. Safety and emergency procedures including the Heimlich maneuver.

4. Promoting residents' independence.

5. Respecting residents' rights.

(2) Basic nursing skills:

1. Taking and recording vital signs.

2. Measuring and recording height and weight.

3. Caring for the residents' environment.

4. Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor.

5. Caring for residents when death is imminent.

(3) Personal care skills, including, but not limited to:

1. Bathing.

2. Grooming, including mouth care.

3. Dressing.

4. Toileting.

5. Assisting with eating and hydration.

6. Proper feeding techniques.

7. Skin care.

8. Transfers, positioning, and turning.

(4) Mental health and social service needs:

1. Modifying aide's behavior in response to residents' behavior.

2. Awareness of developmental tasks associated with the aging process.

3. How to respond to resident behavior.

4. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity.

5. Using the resident's family as a source of emotional support.

(5) Care of cognitively impaired residents:

1. Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others).

2. Communicating with cognitively impaired residents.

3. Understanding the behavior of cognitively impaired residents.

4. Appropriate responses to the behavior of cognitively impaired residents.

5. Methods of reducing the effects of cognitive impairments.

(6) Basic restorative services:

1. Training the resident in self-care according to the resident's ability.
2. Use of assistive devices in transferring, ambulation, eating and dressing.
3. Maintenance of range of motion.
4. Proper turning and positioning in bed and chair.
5. Bowel and bladder training.
6. Care and use of prosthetic and orthotic devices.
- (7) Residents' rights:
 1. Providing privacy and maintenance of confidentiality.
 2. Promoting the residents' rights to make personal choices to accommodate their needs.
 3. Giving assistance in resolving grievances and disputes.
 4. Providing needed assistance in getting to and participating in resident and family groups and other activities.
 5. Maintaining care and security of residents' personal possessions.
 6. Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.
 7. Avoiding the need for restraints in accordance with current professional standards.
- c. Prohibition of charges.
 - (1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program may be charged for any portion of the program including any fees for textbooks or other required evaluation or course materials.
 - (2) If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:
 1. Add all costs incurred by the aides for the course, books, and tests.
 2. Divide the total arrived at in No. 1 above by 12 to prorate the costs over a one-year period and establish a monthly rate.
 3. The aide shall be reimbursed the monthly rate each month the aide works at the facility until one year from the time the aide completed the course.
- d. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.
- e. Records and reports. Nurse aide education programs approved by the department of inspections and appeals shall:
 - (1) Notify the department of inspections and appeals:
 1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.
 2. When a facility or other training entity will no longer be offering nurse aide training courses.
 3. Whenever the person coordinating the training program is hired or terminates employment.
 - (2) Keep a list of faculty members and their qualifications available for department review.
 - (3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.
 - (4) Complete a lesson plan for each unit which includes behavioral objectives, a topic outline and student activities and experiences.
 - (5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

81.16(4) Nurse aide competency evaluation. A competency evaluation program shall contain a written or oral portion and a skills demonstration portion.

a. Notification to person. The department of inspections and appeals shall advise in advance any person who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state's nurse aide registry.

b. Content of the competency evaluation program.

(1) Written or oral examinations. The competency evaluation shall:

1. Allow an aide to choose between a written and oral examination.

2. Address each of the course requirements listed in 81.16(3) "b."

3. Be developed from a pool of test questions, only a portion of which is used in any one examination.

4. Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.

5. If oral, be read from a prepared text in a neutral manner.

6. Be tested for reliability and validity using a nationally recognized standard as determined by the department of education.

7. Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.

(2) Demonstration of skills. The skills demonstration evaluation shall consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills shall include all of the personal care skills listed in 81.16(3) "b"(3).

c. Administration of the competency evaluation.

(1) The competency examination shall be administered and evaluated only by an entity approved by the department of inspections and appeals, which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.

(2) Charging nurse aides for competency testing is prohibited in accordance with 81.16(3) "c."

(3) The skills demonstration part of the evaluation shall be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide and shall be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

d. Facility proctoring of the competency evaluation.

(1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is prohibited from being a competency evaluation site.

(2) The department of inspections and appeals may permit the competency evaluation to be proctored by facility personnel if the department of inspections and appeals finds that the procedure adopted by the facility ensures that the competency evaluation program:

1. Is secure from tampering.

2. Is standardized and scored by a testing, educational, or other organization approved by the department of inspections and appeals.

3. Requires no scoring by facility personnel.

(3) The department of inspections and appeals shall retract the right to proctor nurse aide competency evaluations from facilities in which the department of inspections and appeals finds any evidence of impropriety, including evidence of tampering by facility staff.

e. Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

f. Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas which the person did not pass.
2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

g. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

h. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections and appeals. The department of inspections and appeals shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.16(5) Registry of nurse aides.

a. Establishment of registry. The department of inspections and appeals shall establish and maintain a registry of nurse aides that meets the following requirements. The registry:

(1) Shall include, at a minimum, the information required in 81.16(5)“c.”

(2) Shall be sufficiently accessible to meet the needs of the public and health care providers promptly.

(3) Shall provide that any response to an inquiry that includes a finding of abuse, neglect, mistreatment of a resident or misappropriation of property also include any statement made by the nurse aide which disputes the finding.

b. Registry operation.

(1) Only the department of inspections and appeals may place on the registry findings of abuse, neglect, mistreatment of a resident or misappropriation of property.

(2) The department of inspections and appeals shall determine which persons:

1. Have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program.

2. Have been deemed as meeting these requirements.

3. Do not qualify to remain on the registry because they have performed no nursing or nursing-related services for monetary compensation during a period of 24 consecutive months.

(3) The department of inspections and appeals shall not impose any charges related to registration on persons listed in the registry.

(4) The department of inspections and appeals shall provide information on the registry promptly.

c. Registry content.

(1) The registry shall contain at least the following information on each person who has successfully completed a nurse aide training and competency evaluation program or competency evaluation program which was approved by the department of inspections and appeals or who may function as a nurse aide because of having been deemed competent:

1. The person's full name.

2. Information necessary to identify each person.

3. The date the person became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation or by being deemed competent.

4. The following information on any finding by the department of inspections and appeals of abuse, neglect, mistreatment of residents or misappropriation of property by the person: documentation of the department of inspections and appeals' investigation, including the nature of the allegation and the evidence that led the department of inspections and appeals to conclude that the allegation was valid; the date of the hearing, if the person chose to have one, and its outcome; and a statement by the person disputing the allegation, if the person chooses to make one. This information must be included in the

registry within ten working days of the finding and shall remain in the registry permanently, unless the finding was made in error, the person was found not guilty in a court of law, or the department of inspections and appeals is notified of the person's death.

5. A record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment or misappropriation of resident property.

(2) The registry shall remove entries for persons who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months unless the person's registry entry includes documented findings or convictions by a court of law of abuse, neglect, mistreatment or misappropriation of property.

d. Disclosure of information. The department of inspections and appeals shall:

(1) Disclose all of the information listed in 81.16(5) "c"(1), (3), and (4) to all requesters and may disclose additional information it deems necessary.

(2) Promptly provide persons with all information contained in the registry about them when adverse findings are placed on the registry and upon request. Persons on the registry shall have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

e. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry. The telephone number of the registry is (515)281-4963. The address is Nurse Aide Registry, Lucas State Office Building, Des Moines, Iowa 50319-0083.

(1) Persons employed as nurse aides shall complete Form 427-0496, Nurse Aide Registry Application, within the first 30 days of employment. This form shall be submitted to the department of inspections and appeals. Form 427-0496 may be obtained by calling or writing the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed Form 427-0496 to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide's social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

81.16(6) Hearing. When there is an allegation of abuse against a nurse aide, the department of inspections and appeals shall investigate that allegation. When the investigation by the department of inspections and appeals makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections and appeals. The hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.16(7) Appeals. Adverse decisions made by the department of inspections and appeals in administering these rules may be appealed pursuant to department of inspections and appeals rules 481—Chapter 10.

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

441—81.17(249A) Termination procedures. Rescinded IAB 5/10/95, effective 7/1/95.

441—81.18(249A) Sanctions.

81.18(1) Penalty for falsification of a resident assessment. An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty of not less than \$100 or more than \$1,000 for each falsified assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not less than \$500 nor more than \$5,000 for each

falsified assessment. These fines shall be administratively assessed by the department of inspections and appeals.

a. Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections and appeals or the director's designee may consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

- (1) The number of assessments willingly and knowingly falsified.
- (2) The history of the individual relative to previous assessment falsifications.
- (3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.
- (4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.
- (5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

b. Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

c. Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections and appeals in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and department of inspections and appeals rules 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections and appeals may petition for judicial review in the manner provided by Iowa Code chapter 17A.

81.18(2) *Use of independent assessors.* If the department of inspections and appeals determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections and appeals may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

a. Criteria used to determine the need for independent assessors shall include:

- (1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.
- (2) The facility's response to the falsification of or causing resident assessments to be falsified.
- (3) The method used to prepare facility staff to do resident assessments.
- (4) The number of individuals involved in the falsification.
- (5) The number of falsified resident assessments.
- (6) The extent of harm to residents caused by the falsifications.

b. The department of inspections and appeals will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

c. The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections and appeals before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

d. Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

e. Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections and appeals for completing its own assessments.

(3) The department of inspections and appeals will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

f. Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections and appeals within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision which may be appealed to the director of the department of inspections and appeals pursuant to department of inspections and appeals rules 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

81.18(3) *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed \$2,000.

81.18(4) *Failure to meet requirements for participation.* Rescinded IAB 5/10/95, effective 7/1/95. This rule is intended to implement Iowa Code section 249A.4.

441—81.19(249A) Criteria related to the specific sanctions. Rescinded IAB 5/10/95, effective 7/1/95.

441—81.20(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

81.20(1) *Out-of-state providers.* Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state-operated nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“*f*”(1) plus the non-direct care rate limit pursuant to subparagraph 81.6(16)“*f*”(1), whichever is lower.

a. Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“*f*”(3) plus the non-direct care rate component limit pursuant to subparagraph 81.6(16)“*f*”(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

b. Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.6(16)“*e*”(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

81.20(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

81.20(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 75 percent of the rate paid to the facility by the Iowa Medicaid program.

81.20(4) Rescinded IAB 3/20/91, effective 3/1/91.

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

441—81.21(249A) Outpatient services. Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, House File 479, section 132, subsection 1, paragraph “i.”

441—81.22(249A) Rates for Medicaid eligibles.

81.22(1) Maximum client participation. A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to subrule 79.1(9) or rule 441—81.6(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

81.22(2) Beginning date of payment. When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident’s Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident’s client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning date of eligibility is given on the Facility Card, Form 470-0371. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

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

441—81.23(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

441—81.24 to 81.30 Reserved.

DIVISION II
ENFORCEMENT OF COMPLIANCE

PREAMBLE

These rules specify remedies that may be used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicaid program. These rules also provide for ensuring prompt compliance and specify that these remedies are in addition to any others available under state or federal law.

441—81.31(249A) Definitions.

“CMS” means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

“Deficiency” means a nursing facility’s failure to meet a participation requirement.

“Department” means the Iowa department of human services.

“Immediate jeopardy” means a situation in which immediate corrective action is necessary because the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

“*New admission*” means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor are they subject to the denial of payment.

“*Noncompliance*” means any deficiency that causes a facility to not be in substantial compliance.

“*Plan of correction*” means a plan developed by the facility and approved by the department of inspections and appeals which describes the actions the facility shall take to correct deficiencies and specifies the date by which those deficiencies shall be corrected.

“*Standard survey*” means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

“*Substandard quality of care*” means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

“*Substantial compliance*” means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

“*Temporary management*” means the temporary appointment by the department of inspections and appeals of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility’s operation.

441—81.32(249A) General provisions.

81.32(1) Purpose of remedies. The purpose of remedies is to ensure prompt compliance with program requirements.

81.32(2) Basis for imposition and duration of remedies. The department of inspections and appeals, as the state survey agency under contract with the department, determines the remedy to be applied for noncompliance with program requirements. When the department of inspections and appeals chooses to apply one or more remedies specified in rule 441—81.34(249A), the remedies are applied on the basis of noncompliance found during surveys conducted by the department of inspections and appeals.

81.32(3) Number of remedies. The department of inspections and appeals may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

81.32(4) Plan of correction requirement.

a. Except as specified in paragraph “*b*,” regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements shall submit a plan of correction for approval by the department of inspections and appeals.

b. A facility is not required to submit a plan of correction when the department of inspections and appeals determines the facility has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

81.32(5) Disagreement regarding remedies. If the department of inspections and appeals and CMS disagree on the decision to impose a remedy, the disagreement shall be resolved in accordance with rule 441—81.55(249A).

81.32(6) Notification requirements.

a. The department of inspections and appeals shall give the provider written notice of remedy, including the:

- (1) Nature of the noncompliance.
- (2) Which remedy is imposed.
- (3) Effective date of the remedy.
- (4) Right to appeal the determination leading to the remedy.

b. Except for civil money penalties and state monitoring imposed when there is immediate jeopardy, for all remedies specified in rule 441—81.34(249A) imposed when there is immediate jeopardy, the notice shall be given at least two calendar days before the effective date of the enforcement action.

c. Except for civil money penalties and state monitoring, notice shall be given at least 15 calendar days before the effective date of the enforcement action in situations where there is no immediate jeopardy.

d. The 2- and 15-day notice periods begin when the facility receives the notice, but in no event will the effective date of the enforcement action be later than 20 calendar days after the notice is sent.

e. For civil money penalties, the notices shall be given in accordance with rules 441—81.48(249A) and 441—81.51(249A).

f. For state monitoring imposed when there is immediate jeopardy, no prior notice is required.

81.32(7) Informal dispute resolution.

a. Opportunity to refute survey findings.

(1) For nonfederal surveys, the department of inspections and appeals (DIA) shall offer a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

(2) For a federal survey, the Centers for Medicare and Medicaid Services (CMS) offers a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

b. Delay of enforcement action.

(1) Failure of DIA or CMS, as appropriate, to complete informal dispute resolution timely cannot delay the effective date of any enforcement action against the facility.

(2) A facility may not seek a delay of any enforcement action against it on the grounds that informal dispute resolution has not been completed before the effective date of the enforcement action.

c. If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from the statement of deficiencies and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded.

d. Notification. DIA shall provide the facility with written notification of the informal dispute resolution process.

441—81.33(249A) Factors to be considered in selecting remedies.

81.33(1) Initial assessment. In order to select the appropriate remedy, if any, to apply to a facility with deficiencies, the department of inspections and appeals shall determine the seriousness of the deficiencies.

81.33(2) Determining seriousness of deficiencies. To determine the seriousness of the deficiency, the department of inspections and appeals shall consider at least the following factors:

a. Whether a facility's deficiencies constitute:

- (1) No actual harm with a potential for minimal harm.
- (2) No actual harm with a potential for more than minimal harm, but not immediate jeopardy.
- (3) Actual harm that is not immediate jeopardy.
- (4) Immediate jeopardy to resident health or safety.

b. Whether the deficiencies:

- (1) Are isolated.
- (2) Constitute a pattern.
- (3) Are widespread.

81.33(3) Other factors which may be considered in choosing a remedy within a remedy category. Following the initial assessment, the department of inspections and appeals may consider other factors, which may include, but are not limited to, the following:

a. The relationship of the one deficiency to other deficiencies resulting in noncompliance.

b. The facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

441—81.34(249A) Available remedies. In addition to the remedy of termination of the provider agreement, the following remedies are available:

1. Temporary management.
2. Denial of payment for all new admissions.
3. Civil money penalties.
4. State monitoring.
5. Closure of the facility in emergency situations or transfer of residents, or both.
6. Directed plan of correction.
7. Directed in-service training.

441—81.35(249A) Selection of remedies.

81.35(1) Categories of remedies. Remedies specified in rule 441—81.34(249A) are grouped into categories and applied to deficiencies according to the severity of noncompliance.

81.35(2) Application of remedies. After considering the factors specified in rule 441—81.33(249A), if the department of inspections and appeals applies remedies, as provided in paragraphs 81.35(3) "a," 81.35(4) "a," and 81.35(5) "a," for facility noncompliance, instead of, or in addition to, termination of the provider agreement, the department of inspections and appeals shall follow the criteria set forth in 81.35(3) "b," 81.35(4) "b," and 81.35(5) "b," as applicable.

81.35(3) Category 1.

a. Category 1 remedies include the following:

- (1) Directed plan of correction.
- (2) State monitoring.
- (3) Directed in-services training.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 1 when there:

- (1) Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 1 to any deficiency.

81.35(4) Category 2.

a. Category 2 remedies include the following:

- (1) Denial of payment for new admissions.
- (2) Civil money penalties of \$50 to \$3,000 per day.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 2 when there are:

- (1) Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) One or more deficiencies that constitute actual harm that is not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 2 to any deficiency.

81.35(5) Category 3.

a. Category 3 remedies include the following:

- (1) Temporary management.
- (2) Immediate termination.
- (3) Civil money penalties of \$3,050 to \$10,000 per day.

b. When there is one or more deficiencies that constitute immediate jeopardy to resident health or safety, one or both of the following remedies shall be applied:

- (1) Temporary management.
- (2) Termination of the provider agreement.

In addition the department of inspections and appeals may impose a civil money penalty of \$3,050 to \$10,000 per day.

c. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the department of inspections and appeals may impose temporary management, in addition to Category 2 remedies.

81.35(6) *Plan of correction.*

a. Except as specified in paragraph “b,” each facility that has a deficiency with regard to a requirement for long-term care facilities shall submit a plan of correction for approval by the department of inspections and appeals, regardless of:

- (1) Which remedies are applied.
- (2) The seriousness of the deficiencies.

b. When there are only isolated deficiencies that the department of inspections and appeals determines constitute no actual harm with a potential for minimal harm, the facility need not submit a plan of correction.

81.35(7) *Appeal of a determination of noncompliance.*

a. A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections and appeals within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

(1) A request for a hearing shall be made in writing to the department of inspections and appeals within 60 days from receipt of the notice.

(2) Hearings shall be conducted pursuant to department of inspections and appeals rules 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections and appeals as the final decision maker, with subject matter jurisdiction.

b. A facility may not appeal the choice of remedy, including the factors considered by the department of inspections and appeals in selecting the remedy.

c. A facility may not challenge the level of noncompliance found by the department of inspections and appeals, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections and appeals only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

d. Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

441—81.36(249A) Action when there is immediate jeopardy.

81.36(1) *Terminate agreement or appoint temporary manager.* If there is immediate jeopardy to resident health or safety, the department of inspections and appeals shall appoint a temporary manager to remove the immediate jeopardy or the provider agreement shall be terminated within 23 calendar days of the last date of the survey.

The rules for appointment of a temporary manager in an immediate jeopardy situation are as follows:

a. The department of inspections and appeals shall notify the facility that a temporary manager is being appointed.

b. If the facility fails to relinquish control to the temporary manager, the provider agreement shall be terminated within 23 calendar days of the last day of the survey if the immediate jeopardy is not removed. In these cases, state monitoring may be imposed pending termination.

c. If the facility relinquishes control to the temporary manager, the department of inspections and appeals shall notify the facility that, unless it removes the immediate jeopardy, its provider agreement shall be terminated within 23 calendar days of the last day of the survey.

d. The provider agreement shall be terminated within 23 calendar days of the last day of survey if the immediate jeopardy has not been removed.

81.36(2) Other remedies. The department of inspections and appeals may also impose other remedies, as appropriate.

81.36(3) Notification of CMS. In a nursing facility or dually participating facility, if the department of inspections and appeals finds that a facility's noncompliance poses immediate jeopardy to resident health or safety, the department of inspections and appeals shall notify CMS of the finding.

81.36(4) Transfer of residents. The department shall provide for the safe and orderly transfer of residents when the facility is terminated from participation.

81.36(5) Notification of physicians and state board. If the immediate jeopardy is also substandard quality of care, the department of inspections and appeals shall notify attending physicians and the Iowa board of nursing home administrators of the finding of substandard quality of care.

441—81.37(249A) Action when there is no immediate jeopardy.

81.37(1) Termination of agreement or limitation of participation. If a facility's deficiencies do not pose immediate jeopardy to residents' health or safety, and the facility is not in substantial compliance, the facility's provider agreement may be terminated or the facility may be allowed to continue to participate for no longer than six months from the last day of the survey if:

a. The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility's provider agreement;

b. The department of inspections and appeals has submitted a plan of correction approved by CMS; and

c. The facility agrees to repay payments received after the last day of the survey that first identified the deficiencies if corrective action is not taken in accordance with the approved plan of correction and posts bond acceptable to the department to guarantee the repayment.

81.37(2) Termination. If a facility does not meet the criteria for continuation of payment under subrule 81.37(1), the facility's provider agreement shall be terminated.

81.37(3) Denial of payment. Payment shall be denied for new admissions when the facility is not in substantial compliance three months after the last day of the survey.

81.37(4) Failure to comply. The provider agreement shall be terminated and all payments stopped to a facility for which participation was continued under subrule 81.37(1) if the facility is not in substantial compliance within six months of the last day of the survey.

441—81.38(249A) Action when there is repeated substandard quality of care.

81.38(1) General. If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies provided:

a. Payment for all new admissions shall be denied, as specified in rule 441—81.40(249A).

b. The department of inspections and appeals shall impose state monitoring, as specified in rule 441—81.42(249A) until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.

81.38(2) Repeated noncompliance. For purposes of this rule, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact deficiency was repeated.

81.38(3) Standard surveys to which this provision applies. Standard surveys completed by the department of inspections and appeals on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

81.38(4) Program participation.

a. The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility's program participation (that is, any standard survey completed for Medicare, Medicaid or both programs will be considered).

b. Termination would allow the count of repeated substandard quality of care surveys to start over.

c. Change of ownership.

- (1) A facility may not avoid a remedy on the basis that it underwent a change of ownership.
- (2) In a facility that has undergone a change of ownership, the department of inspections and appeals may not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the department of inspections and appeals that the poor past performance no longer is a factor due to the change in ownership.

81.38(5) Compliance. Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified.

a. If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with the requirements and that it will remain in substantial compliance for a period of time specified by the department of inspections and appeals.

b. A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it:

- (1) Alleges correction of the deficiencies cited in the most recent standard survey; or
- (2) Achieves compliance before the effective date of the remedies.

441—81.39(249A) Temporary management. The department of inspections and appeals may appoint a temporary manager from qualified applicants.

81.39(1) Qualifications. The temporary manager must:

- a.* Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the department of inspections and appeals.
- b.* Not have been found guilty of misconduct by any licensing board or professional society in any state.
- c.* Have, or a member of the manager's immediate family have, no financial ownership interest in the facility.
- d.* Not currently serve or, within the past two years, have served as a member of the staff of the facility.

81.39(2) Payment of salary. The temporary manager's salary:

- a.* Is paid directly by the facility while the temporary manager is assigned to that facility.
- b.* Shall be at least equivalent to the sum of the following:
 - (1) The prevailing salary paid by providers for positions of this type in the facility's geographic area.
 - (2) Additional costs that would have reasonably been incurred by the provider if the person had been in an employment relationship.
 - (3) Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement up to the maximum per diem for state employees.
- c.* May exceed the amount specified in paragraph "b" if the department of inspections and appeals is otherwise unable to attract a qualified temporary manager.

81.39(3) Failure to relinquish authority to temporary management.

- a.* If a facility fails to relinquish authority to the temporary manager, the provider agreement shall be terminated in accordance with rule 441—81.57(249A).
- b.* A facility's failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

81.39(4) Duration of temporary management. Temporary management ends when the facility meets any of the conditions specified in subrule 81.56(3).

441—81.40(249A) Denial of payment for all new admissions.

81.40(1) Optional denial of payment. Except as specified in subrule 81.40(2), the denial of payment for all new admissions may be imposed when a facility is not in substantial compliance with the requirements.

81.40(2) Required denial of payment. Payment for all new admissions shall be denied when:

a. The facility is not in substantial compliance three months after the last day of the survey identifying the noncompliance; or

b. The department of inspections and appeals has cited a facility with substandard quality of care on the last three consecutive standard surveys.

81.40(3) Resumption of payments. Repeated instances of substandard quality of care. When a facility has repeated instances of substandard quality of care, payments to the facility resume on the date that:

a. The facility achieves substantial compliance as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

b. The department of inspections and appeals determines that the facility is capable of remaining in substantial compliance.

81.40(4) Resumption of payments. No repeated instances of substandard quality of care. When a facility does not have repeated instances of substandard quality of care, payments to the facility resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

81.40(5) Restriction. No payments to a facility are made for the period between the date that the denial of payment remedy is imposed and the date the facility achieves substantial compliance, as determined by the department of inspections and appeals.

441—81.41(249A) Secretarial authority to deny all payments.

81.41(1) CMS option to deny all payment. If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in rule 441—81.40(249A), CMS may deny any further payment to the state for all Medicaid residents in the facility. When CMS denies payment to the state, the department shall deny payment to the facility.

81.41(2) Resumption of payment. When CMS resumes payment to the state, the department shall also resume payment to the facility. The department shall make payments to the facility for the same periods for which payment is made to the state.

441—81.42(249A) State monitoring.

81.42(1) State monitor. A state monitor:

a. Oversees the correction of deficiencies specified by the department of inspections and appeals at the facility site and protects the facility's residents from harm.

b. Is an employee or a contractor of the department of inspections and appeals.

c. Is identified by the department of inspections and appeals as an appropriate professional to monitor cited deficiencies.

d. Is not an employee of the facility.

e. Does not function as a consultant to the facility.

f. Does not have an immediate family member who is a resident of the facility to be monitored.

81.42(2) Use of state monitor. A state monitor shall be used when the department of inspections and appeals has cited a facility with substandard quality of care deficiencies on the last three consecutive standard surveys.

81.42(3) Discontinuance of state monitor. State monitoring is discontinued when:

a. The facility has demonstrated that it is in substantial compliance with the requirement, and it will remain in compliance for a period of time specified by the department of inspections and appeals.

b. Termination procedures are completed.

441—81.43(249A) Directed plan of correction. The department of inspections and appeals or the temporary manager (with department of inspections and appeals' approval) may develop a plan of correction and require a facility to take action within specified time frames.

441—81.44(249A) Directed in-service training.

81.44(1) Required training. The department of inspections and appeals may require the staff of a facility to attend an in-service training program if:

- a. The facility has a pattern of deficiencies that indicate noncompliance; and
- b. Education is likely to correct the deficiencies.

81.44(2) Action following training. After the staff has received in-service training, if the facility has not achieved substantial compliance, the department of inspections and appeals may impose one or more other remedies.

81.44(3) Payment. The facility is responsible for the payment for the directed in-service training.

441—81.45(249A) Closure of a facility or transfer of residents, or both.

81.45(1) Closure during an emergency. In an emergency, the department and the department of inspections and appeals have the authority to:

- a. Transfer Medicaid and Medicare residents to another facility; or
- b. Close the facility and transfer the Medicaid and Medicare residents to another facility.

81.45(2) Required transfer in immediate jeopardy situations. When a facility's provider agreement is terminated for a deficiency that constitutes immediate jeopardy, the department arranges for the safe and orderly transfer of all Medicaid and Medicare residents to another facility.

81.45(3) All other situations. Except for immediate jeopardy situations, as specified in subrule 81.45(2), when a facility's provider agreement is terminated, the department arranges for the safe and orderly transfer of all Medicare and Medicaid residents to another facility.

441—81.46(249A) Civil money penalties—basis for imposing penalty. The department of inspections and appeals may impose a civil money penalty for the number of days a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy.

The department of inspections and appeals may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

441—81.47(249A) Civil money penalties—when penalty is collected.

81.47(1) When facility requests a hearing.

a. A facility shall request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty within the time limit specified in subrule 81.35(7).

b. If a facility requests a hearing within the time specified in subrule 81.35(7), the department of inspections and appeals initiates collection of the penalty when there is a final administrative decision that upholds the department of inspections and appeals' determination of noncompliance after the facility achieves substantial compliance or is terminated.

81.47(2) When facility does not request a hearing. If a facility does not request a hearing, in accordance with subrule 81.47(1), the department of inspections and appeals initiates collection of the penalty when the facility:

- a. Achieves substantial compliance; or
- b. Is terminated.

81.47(3) When facility waives a hearing. If a facility waives its right to a hearing in writing, as specified in rule 441—81.49(249A), the department of inspections and appeals initiates collection of the penalty when the facility:

- a. Achieves substantial compliance; or
- b. Is terminated.

81.47(4) Accrual and computation of penalties. Accrual and computation of penalties for a facility that:

- a. Requests a hearing or does not request a hearing as specified in rule 441—81.50(249A);

b. Waives its right to a hearing in writing, as specified in subrule 81.49(2) and rule 441—81.50(249A).

81.47(5) Collection. The collection of civil money penalties is made as provided in rule 441—81.52(249A).

441—81.48(249A) Civil money penalties—notice of penalty. The department of inspections and appeals shall notify the facility of intent to impose a civil money penalty in writing. The notice shall include, at a minimum, the following information:

1. The nature of the noncompliance.
2. The statutory basis for the penalty.
3. The amount of penalty per day of noncompliance.
4. Any factors specified in subrule 81.50(6) that were considered when determining the amount of the penalty.
5. The date on which the penalty begins to accrue.
6. When the penalty stops accruing.
7. When the penalty is collected.
8. Instructions for responding to the notice, including a statement of the facility's right to a hearing, and the implication of waiving a hearing, as provided in rule 441—81.49(249A).

441—81.49(249A) Civil money penalties—waiver of hearing, reduction of penalty amount.

81.49(1) Waiver of a hearing. The facility may waive the right to a hearing, in writing, within 60 days from the date of the notice of intent to impose the civil money penalty.

81.49(2) Reduction of penalty amount.

a. If the facility waives its right to a hearing, the department of inspections and appeals reduces the civil money penalty amount by 35 percent.

b. If the facility does not waive its right to a hearing, the civil money penalty is not reduced by 35 percent.

441—81.50(249A) Civil money penalties—amount of penalty.

81.50(1) Amount of penalty. The penalties are within the following ranges, set at \$50 increments:

a. Upper range—\$3,050 to \$10,000. Penalties in the range of \$3,050 to \$10,000 per day are imposed for deficiencies constituting immediate jeopardy, as specified in 81.50(4) “*b.*”

b. Lower range—\$50 to \$3,000. Penalties in the range of \$50 to \$3,000 per day are imposed for deficiencies that do not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm.

81.50(2) Basis for penalty amount. The amount of penalty is based on the department of inspections and appeals' assessment of factors listed in subrule 81.50(6).

81.50(3) Decreased penalty amounts. Except as specified in 81.50(4) “*b.*,” if immediate jeopardy is removed, but the noncompliance continues, the department of inspections and appeals shall shift the penalty amount to the lower range.

81.50(4) Increased penalty amounts.

a. Before the hearing, the department of inspections and appeals may propose to increase the penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.

b. The department of inspections and appeals shall increase the penalty amount for any repeated deficiencies for which a lower level penalty amount was previously imposed, regardless of whether the increased penalty amount would exceed the range otherwise reserved for nonimmediate jeopardy deficiencies.

c. Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

81.50(5) *Review of the penalty.* When an administrative law judge (or director of the department of inspections and appeals) finds that the basis for imposing a civil money penalty exists, the administrative law judge (or director) may not:

- a. Set a penalty of zero or reduce a penalty to zero.
- b. Review the exercise of discretion by the department of inspections and appeals to impose a civil money penalty.
- c. Consider any factors in reviewing the amount of the penalty other than those specified in subrule 81.50(6).

81.50(6) *Factors affecting the amount of penalty.* In determining the amount of penalty, the department of inspections and appeals shall take into account the following factors:

- a. The facility's history of noncompliance, including repeated deficiencies.
- b. The facility's financial condition.
- c. The factors specified in rule 441—81.33(249A).
- d. The facility's degree of culpability. Culpability includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.

441—81.51(249A) Civil money penalties—effective date and duration of penalty.

81.51(1) *When penalty begins to accrue.* The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by the department of inspections and appeals.

81.51(2) *Duration of penalty.* The civil money penalty is computed and collectible, as specified in rules 441—81.47(249A) and 441—81.52(249A), for the number of days of noncompliance until the date the facility achieves substantial compliance or, if applicable, the date of termination when:

- a. The department of inspections and appeals' decision of noncompliance is upheld after a final administrative decision;
- b. The facility waives its right to a hearing in accordance with rule 441—81.49(249A); or
- c. The time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(3) *Penalty due.* The entire accrued penalty is due and collectible, as specified in the notice sent to the provider under subrules 81.51(4) and 81.54(5).

81.51(4) *Notice after facility achieves compliance.* When a facility achieves substantial compliance, the department of inspections and appeals shall send a separate notice to the facility containing:

- a. The amount of penalty per day;
- b. The number of days involved;
- c. The total amount due;
- d. The due date of the penalty; and
- e. The rate of interest assessed on the unpaid balance beginning on the due date, as provided in rule 441—81.52(249A).

81.51(5) *Notice to terminated facility.* In the case of a terminated facility, the department of inspections and appeals shall send this penalty information after the:

- a. Final administrative decision is made;
- b. Facility has waived its right to a hearing in accordance with rule 441—81.49(249A); or
- c. Time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(6) *Accrual of penalties when there is no immediate jeopardy.*

a. In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of civil money penalties is imposed for the days of noncompliance prior to the notice specified in rule 441—81.48(249A) and an additional period of no longer than six months following the last day of the survey.

b. After the period specified in paragraph "a," if the facility has not achieved substantial compliance, the provider agreement may be terminated.

81.51(7) *Accrual of penalties when there is immediate jeopardy.*

- a. When a facility has deficiencies that pose immediate jeopardy, the provider agreement shall be terminated within 23 calendar days after the last day of the survey if the immediate jeopardy remains.
- b. The accrual of the civil money penalty stops on the day the provider agreement is terminated.

81.51(8) *Documenting substantial compliance.*

- a. If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to the department of inspections and appeals that substantial compliance was achieved on a date preceding the revisit, penalties only accrue until that date of correction for which there is written credible evidence.
- b. If an on-site revisit is not necessary to confirm substantial compliance, penalties only accrue until the date of correction for which the department of inspections and appeals receives and accepts written credible evidence.

441—81.52(249A) Civil money penalties—due date for payment of penalty.**81.52(1) *When payments are due.***

- a. A civil money penalty payment is due 15 days after a final administrative decision is made when:
 - (1) The facility achieves substantial compliance before the final administrative decision; or
 - (2) The effective date of termination occurs before the final administrative decision.
- b. A civil money penalty is due 15 days after the time period for requesting a hearing has expired and a hearing request was not received when:
 - (1) The facility achieves substantial compliance before the hearing request was due; or
 - (2) The effective date of termination occurs before the hearing request was due.
- c. A civil money penalty payment is due 15 days after receipt of the written request to waive a hearing when:
 - (1) The facility achieved substantial compliance before the department of inspections and appeals received the written waiver of hearing; or
 - (2) The effective date of termination occurs before the department of inspections and appeals received the written waiver of hearing.
- d. A civil money penalty payment is due 15 days after substantial compliance is achieved when:
 - (1) The final administrative decision is made before the facility came into compliance;
 - (2) The facility did not file a timely hearing request before it came into substantial compliance; or
 - (3) The facility waived its right to a hearing before it came into substantial compliance.
- e. A civil money penalty payment is due 15 days after the effective date of termination, if before the effective date of termination:
 - (1) The final administrative decision was made;
 - (2) The time for requesting a hearing has expired and the facility did not request a hearing; or
 - (3) The facility waived its right to a hearing.
- f. In the cases specified in paragraph “d,” the period of noncompliance may not extend beyond six months from the last day of the survey.

81.52(2) *Deduction of penalty from amount owed.* The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

81.52(3) *Interest.* Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

81.52(4) *Penalties collected by the department.*

- a. Civil money penalties collected by the department shall be applied to the protection of the health or property of residents of facilities that the department of inspections and appeals finds deficient, such as:
 - (1) Payment for the cost of relocating residents to other facilities;
 - (2) State costs related to the operation of a facility pending correction of deficiencies or closure;
- and

(3) Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents.

b. Reserved.

441—81.53(249A) Civil money penalties—settlement of penalties. The department of inspections and appeals has the authority to settle cases at any time prior to the evidentiary hearing decision.

441—81.54(249A) Continuation of payments to a facility with deficiencies.

81.54(1) Criteria.

a. The department may continue payments to a facility that is not in substantial compliance for the periods specified in subrule 81.54(3) if the following criteria are met:

(1) The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility;

(2) The department of inspections and appeals has submitted a plan and timetable for corrective action approved by CMS; and

(3) The facility agrees to repay the department for all payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action and posts a bond acceptable to the department to guarantee agreement to repay.

b. The facility provider agreement may be terminated before the end of the correction period if the criteria in 81.54(1)“a” are not met.

81.54(2) Cessation of payments. If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria in 81.54(1)“a” are not met or agreed to by either the facility or the department, the facility shall receive no payments, as applicable, from the last day of the survey.

81.54(3) Period of continued payments. If the conditions in 81.54(1)“a” are met, the department may continue payments to a facility with noncompliance that does not constitute immediate jeopardy for up to six months from the last day of the survey.

81.54(4) Failure to achieve substantial compliance. If the facility does not achieve substantial compliance by the end of the period specified in subrule 81.54(3), the provider agreement for the facility may be terminated.

441—81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy. This rule applies when CMS and the department of inspections and appeals disagree over findings of noncompliance or application of remedies.

81.55(1) Disagreement over whether facility has met requirements.

a. The department of inspections and appeals’ finding of noncompliance takes precedence when:

(1) CMS finds the facility is in substantial compliance with the participation requirements; and

(2) The department of inspections and appeals finds the facility has not achieved substantial compliance.

b. CMS’s findings of noncompliance take precedence when:

(1) CMS finds that a facility has not achieved substantial compliance; and

(2) The department of inspections and appeals finds the facility is in substantial compliance with the participation requirements.

c. When CMS’s survey findings take precedence, CMS may:

(1) Impose any of the alternative remedies specified in rule 441—81.34(249A);

(2) Terminate the provider agreement subject to the applicable conditions of rule 441—81.54(249A); and

(3) Stop federal financial participation to the department for a nursing facility.

81.55(2) Disagreement over decision to terminate.

a. CMS’s decision to terminate the participation of a facility takes precedence when:

(1) Both CMS and the department of inspections and appeals find that the facility has not achieved substantial compliance; and

(2) CMS, but not the department of inspections and appeals, finds that the facility's participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination, not to exceed six months, if the applicable conditions of rule 441—81.54(249A) are met.

b. The department of inspections and appeals' decision to terminate a facility's participation and the procedures for appealing the termination take precedence when:

(1) The department of inspections and appeals, but not CMS, finds that a facility's participation should be terminated; and

(2) The department of inspections and appeals' effective date for the termination of the nursing facility's provider agreement is no later than six months after the last day of survey.

81.55(3) *Disagreement over timing of termination of facility.* The department of inspections and appeals' timing of termination takes precedence if it does not occur later than six months after the last day of the survey when both CMS and the department of inspections and appeals find that:

a. A facility is not in substantial compliance; and

b. The facility's participation should be terminated.

81.55(4) *Disagreement over remedies.*

a. When CMS or the department of inspections and appeals, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when:

(1) Both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance; and

(2) Both CMS and the department of inspections and appeals find that no immediate jeopardy exists.

b. When CMS and the department of inspections and appeals establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance.

81.55(5) *One decision.* Regardless of whether CMS's or the department of inspections and appeals' decision controls, only one noncompliance and enforcement decision is applied to the Medicaid agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.

441—81.56(249A) Duration of remedies.

81.56(1) *Remedies continue.* Except as specified in subrule 81.56(2), alternative remedies continue until:

a. The facility has achieved substantial compliance as determined by the department of inspections and appeals based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or

b. The provider agreement is terminated.

81.56(2) *State monitoring.* In the cases of state monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or

b. The provider agreement is terminated.

81.56(3) *Temporary management.* In the case of temporary management, the remedy continues until:

a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance;

b. The provider agreement is terminated; or

c. The facility which has not achieved substantial compliance reassumes management control. In this case, the department of inspections and appeals initiates termination of the provider agreement and may impose additional remedies.

81.56(4) *Facility in compliance.* If the facility can supply documentation acceptable to the department of inspections and appeals that it was in substantial compliance, and was capable of

remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that the department of inspections and appeals can verify as the date that substantial compliance was achieved.

441—81.57(249A) Termination of provider agreement.

81.57(1) *Effect of termination.* Termination of the provider agreement ends payment to the facility and any alternative remedy.

81.57(2) *Basis of termination.*

a. A facility's provider agreement may be terminated if a facility:

(1) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or

(2) Fails to submit an acceptable plan of correction within the time frame specified by the department of inspections and appeals.

b. A facility's provider agreement shall be terminated if a facility:

(1) Fails to relinquish control to the temporary manager, if that remedy is imposed by the department of inspections and appeals; or

(2) Does not meet the eligibility criteria for continuation of payment as set forth in 81.37(1)“a.”

81.57(3) *Notice of termination.* Before a provider agreement is terminated, the department of inspections and appeals shall notify the facility and the public:

a. At least two calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and

b. At least 15 calendar days before the effective date of termination for a facility with nonimmediate jeopardy deficiencies that constitute noncompliance.

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

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- ¹ Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.
- ² Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.
- ³ Effective date of 81.13(7) “c”(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.
- ⁴ Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.
- ⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

OBJECTION

At its meeting held August 11, 1992, the Administrative Rules Review Committee voted to object to the amendments published in **ARC 3069A** on the grounds the amendments are unreasonable. This filing is published in IAB Vol. XIV No. 253 (06-10-92). It is codified as an amendment to paragraph 441 IAC 81.13(7)“c”(1).

In brief, this filing provides that care facilities shall not employ persons who have been found guilty in a court of law of abusing, neglecting or mistreating facility residents, or who have had a “finding” entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Additionally, the filing eliminates a previous provision which allowed the Department of Inspections and Appeals some discretion in deciding whether the lifetime ban on employment should be applied.

This language originated in the federal government which mandated that the department adopt these provisions or possibly face sanctions. The Committee does not believe these amendments are an improvement to Iowa’s system and has the following objection. The Committee believes that the amendments published in **ARC 3069A** are unreasonable because of the inconsistency in the burdens of proof and the levels of procedural safeguards in the two proceedings. A facility employee may either be found guilty in a court of law or have an administrative finding entered into the registry. In either case the result is the same, the employee is permanently banned from further employment in a care facility; however, the two paths to the result are significantly different. The first proceeding is a criminal tribunal in which the burden of proof is “beyond a reasonable doubt.” The second proceeding is a simple administrative hearing in which the burden is “preponderance of the evidence.” The two proceedings also differ in the level of many other due process protections accorded to the individual. A criminal proceeding provides the accused with the opportunity for a trial by jury, competent legal counsel, strict rules of evidence and many procedural protections not present in administrative hearings. It should also be noted that the penalty in this situation—a lifetime ban on employment—is more serious than is usually imposed in contested cases. In licensee discipline cases, a license can be revoked, but the possibility of reinstatement exists; under this new rule no reinstatement is allowed, the facility employee is banned from employment no matter how serious or minor the offense or how far in the past it occurred. Because of the magnitude of this penalty, the Committee believes that the accused should be provided with greater procedural protections than are generally found in administrative hearings.

The Committee also believes this filing is unreasonable because it eliminates the discretion accorded to the Department of Inspections and Appeals to not apply the lifetime ban on employment. Under the previous rule, the department’s discretion in applying the employment ban acted as a safeguard against unjust results. It recognized that a person would make amends for past offenses and earn a second chance. The provision was a genuine improvement in the process; it recognized that flexibility was needed in government decision making and that some decisions should be made on a case-by-case basis. There does not appear to be any rational basis to justify the elimination of this safeguard and, therefore, the Committee believes this action to be unreasonable.

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

[Prior to 7/1/83, Social Services[770] Ch 82]

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

441—82.1(249A) Definition.

“*Department*” means the Iowa department of human services.

This rule is intended to implement Iowa Code section 249A.12.

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as a hospital, nursing facility, or an intermediate care facility for the mentally retarded by the department of inspections and appeals under the department of inspections and appeals rules 481—Chapter 64. The facility shall meet the following conditions of participation:

82.2(1) Governing body and management.

a. Governing body. The facility shall identify an individual or individuals to constitute the governing body of the facility. The governing body shall:

- (1) Exercise general policy, budget, and operating direction over the facility.
- (2) Set the qualifications (in addition to those already set by state law) for the administrator of the facility.
- (3) Appoint the administrator of the facility.

b. Compliance with federal, state, and local laws. The facility shall be in compliance with all applicable provisions of federal, state and local laws, regulations and codes pertaining to health, safety, and sanitation.

c. Client records.

(1) The facility shall develop and maintain a record-keeping system that includes a separate record for each client and that documents the clients’ health care, active treatment, social information, and protection of the client’s rights.

(2) The facility shall keep confidential all information contained in the clients’ records, regardless of the form or storage method of the records.

(3) The facility shall develop and implement policies and procedures governing the release of any client information, including consents necessary from the client or parents (if the client is a minor) or legal guardian.

(4) Any individual who makes an entry in a client’s record shall make it legibly, date it, and sign it.

(5) The facility shall provide a legend to explain any symbol or abbreviation used in a client’s record.

(6) The facility shall provide each identified residential living unit with appropriate aspects of each client’s record.

d. Services provided under agreements with outside sources.

(1) If a service required under this rule is not provided directly, the facility shall have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement shall:

1. Contain the responsibilities, functions, objectives, and other terms agreed to by both parties.

2. Provide that the facility is responsible for ensuring that the outside services meet the standards for quality of services contained in this rule.

(3) The facility shall ensure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/MR, the ICF/MR remains directly responsible for the standards relating to physical environment that are specified in subrule 82.2(7), paragraphs “a” to “g,” “j,” and “k.”

e. Disclosure of ownership. The facility shall supply to the licensing agency full and complete information, and promptly report any changes which would affect the current accuracy of the information, as to identify:

(1) Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.

(2) Each officer and director of the corporation, if the facility is organized as a corporation.

(3) Each partner, if the facility is organized as a partnership.

82.2(2) Client protections.

a. Protection of clients' rights. The facility shall ensure the rights of all clients. Therefore, the facility shall:

(1) Inform each client, parent (if the client is a minor), or legal guardian of the client's rights and the rules of the facility.

(2) Inform each client, parent (if the child is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints and the right to due process.

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.

(5) Ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment.

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs.

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail.

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.

(11) Ensure clients the opportunity to participate in social, religious, and community group activities.

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in the client's own clothing each day.

(13) Permit a husband and wife who both reside in the facility to share a room.

b. Client finances.

(1) The facility shall establish and maintain a system that ensures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients and precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record shall be available on request to the client, parents (if the client is a minor), or legal guardian.

c. Communication with clients, parents, and guardians. The facility shall:

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate.

(2) Answer communications from clients' families and friends promptly and appropriately.

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate.

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy.

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations.

(6) Notify promptly the client's parents or guardian of any significant incidents or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

d. Staff treatment of clients.

(1) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

1. Staff of the facility shall not use physical, verbal, sexual or psychological abuse or punishment.

2. Staff shall not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

3. The facility shall prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility shall ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations shall be reported to the administrator or designated representative or to other officials in accordance with state law within five working days of the incident, and, if the alleged violation is verified, appropriate corrective action shall be taken.

82.2(3) Facility staffing.

a. Qualified mental retardation professional. Each client's active treatment program shall be integrated, coordinated and monitored by a qualified mental retardation professional who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and is one of the following:

(1) A doctor of medicine or osteopathy.

(2) A registered nurse.

(3) An individual who holds at least a bachelor's degree in a professional category specified in 82.2(3) "b"(5).

b. Professional program services.

(1) Each client shall receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff shall work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.

(2) The facility shall have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff shall participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

(5) Professional program staff shall be licensed, certified, or registered, as applicable, to provide professional services by the state in which the staff practices. Those professional program staff who do not fall under the jurisdiction of state licensure, certification, or registration requirements shall meet the following qualifications:

1. To be designated as an occupational therapist, an individual shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

2. To be designated as an occupational therapy assistant, an individual shall be eligible for certification as an occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

3. To be designated as a physical therapist, an individual shall be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

4. To be designated as a physical therapy assistant, an individual shall be eligible for registration as a physical therapy assistant by the American Physical Therapy Association or be a graduate of a two-year college-level program approved by the American Physical Therapy Association or another comparable body.

5. To be designated as a psychologist, an individual shall have at least a master's degree in psychology from an accredited school.

6. To be designated as a social worker, an individual shall hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or hold a bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

7. To be designated as a speech-language pathologist or audiologist, an individual shall be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

8. To be designated as a professional recreation staff member, an individual shall have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. To be designated as a professional dietitian, an individual shall be eligible for registration by the American Dietetics Association.

10. To be designated as a human services professional, an individual shall have at least a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling and psychology).

(6) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of 82.2(3)"b"(5) are not required except for qualified mental retardation professionals who must meet the requirements set forth in 82.2(3)"a."

c. Facility staffing.

(1) The facility shall not depend upon clients or volunteers to perform direct care services for the facility.

(2) There shall be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: clients for whom a physician has ordered a medical care plan; clients who are aggressive, assaultive or security risks; more than 16 clients; or fewer than 16 clients within a multi-unit building.

(3) There shall be a responsible direct care staff person on duty on a 24-hour basis, when clients are present, to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing: clients for whom a physician has not ordered a medical care plan; clients who are not aggressive, assaultive or security risks; and 16 or fewer clients.

(4) The facility shall provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

d. Direct care (residential living unit) staff.

(1) The facility shall provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

(3) Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to clients:

1. For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive,

assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff-to-client ratio is 1 to 3.2.

2. For each defined residential living unit serving moderately retarded clients, the staff-to-client ratio is 1 to 4.

3. For each defined residential living unit serving clients who function within the range of mild retardation, the staff-to-client ratio is 1 to 6.4.

4. When there are no clients present in the living unit, a responsible staff member must be available by telephone.

e. Staff training program.

(1) The facility shall provide each employee with initial and continuing training that enables the employee to perform the employee's duties effectively, efficiently, and competently.

(2) For employees who work with clients, training shall focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff shall be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff shall be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

82.2(4) Active treatment services.

a. Active treatment.

(1) Each client shall receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this paragraph, that is directed toward: the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

b. Admissions, transfers, and discharge.

(1) Clients who are admitted by the facility shall be in need of and receiving active treatment services.

(2) Admission decisions shall be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation shall contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility shall have documentation in the client's record that the client was transferred or discharged for good cause, and shall provide a reasonable time to prepare the client and the client's parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility shall develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies, and shall provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

c. Individual program plan.

(1) Each client shall have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the client's needs, as described by the comprehensive functional assessments required in 82.2(4) "c"(3), and designing programs that meet the client's needs.

(2) Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, the client's parents (if the

client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team shall perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment shall take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and shall:

1. Identify the presenting problems and disabilities and, where possible, their causes.
2. Identify the client's specific developmental strengths.
3. Identify the client's specific developmental and behavioral management needs.
4. Identify the client's need for services without regard to the actual availability of the services needed.
5. Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and, as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team shall prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by 82.2(4) "c"(3), and the planned sequence for dealing with those objectives. These objectives shall:

1. Be stated separately, in terms of a single behavioral outcome.
2. Be assigned projected completion dates.
3. Be expressed in behavioral terms that provide measurable indices of performance.
4. Be organized to reflect a developmental progression appropriate to the individual.
5. Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan shall specify:

1. The methods to be used.
2. The schedule for use of the method.
3. The person responsible for the program.
4. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.
5. The inappropriate client behaviors, if applicable.
6. Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan shall also:

1. Describe relevant interventions to support the individual toward independence.
2. Identify the location where program strategy information (which shall be accessible to any person responsible for implementation) can be found.
3. Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.
4. Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan shall specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.
5. Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.
6. Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan shall be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

d. Program implementation.

(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client shall receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

(2) The facility shall develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan shall be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

e. Program documentation.

(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives shall be documented in measurable terms.

(2) The facility shall document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.

f. Program monitoring and change.

(1) The individual program plan shall be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to, situations in which the client:

1. Has successfully completed an objective or objectives identified in the individual program plan.
2. Is regressing or losing skills already gained.
3. Is failing to progress toward identified objectives after reasonable efforts have been made.
4. Is being considered for training toward new objectives.

(2) At least annually, the comprehensive functional assessment of each client shall be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan shall be revised, as appropriate, repeating the process set forth in 82.2(4) "c."

(3) The facility shall designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to:

1. Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.
2. Ensure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian.
3. Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes needs to be addressed.

(4) The provisions of 82.2(4) "f"(3) may be modified only if, in the judgment of the department of inspections and appeals, court decrees, state law or regulations provide for equivalent client protection and consultation.

82.2(5) Client behavior and facility practices.

a. Facility practices—conduct toward clients.

(1) The facility shall develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures shall:

1. Promote the growth, development and independence of the client.
2. Address the extent to which client choice will be accommodated in daily decision making, emphasizing self-determination and self-management, to the extent possible.
3. Specify client conduct to be allowed or not allowed.

4. Be available to all staff, clients, parents of minor children, and legal guardians.
- (2) To the extent possible, clients shall participate in the formulation of these policies and procedures.
- (3) Clients shall not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.
- b. Management of inappropriate client behavior.*
 - (1) The facility shall develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures shall be consistent with the provisions of 82.2(5) "a." These procedures shall:
 1. Specify all facility-approved interventions to manage inappropriate client behavior.
 2. Designate these interventions on a hierarchy to be implemented ranging from most positive or least intrusive to least positive or most intrusive.
 3. Ensure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and have been demonstrated to be ineffective.
 4. Address the use of time-out rooms, the use of physical restraints, the use of drugs to manage inappropriate behavior, the application of painful or noxious stimuli, the staff members who may authorize the use of specified interventions, and a mechanism for monitoring and controlling the use of these interventions.
 - (2) Interventions to manage inappropriate client behavior shall be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.
 - (3) Techniques to manage inappropriate client behavior shall never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.
 - (4) The use of systematic interventions to manage inappropriate client behavior shall be incorporated into the client's individual program plan, in accordance with 82.2(4) "c"(4) and (5).
 - (5) Standing or as-needed programs to control inappropriate behavior are not permitted.
- c. Time-out rooms.*
 - (1) A client may be placed in a room from which egress is prevented only if the following conditions are met:
 1. The placement is a part of an approved systematic time-out program as required by 82.2(5) "b."
 2. The client is under the direct constant visual supervision of designated staff.
 3. The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.
 - (2) Placement of a client in a time-out room shall not exceed one hour.
 - (3) Clients placed in time-out rooms shall be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.
 - (4) A record of time-out activities shall be kept.
- d. Physical restraints.*
 - (1) The facility may employ physical restraint only:
 1. As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.
 2. As an emergency measure, but only if absolutely necessary to protect the client or others from injury.
 3. As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.
 - (2) Authorizations to use or extend restraints as an emergency shall be in effect no longer than 12 consecutive hours and shall be obtained as soon as the client is restrained or stable.
 - (3) The facility shall not issue orders for restraint on a standing or as-needed basis.

(4) A client placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, shall be released from the restraint as quickly as possible, and a record of these checks and usage shall be kept.

(5) Restraints shall be designated and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

(6) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two-hour period in which restraint is employed, and a record of the activity shall be kept.

(7) Barred enclosures shall not be more than three feet in height and shall not have tops.

e. Drug usage.

(1) The facility shall not use drugs in doses that interfere with the individual client's daily living activities.

(2) Drugs used for control of inappropriate behavior shall be approved by the interdisciplinary team and be used only as an integral part of the client's individual program plan that is directed specifically toward the reduction and eventual elimination of the behaviors for which the drugs are employed.

(3) Drugs used for control of inappropriate behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

(4) Drugs used for control of inappropriate behavior shall be monitored closely, in conjunction with the physician and the drug regimen review requirement at 82.2(6) "j," for desired responses and adverse consequences by facility staff, and shall be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

82.2(6) Health care services.

a. Physician services.

(1) The facility shall ensure the availability of physician services 24 hours a day.

(2) The physician shall develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This plan shall be integrated in the individual program plan.

(3) The facility shall provide or obtain preventive and general medical care as well as annual physical examinations of each client that at a minimum include the following:

1. Evaluation of vision and hearing.

2. Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

3. Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.

4. Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American Academy of Pediatrics, or both.

(4) To the extent permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this subrule.

b. Physician participation in the individual program plan. A physician shall participate in:

(1) The establishment of each newly admitted client's initial individual program plan.

(2) If appropriate, physicians shall participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

c. Nursing services. The facility shall provide clients with nursing services in accordance with their needs. These services shall include:

(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process.

(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan.

(3) For those clients certified as not needing a medical care plan, a review of their health status which shall:

1. Be by a direct physical examination.
2. Be by a licensed nurse.
3. Be on a quarterly or more frequent basis depending on client need.
4. Be recorded in the client's record.
5. Result in any necessary action including referral to a physician to address client health problems.

(4) Other nursing care as prescribed by the physician or as identified by client needs.

(5) Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to:

1. Training clients and staff as needed in appropriate health and hygiene methods.
2. Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control.
3. Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

d. Nursing staff.

(1) Nurses providing services in the facility shall have a current license to practice in the state.

(2) The facility shall employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

(3) The facility shall utilize registered nurses as appropriate and required by state law to perform the health services specified in this subrule.

(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it shall have a formal arrangement with a registered nurse to be available for verbal or on-site consultation with the licensed practical or vocational nurse.

(5) Nonlicensed nursing personnel who work with clients under a medical care plan shall do so under the supervision of licensed persons.

e. Dental services.

(1) The facility shall provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists, either through organized dental services in-house or through arrangement.

(2) If appropriate, dental professionals shall participate in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

(3) The facility shall provide education and training in the maintenance of oral health.

f. Comprehensive dental diagnostic services. Comprehensive dental diagnostic services include:

(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, not later than one month after admission to the facility unless the examination was completed within 12 months before admission.

(2) Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease.

(3) A review of the results of examination and entry of the results in the client's dental record.

g. Comprehensive dental treatment. The facility shall ensure comprehensive dental treatment services that include:

(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist.

(2) Dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

h. Documentation of dental services.

(1) If the facility maintains an in-house dental service, the facility shall keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.

(2) If the facility does not maintain an in-house dental service, the facility shall obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.

i. Pharmacy services. The facility shall provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

j. Drug regimen review.

(1) A pharmacist with input from the interdisciplinary team shall review the drug regimen of each client at least quarterly.

(2) The pharmacist shall report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

(3) The pharmacist shall prepare a record of each client's drug regimen reviews and the facility shall maintain that record.

(4) An individual medication administration record shall be maintained for each client.

(5) As appropriate, the pharmacist shall participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

k. Drug administration. The facility shall have an organized system for drug administration that identifies each drug up to the point of administration. The system shall ensure that:

(1) All drugs are administered in compliance with the physician's orders.

(2) All drugs, including those that are self-administered, are administered without error.

(3) Unlicensed personnel are allowed to administer drugs only if state law permits.

(4) Clients are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client.

(6) No client self-administers medications until the client demonstrates the competency to do so.

(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with state law.

(8) Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

l. Drug storage and record keeping.

(1) The facility shall store drugs under proper conditions of sanitation, temperature, light, humidity, and security.

(2) The facility shall keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self-administer drugs in accordance with 82.2(6) "k"(4) may have access to keys to their individual drug supply.

(3) The facility shall maintain records of the receipt and disposition of all controlled drugs.

(4) The facility shall, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in Schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq.).

(5) If the facility maintains a licensed pharmacy, the facility shall comply with the regulations for controlled drugs.

m. Drug labeling.

(1) Labeling of drugs and biologicals shall be based on currently accepted professional principles and practices, and shall include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

(2) The facility shall remove from use outdated drugs and drug containers with worn, illegible, or missing labels.

(3) Drugs and biologicals packaged in containers designated for a particular client shall be immediately removed from the client's current medication supply if discontinued by the physician.

n. Laboratory services.

(1) For purposes of this subrule, “laboratory” means an entity for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(2) If a facility chooses to provide laboratory services, the laboratory shall meet the management requirements specified in 42 CFR 493.1407 and provide personnel to direct and conduct the laboratory services.

The laboratory director shall be technically qualified to supervise the laboratory personnel and test performance and shall meet licensing or other qualification standards established by the state with respect to directors of clinical laboratories.

The laboratory director shall provide adequate technical supervision of the laboratory services and ensure that tests, examinations and procedures are properly performed, recorded and reported.

The laboratory director shall ensure that the staff has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; is sufficient in number for the scope and complexity of the services provided; and receives in-service training appropriate to the type of complexity of the laboratory services offered.

The laboratory technologists shall be technically competent to perform test procedures and report test results promptly and proficiently.

(3) The laboratory shall meet the proficiency testing requirements specified in 42 CFR 493.801.

(4) The laboratory shall meet the quality control requirements specified in 42 CFR 493.1501.

(5) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be an approved Medicare laboratory.

82.2(7) Physical environment.

a. Client living environment.

(1) The facility shall not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(2) The facility shall not segregate clients solely on the basis of their physical disabilities. It shall integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders with others of comparable social and intellectual development.

b. Client bedrooms.

(1) Bedrooms shall:

1. Be rooms that have at least one outside wall.

2. Be equipped with or located near toilet and bathing facilities.

3. Accommodate no more than four clients unless granted a variance under 82.2(7)“b”(3).

4. Measure at least 60 square feet per client in multiple-client bedrooms and at least 80 square feet in single-client bedrooms.

5. In all facilities initially certified or in buildings constructed or with major renovations or conversions, have walls that extend from floor to ceiling.

(2) If a bedroom is below grade level, it shall have a window that is usable as a second means of escape by the client occupying the rooms and shall be no more than 44 inches measured to the windowsill above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches measured to the windowsill above the floor.

(3) The department of inspections and appeals may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified mental retardation professional certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours and documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.

(4) The facility shall provide each client with:

1. A separate bed of proper size and height for the convenience of the client.

2. A clean, comfortable mattress.
3. Bedding appropriate to the weather and climate.
4. Functional furniture appropriate to the client's needs, and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.

c. Storage space in bedroom. The facility shall provide:

(1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety.

(2) Suitable storage space, accessible to clients, for personal possessions such as televisions, radios, prosthetic equipment and clothing.

d. Client bathrooms. The facility shall:

(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients.

(2) Provide for individual privacy in toilets, bathtubs, and showers.

(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

e. Heating and ventilation.

(1) Each client bedroom in the facility shall have at least one window to the outside and direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.

(2) The facility shall maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means and ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.

f. Floors. The facility shall have:

(1) Floors that have a resilient, nonabrasive, and slip-resistant surface.

(2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor.

(3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.

g. Space and equipment. The facility shall:

(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this rule and as identified in each client's individual program plan.

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

(3) Provide adequate clean linen and dirty linen storage areas.

h. Emergency plan and procedures.

(1) The facility shall develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility shall communicate, periodically review, make the plan available, and provide training to the staff.

i. Evacuation drills.

(1) The facility shall hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility shall actually evacuate clients during at least one drill each year on each shift; make special provisions for the evacuation of clients with physical disabilities; file a report and evaluation on each evacuation drill; and investigate all problems with evacuation drills, including accidents, and take corrective action. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities shall meet the requirements of 82.2(7) "i"(1) and (2) for any live-in and relief staff they utilize.

j. Fire protection.

(1) General.

1. Except as specified in 82.2(7) "i"(2), the facility shall meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference.

2. The department of inspections and appeals may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

3. A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds shall have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

(2) Exceptions.

1. For facilities that meet the LSC definition of a health care occupancy, the Centers for Medicare and Medicaid Services may waive, for a period it considers appropriate, specific provisions of the LSC if the waiver would not adversely affect the health and safety of the clients and rigid application of specific provisions would result in an unreasonable hardship for the facility.

The department of inspections and appeals may apply the state's fire and safety code instead of the LSC if the Secretary of the Department of Health and Human Services finds that the state has a code imposed by state law that adequately protects a facility's clients.

Compliance on November 28, 1982, with the 1967 edition of the LSC or compliance on April 18, 1986, with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard as long as the facility continues to remain in compliance with that edition of the code.

2. For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the department of inspections and appeals may apply the state's fire and safety code as specified above.

k. Paint. The facility shall:

(1) Use lead-free paint inside the facility.

(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

l. Infection control.

(1) The facility shall provide a sanitary environment to avoid sources and transmission of infections. There shall be an active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility shall implement successful corrective action in affected problem areas.

(3) The facility shall maintain a record of incidents and corrective actions related to infections.

(4) The facility shall prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

82.2(8) *Dietetic services.*

a. Food and nutrition services.

(1) Each client shall receive a nourishing, well-balanced diet including modified and specially prescribed diets.

(2) A qualified dietitian shall be employed either full-time, part-time or on a consultant basis at the facility's discretion.

(3) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services.

(4) The client's interdisciplinary team, including a qualified dietitian and physician, shall prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

(6) Unless otherwise specified by medical needs, the diet shall be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

b. Meal services.

(1) Each client shall receive at least three meals daily, at regular times comparable to normal mealtimes in the community with:

1. Not more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast.

2. Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under 82.2(8)“b”(1)“1.”

(2) Food shall be served:

1. In appropriate quantity.
2. At appropriate temperature.
3. In a form consistent with the developmental level of the client.
4. With appropriate utensils.

(3) Food served to clients individually and uneaten shall be discarded.

c. Menus.

(1) Menus shall:

1. Be prepared in advance.
2. Provide a variety of foods at each meal.
3. Be different for the same days of each week and adjusted for seasonal change.
4. Include the average portion sizes for menu items.

(2) Menus for food actually served shall be kept on file for 30 days.

d. Dining areas and service. The facility shall:

(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician.

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs.

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to ensure that each client receives enough food and to ensure that each client eats in a manner consistent with the client's developmental level.

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or physician.

This rule is intended to implement Iowa Code section 249A.12.

441—82.3(249A) Conditions of participation for intermediate care facilities for the mentally retarded. All intermediate care facilities for the mentally retarded must enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

82.3(1) Procedures for establishing health care facilities as Title XIX facilities. All survey procedures and the certification process shall be in accordance with Department of Health and Human Services publication “Providers Certification State Operations Manual.”

a. The facility shall obtain the applicable license from the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The department shall transmit an application form and copies of standards to the facility.

d. The facility shall complete its portion of the application form and submit it to the department.

e. The department shall review the application form and forward it to the department of inspections and appeals.

- f.* The department of inspections and appeals shall schedule and complete a survey of the facility.
- g.* The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.
- h.* The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division, department of inspections and appeals. This plan must be approved before the facility can be certified.
- i.* The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.
- j.* When certification is recommended, the department of inspections and appeals shall notify the department recommending terms and conditions of a provider agreement.
- k.* The department shall review the certification data and:
 - (1) Transmit the provider agreement as recommended, or
 - (2) Transmit the provider agreement for a term less than recommended by the department of inspections and appeals or elect not to execute an agreement for reasons of good cause as defined in 82.3(2) "c."

82.3(2) Title XIX provider agreements. The health care facility must be recommended for certification by the Iowa department of inspections and appeals for participation as an intermediate care facility for the mentally retarded before a provider agreement may be issued. All survey procedures and certification processes shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

- a.* Terms of the agreement for facilities without deficiencies are as follows:
 - (1) The provider agreement shall be issued for a period not to exceed 12 months.
 - (2) The provider agreement shall be for the term of and in accordance with the provisions of certification, except that for good cause, the department may elect to execute an agreement for a term less than the period of certification, elect not to execute an agreement for reasons of good cause, or cancel an agreement.
- b.* Terms of the agreement for facilities with deficiencies are as follows:
 - (1) A new provider agreement may be executed for a period not to exceed 60 days from the time required to correct deficiencies up to a period of 12 months.
 - (2) A new provider agreement may be issued for a period of up to 12 months subject to automatic cancellation 60 days following the scheduled date for correction unless required corrections have been completed or unless the survey agency finds and notifies the department that the facility has made substantial progress in correcting the deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency.
 - (3) There will be no new agreement when the facility continues to be out of compliance with the same standard(s) at the end of the term of agreement.
- c.* The department may, for good cause, elect not to execute an agreement. Good cause shall be defined as a continued or repeated failure to operate an intermediate care facility for the mentally retarded in compliance with rules and regulations of the program.
- d.* The department may at its option extend an agreement with a facility for two months under either of the following conditions:
 - (1) The health and safety of the residents will not be jeopardized thereby and the extension is necessary to prevent irreparable harm to the facility or hardship to the resident.
 - (2) It is impracticable to determine whether the facility is complying with the provisions and requirements of the provider agreement.
- e.* When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation if the extension is necessary to ensure the orderly transfer of residents.
- f.* When the department of inspections and appeals survey indicates deficiencies in the areas of the Life Safety Code (LSC) or environment and sanitation, a timetable detailing corrective measures shall be

submitted to the department of inspections and appeals before a provider agreement can be issued. This timetable shall not exceed two years from the date of initial certification and shall detail corrective steps to be taken and when corrections will be accomplished. The following shall apply in these instances.

(1) The department of inspections and appeals shall determine that the facility can make corrections within the two-year period.

(2) During the period allowed for corrections, the facility shall be in compliance with existing state fire safety and sanitation codes and regulations.

(3) The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.

82.3(3) Appeals of decertification. A facility may appeal a decertification action according to 441—subrule 81.13(28).

This rule is intended to implement Iowa Code section 249A.12.

441—82.4 Rescinded, effective March 1, 1987.

441—82.5(249A) Financial and statistical report. All facilities wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the department. These reports shall be based on the following rules.

82.5(1) Failure to maintain records. Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

82.5(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

82.5(3) Submission of reports. The facility's cost report shall be submitted to the department no later than September 30 each year except as described in subrule 82.5(14). Failure to submit the report within this time shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

82.5(4) Payment at new rate. When a new rate is established, payment at the new rate shall be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments shall be included in the payment the third month after the receipt of the report.

82.5(5) Accrual basis. Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses which pertain to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

82.5(6) Census of Medicaid members. Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

82.5(7) Patient days. In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

82.5(8) Opinion of accountant. The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

82.5(9) Calculating patient days. When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

82.5(10) Revenues. Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services which include room, board, nursing services, and such services as supervision, feeding, incontinency, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private-pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

82.5(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid directors and nonworking officer's salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

e. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. It includes salary amounts paid for managerial, administrative, professional, and other services; amounts paid by the facility for the personal benefit of the proprietor or immediate relative; the cost of assets and services which the proprietor or immediate relative receives from the facility; and deferred compensation.

(2) Reasonableness—requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary—requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$1,926 per month plus \$20.53 per month per licensed bed capacity for each bed over 60, not to exceed \$2,852 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On a semiannual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by the inflation factor applied to facility rates.

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

f. Management fees and home office costs shall be allowed only to the extent that they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

g. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 82.5(12).

h. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) “Necessary” requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) “Proper” requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider’s qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will

be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

i. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

j. A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return shall be defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

k. Each facility which supplies transportation services as defined in Iowa Code section 324A.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, shall result in disallowance of vehicle costs and other costs associated with transporting residents.

l. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

m. Reasonable legal fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable

costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs for more than 120 days following the decertification date.

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. Initial cost report. 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 (hereafter referred to as the Consumer Price Index). For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used to adjust costs for inflation, instead of the annual percentage increase of the Consumer Price Index. Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges 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.

c. Standardization of cost reporting period for new facilities.

(1) Facilities receiving initial certification between July 1 and December 31 (inclusive) shall submit three successive six-month cost reports covering their first 18 months of operation. The fourth six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(3) All facilities shall comply with the requirements of subrule 82.5(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/MR as described in subrule 82.5(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the

accounting firm under contract with the department. Based on the audited cost report, a rate shall be established for the facility. This rate shall be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the prior year's maximum allowable base cost shall be increased by 3 percent, instead of the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities shall be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/MR with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities which complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.5(14) "d," shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed is the incentive factor. For the period beginning July 1, 2009, and ending June 30, 2010, the incentive factor shall be calculated using 3 percent in place of the percentage increase of the Consumer Price Index.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

g. Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates shall be subject to the prevailing maximum rate.

82.5(15) Payment to new owner. An existing facility with a new owner shall continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.5(16). The facility may submit a report for the period of July 1 to June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

82.5(16) Payment to existing facilities. The following reimbursement limits shall apply to all non-state-owned ICFs/MR:

a. Each facility shall file a cost report covering the period from January 1, 1992, to June 30, 1992. This cost report shall be used to establish a reimbursement rate to be paid to the facility and shall be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 to June 30.

b. The reimbursement rate established based on the report covering January 1, 1992, to June 30, 1992, shall be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

c. The audited per unit cost from the January 1, 1992, to June 30, 1992, cost report shall become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.5(14) "d."

d. Facilities which have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index or of less than 3 percent for rates effective July 1, 2009, through June 30, 2010, shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year shall receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment. For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used in lieu of the percentage increase in the Consumer Price Index.

e. Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include, but are not necessarily limited to, the administrative portion of the following:

- (1) Administrator's salary.
- (2) Assistant administrator's salary.
- (3) Bookkeeper's salary.
- (4) Other accounting and bookkeeping costs.
- (5) Other clerical salaries and clerical costs.
- (6) Administrative payroll taxes.
- (7) Administrative unemployment taxes.
- (8) Administrative group insurance.
- (9) Administrative general liability and worker's compensation insurance.
- (10) Directors' and officers' insurance or salaries.
- (11) Management fees.
- (12) Indirect business expenses and other costs related to the management of the facility including home office and other organizational costs.
- (13) Legal and professional fees.
- (14) Dues, conferences and publications.
- (15) Postage and telephone.
- (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 the period beginning July 1, 2009, and ending June 30, 2010, the inflation increase shall be 3 percent, notwithstanding the percentage change in the Consumer Price Index.

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. For the period beginning July 1, 2009, and ending June 30, 2010, costs of operation shall be inflated by 3 percent instead of the percentage change in the Consumer Price Index.

i. The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

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 of level of 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 Medicaid enterprise (IME) medical services unit. The IME medical services unit shall review ICF/MR admissions and transfers only when documentation is provided which verifies a referral from targeted case management that 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 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 according to the procedures in 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

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 Medicaid enterprise (IME) medical services unit.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.9(249A) Arrangements with residents.

82.9(1) Resident care agreement. The ICF/MR Resident Care Agreement, Form 470-0374, shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

82.9(2) Financial participation by resident. A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

82.9(3) Personal needs account. When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department of inspections and appeals and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the

accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, itemized, dated receipt shall be required to be deposited in the resident's files.

d. The receipts for each resident shall be kept until canceled by auditors.

e. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections and appeals representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

f. Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department shall turn the funds over to the member's estate.

82.9(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.10(249A) Discharge and transfer.

82.10(1) *Notice.* When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

82.10(2) *Case activity report.* A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

82.10(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

82.10(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

c. Transfer orders.

d. Nursing care plan.

e. Physician's or qualified mental retardation professional's orders for care.

f. The resident's personal records.

g. When applicable, the personal needs fund record.

82.10(5) *Income refund.* When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.11(249A) *Continued stay review.* The Iowa Medicaid enterprise (IME) medical services unit shall be responsible for reviews of each resident's need for continuing care in intermediate care facilities for the mentally retarded.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.12(249A) *Quality of care review.* The Iowa Medicaid enterprise (IME) medical services unit shall carry out the quality of care studies in intermediate care facilities for the mentally retarded.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.13(249A) *Records.*

82.13(1) *Content.* The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act.

c. Records of all treatments, drugs and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

d. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

f. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

g. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for residents in skilled, intermediate, and residential care.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

h. Resident accounts.

i. Inservice education program records.

j. Inspection reports pertaining to conformity with federal, state, and local laws.

k. Residents' personal records.

l. Residents' medical records.

m. Disaster preparedness reports.

82.13(2) *Retention.* Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

82.13(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code section 249A.12.

441—82.14(249A) Payment procedures.

82.14(1) Method of payment. Facilities shall be reimbursed under a cost-related vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—82.5(249A).

82.14(2) Payment responsibility. The department shall send the resident's county of legal settlement Form 470-0375, ICF/MR Placement Statement, notifying them of the resident's entry into the facility.

82.14(3) Rescinded IAB 8/9/89, effective 10/1/89.

82.14(4) Periods authorized for payment.

a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in an intermediate care facility for the mentally retarded.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified mental retardation professional, shall be maintained at the facility.

e. Payment will be approved for a period not to exceed ten days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

82.14(5) Supplementation. Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person.

EXCEPTION: The resident, the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over 10 days on a hospital stay. When the resident is not discharged from the facility, the payments shall not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

82.14(6) Payment for out-of-state care. Rescinded IAB 9/5/90, effective 11/1/90.

This rule is intended to implement Iowa Code section 249A.12.

441—82.15(249A) Billing procedures.

82.15(1) Claims. Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims may be submitted electronically on software provided by the Iowa Medicaid enterprise or in writing on Form 470-0039, Iowa Medicaid Long-Term Care Claim.

a. When payment is made, the facility will receive a copy of Form 470-0039. The white copy of the original shall be returned as a claim for the next month. If the claim is submitted electronically, the facility will receive a remittance statement of the claims paid.

b. When there has been a new admission, a discharge, a correction, or a claim for a reserved bed, the facility shall submit Form 470-0039 with the changes noted. Adjustments to electronically submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise.

82.15(2) Reserved.

This rule is intended to implement Iowa Code section 249A.12.

441—82.16(249A) Closing of facility. When a facility is planning on closing, the department shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the county office of the department.

This rule is intended to implement Iowa Code section 249A.12.

441—82.17(249A) Audits.

82.17(1) Audits of financial and statistical report. Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—82.5(249A). These audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agents.

a. When a proper per diem rate cannot be determined, through generally accepted auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing fiscal period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

b. When a facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

82.17(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.

This rule is intended to implement Iowa Code section 249A.12.

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.

This rule is intended to implement Iowa Code section 249A.12.

441—82.19(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with mental retardation who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

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◊ Two or more ARCs

CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

PREAMBLE

These rules define and structure the department of human services healthy and well kids in Iowa (HAWK-I) program. The purpose of this program is to provide transitional health and dental care coverage to uninsured children who are ineligible for Title XIX (Medicaid) assistance. The program is implemented and administered in compliance with Title XXI of the federal Social Security Act. The rules establish requirements for the third-party administrator responsible for the program administration and for the participating health and dental plans that will be delivering services to the enrollees.

441—86.1(514I) Definitions.

“Applicant” shall mean all parents, spouses, and children under the age of 19 who are counted in the HAWK-I family size and who are listed on the application or renewal form.

“Benchmark benefit package for health care coverage” shall mean any of the following:

1. The standard Blue Cross Blue Shield preferred provider option service benefit plan, described in and offered under 5 U.S.C. Section 8903(1).

2. A health benefits coverage plan that is offered and generally available to state employees in this state.

3. The plan of a health maintenance organization, as defined in 42 U.S.C. Section 300e, with the largest insured commercial, nonmedical assistance enrollment of covered lives in the state.

“Capitation rate” shall mean the fee the department pays monthly to a participating health or dental plan for each enrollee for the provision of covered medical or dental services whether or not the enrollee received services during the month for which the fee is intended.

“Contract” shall mean the contract between the department and the person or entity selected as the third-party administrator or the contract between the department and the participating health or dental plan for the provision of medical or dental services to HAWK-I enrollees for whom the participating health or dental plans assume risk.

“Cost sharing” shall mean the payment of a premium or copayment as provided for by Title XXI of the federal Social Security Act and Iowa Code section 514I.10.

“Covered services” shall mean all or a part of those medical and dental services set forth in rule 441—86.14(514I).

“Dentist” shall mean a person who is licensed to practice dentistry.

“Department” shall mean the Iowa department of human services.

“Director” shall mean the director of the Iowa department of human services.

“Earned income” means the earned income of all parents, spouses, and children under the age of 19 who are not students who are living together in accordance with subrule 86.2(3). Income shall be countable earned income when a person produces it as a result of the performance of services. “Earned income” includes:

1. All income in the form of a salary, wages, tips, bonuses, and commissions earned as an employee, and

2. The net profit from self-employment determined by comparing gross income produced from self-employment with the allowable costs of producing the income. The allowable costs of producing self-employment income shall be determined by the costs allowed for income tax purposes. Additionally, the cost of depreciation of capital assets identified for income tax purposes shall be allowed as a cost of doing business for self-employed persons. Losses from a self-employment enterprise may not be used to offset income from any other source.

“Eligible child” shall mean an individual who meets the criteria for participation in the HAWK-I program as set forth in rule 441—86.2(514I).

“Emergency dental condition” shall mean an oral condition that occurs suddenly and creates an urgent need for professional consultation or treatment. Emergency conditions may include hemorrhage, infection, pain, broken teeth, knocked-out teeth, or other trauma.

“Emergency medical condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

“Emergency services” shall mean, with respect to an individual enrolled with a plan, covered inpatient and outpatient services which are furnished by a provider qualified to furnish these services and which are needed to evaluate and stabilize an emergency medical or dental condition.

“Enrollee” shall mean a child who has been determined eligible for the program and who has been enrolled with a participating health plan.

“Family” shall mean all parents, spouses, and children under the age of 19 who are counted in the HAWK-I family size.

“Federal poverty level” shall mean the poverty income guidelines revised annually and published in the Federal Register by the United States Department of Health and Human Services.

“Good cause” shall mean the family has demonstrated that one or more of the following conditions exist:

1. There was a serious illness or death of the enrollee or a member of the enrollee’s family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. There was a reason beyond the enrollee’s control.
4. There was a failure to receive the third-party administrator’s request for a reason not attributable to the enrollee. Lack of a forwarding address is attributable to the enrollee.

“Gross countable income” means gross income minus exemptions permitted by paragraph 86.2(2) “b.”

“Gross income” means a combination of the following:

1. Earned income,
2. Unearned income, and
3. Recurring lump-sum income prorated over the time the income is intended to cover.

“HAWK-I board” or *“board”* shall mean the entity that adopts rules, establishes policy, and directs the department regarding the HAWK-I program.

“HAWK-I program” or *“program”* shall mean the healthy and well kids in Iowa program implemented in this chapter to provide health and dental care coverage to eligible children.

“Health insurance coverage” shall mean health insurance coverage as defined in 45 CFR Section 144.103, as amended to October 1, 2008.

“Institution for mental diseases” shall mean a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

“Nonmedical public institution” shall mean an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control as defined in 42 CFR Section 435.1009 as amended November 10, 1994.

“Participating dental plan” shall mean any entity licensed by the division of insurance of the department of commerce to provide dental insurance in Iowa that has contracted with the department to provide dental insurance coverage to eligible children under this chapter.

“Participating health plan” shall mean any entity licensed by the division of insurance of the department of commerce to provide health insurance in Iowa or an organized delivery system licensed by the director of public health that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

“Physician” shall be defined as provided in Iowa Code subsection 135.1(4).

“*Provider*” shall mean an individual, firm, corporation, association, or institution that is providing or has been approved to provide medical or dental care or services to an enrollee pursuant to the HAWK-I program.

“*Recurring lump-sum income*” means earned and unearned lump-sum income that is received on a regular basis. These payments may include, but are not limited to:

1. Annual bonuses.
2. Lottery winnings that are paid out annually.

“*Regions*” shall mean the six regions of the state as follows:

- Region 1: Lyon, Osceola, Dickinson, Emmet, Sioux, O’Brien, Clay, Palo Alto, Plymouth, Cherokee, Buena Vista, Woodbury, Ida, Sac, Monona, Crawford, and Carroll.

- Region 2: Kossuth, Winnebago, Worth, Mitchell, Howard, Hancock, Cerro Gordo, Floyd, Pocahontas, Humboldt, Wright, Franklin, Calhoun, Webster, Hamilton, Hardin, Greene, Boone, Story, Marshall, and Tama.

- Region 3: Winneshiek, Allamakee, Chickasaw, Fayette, Clayton, Butler, Bremer, Grundy, Black Hawk, Buchanan, Delaware, Dubuque, Jones, Jackson, Cedar, Clinton, and Scott.

- Region 4: Harrison, Shelby, Audubon, Pottawattamie, Cass, Mills, Montgomery, Fremont, and Page.

- Region 5: Guthrie, Dallas, Polk, Jasper, Adair, Madison, Warren, Marion, Adams, Union, Clarke, Lucas, Taylor, Ringgold, Decatur, and Wayne.

- Region 6: Benton, Linn, Poweshiek, Iowa, Johnson, Muscatine, Mahaska, Keokuk, Washington, Louisa, Monroe, Wapello, Jefferson, Henry, Des Moines, Appanoose, Davis, Van Buren, and Lee.

“*Self-employed*” means that a person satisfies any of the following conditions:

1. The person is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions; or
2. The person establishes the person’s own working hours, territory, and methods of work; or
3. The person files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

“*Third-party administrator*” shall mean the person or entity with which the department contracts to provide administrative services for the HAWK-I program.

“*Unearned income*” means cash income of all parents, spouses, and children under the age of 19 who are living together in accordance with subrule 86.2(3) that is not gained by labor or service. The available unearned income shall be the amount remaining after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Examples of unearned income include, but are not limited to:

1. Social security benefits, meaning the amount of the entitlement before withholding of a Medicare premium.
2. Child support and alimony payments received for a member of the family.
3. Unemployment compensation.
4. Veterans benefits.

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441—86.2(514I) Eligibility factors. The decision with respect to eligibility shall be based primarily on information furnished by the applicant, the enrollee, or a person acting on behalf of the applicant or enrollee. A child must meet the following eligibility factors to participate in the HAWK-I program.

86.2(1) Age. The child shall be under 19 years of age. Eligibility for the program ends the first day of the month following the month of the child’s nineteenth birthday.

86.2(2) Income.

a. Gross countable income. In determining initial and ongoing eligibility for the HAWK-I program, gross countable income shall not exceed 300 percent of the federal poverty level for a family of the same size.

b. Exempt income. The following shall not be counted toward the income limit when establishing eligibility for the HAWK-I program.

(1) Nonrecurring lump sum income. Nonrecurring lump sum income is income that is not expected to be received more than once. These payments may include, but are not limited to:

1. An inheritance.
2. A one-time bonus.
3. Lump sum lottery winnings.
4. Other one-time payments.

(2) Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

(3) The value of benefits issued in the Food Assistance Program.

(4) The value of the United States Department of Agriculture donated foods (surplus commodities).

(5) The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

(6) Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

(7) Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

(8) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

(9) Interest and dividend income.

(10) Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe.

(11) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program.

(12) Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

(13) Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

(14) Experimental housing allowance program payments.

(15) The income of a Supplemental Security Income (SSI) recipient.

(16) Income of an ineligible child if the family chooses not to include the child in the eligibility determination in accordance with the provisions of paragraph 86.2(3)“c.”

(17) Income in kind.

(18) Family support subsidy program payments.

(19) All earned and unearned educational funds of an undergraduate or graduate student or a person in training. However, any additional amount of educational funds received for the person's dependents that are in the eligible group shall be considered as nonexempt income.

(20) Bona fide loans.

(21) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

(22) Payment for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

(23) Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383 entitled Wartime Relocation of Civilians.

(24) Payments received from the Radiation Exposure Compensation Act.

(25) Reimbursements from a third party or from an employer for job-related expenses.

(26) Payments received for providing foster care when the family is operating a licensed foster home.

(27) Any payments received as a result of an urban renewal or low-cost housing project from any governmental agency.

(28) Retroactive corrective payments.

(29) The training allowance issued by the division of vocational rehabilitation, department of education.

(30) Payments from the PROMISE JOBS program.

(31) The training allowance issued by the department for the blind.

(32) Payments from passengers in a car pool.

(33) Compensation in lieu of wages received by a child under the Job Training Partnership Act of 1982.

(34) Any amount for training expenses included in a payment issued under the Job Training Partnership Act of 1982.

(35) Earnings of a child under the age of 19 who is a full-time student as defined at 441—75.54(1) “b”(1) and (2).

(36) Incentive payments received from participation in the adolescent pregnancy prevention programs.

(37) Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complementary assistance by federal regulations.

(38) Incentive allowance payments received from the work force investment project, provided the payments are considered complementary assistance by federal regulation.

(39) Honorarium income and all moneys paid to an eligible family in connection with the welfare reform longitudinal study.

(40) Family investment program (FIP) benefits.

(41) Moneys received through pilot self-sufficiency grants or diversion programs.

(42) Income that has ended as of the date of application.

(43) Any income restricted by law or regulation that is paid to a representative payee living outside the home, other than to a parent who is the applicant or recipient, unless the income is actually made available to the applicant or recipient by the representative payee.

(44) A federal or state earned income tax credit, regardless of whether the payment is received with the regular paycheck or as a lump sum with the federal or state income tax refund.

(45) All earnings received by temporary workers from the U.S. Bureau of the Census.

c. Verification of income. Income shall be verified using the best information available. For example, earnings from the 30 days before the date of application may be used to verify earned income if it is representative of the income expected in future months.

(1) Pay stubs, tip records, tax records and employers’ statements are acceptable forms of verification of earned income.

(2) Unearned income shall be verified through data matches when possible, award letters, warrant copies, or other acceptable means of verification.

(3) Self-employment income shall be verified using business records or income tax returns from the previous year if they are representative of anticipated earnings.

(4) When a child who has been determined ineligible for Medicaid is referred to the HAWK-I program, the third-party administrator shall use the income amount used by the Medicaid program unless rules in this chapter require the income to be treated differently.

d. Changes in income. Once initial eligibility is established, changes in income during the 12-month enrollment period shall not affect the child’s eligibility to participate in the HAWK-I program. However, if income has decreased, the family may request a review of their income to establish whether they are required to continue paying a premium in accordance with rule 441—86.8(514I).

86.2(3) Family size. For purposes of establishing initial and ongoing eligibility under the HAWK-I program, the family size shall consist of all persons living together who are children under the age of 19 or who are parents of those children as defined below.

EXCEPTION: Persons who are receiving Supplemental Security Income (SSI) under Title XVI of the Social Security Act or who are voluntarily excluded in accordance with the provisions of paragraph “c” below are not considered in determining family size.

a. Children. A child under the age of 19 and any siblings under the age of 19 of whole or half blood or adoptive shall be considered together unless the child is emancipated due to marriage, in which case, the emancipated child is not included in the family size unless the marriage has been annulled. Emancipated children, their spouses, and children who live with parents or siblings of the emancipated child shall be considered as a separate family when establishing eligibility for the HAWK-I program.

b. Parents. Any parent living with the child under the age of 19 shall be included in the family size. This includes the biological parent, stepparent, or adoptive parent of the child and is not dependent upon whether the parents are married to each other. In situations where the parents do not live together but share joint physical custody of the children, the family size shall be based on the household in which the child spends the majority of time. If both parents share physical custody equally, either parent may apply on behalf of the child and the family size shall be based on the household of the applying parent.

c. Persons who may be excluded when determining family size. If including a child in the family size causes siblings to be ineligible, the family may choose not to count the child in the family size. However, this rule shall not apply when the child is receiving Supplemental Security Income (SSI) benefits because SSI recipients are not counted in determining family size for the purposes of HAWK-I eligibility.

d. Temporary absence from the home. The following policies shall be applied to any person who would be counted in the family size in accordance with paragraphs “a” and “b” who is temporarily absent from the home.

(1) When a person is absent from the home to secure education or training (e.g., the person is attending college), the person shall be included when establishing the size of the family at home and, if otherwise eligible, shall be covered under the program.

(2) When a person is absent from the home to secure medical care, the person shall be included when establishing the size of the family at home and, if otherwise eligible, shall be covered under the program when the reason for the absence is expected to last less than 12 months.

(3) When a person is absent from the home because the person is an inmate in a nonmedical public institution (e.g., a penal institution) in accordance with the provisions of subrule 86.2(9), the person shall be included when establishing the size of the family at home if the absence is expected to be less than three months. However, when the person is a child under the age of 19, coverage under the program shall not be provided pursuant to subrule 86.2(10) until the child returns to the home.

(4) When a child is absent from the home because the child is in foster care, the child shall not be included when establishing the size of the family at home.

(5) When a child is absent from the home for a vacation or a visit to an absent parent, for example, the child shall be included in establishing the size of the family at home and, if otherwise eligible, shall be covered under the program if the absence is expected to be less than three months.

86.2(4) Uninsured status. The child must be uninsured.

a. A child who is currently enrolled in an individual or group health plan is not eligible to participate in the HAWK-I program. However, a child who is enrolled in a plan shall not be considered insured for purposes of the HAWK-I program if:

(1) The plan provides coverage only for a specific disease or service (such as a vision, dental, or cancer policy), or

(2) The child does not have reasonable geographic access to care under that plan. “Reasonable geographic access” means that the plan or an option available under the plan does not have service area limitations or, if the plan has service area limitations, the child lives within 30 miles or 30 minutes of a network primary care provider.

b. A child whose health insurance ends in the month of application shall be considered uninsured for purposes of HAWK-I eligibility. However, a one-month waiting period may be imposed pursuant to subrule 86.5(1) for a child who is subject to a monthly premium pursuant to paragraph 86.8(2) “c.”

c. American Indian and Alaska Native. American Indian and Alaska Native children are eligible for the HAWK-I program on the same basis as other children in the state, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care.

86.2(5) *Ineligibility for Medicaid.* The child shall not be receiving Medicaid or eligible to receive Medicaid if application were made except when the child would be required to meet a spenddown under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

a. A child who would be eligible for Medicaid except for the parent's failure or refusal to cooperate in establishing initial or ongoing eligibility shall not be eligible for coverage under the HAWK-I program.

b. Children who are excluded from the Medicaid household due to the income or resources of the child may participate in the HAWK-I program if otherwise eligible.

86.2(6) *Iowa residency.* The child shall be a resident of the state of Iowa. A resident of Iowa is a person:

a. Who is living in Iowa voluntarily with the intention of making that person's home in Iowa and not for a temporary purpose; or

b. Who, at the time of application, is not receiving assistance from another state and entered Iowa with a job commitment or to seek employment or who is living with parents or guardians who entered Iowa with a job commitment or to seek employment.

86.2(7) *Citizenship and alien status.* The child shall be a citizen or lawfully admitted alien. The criteria established under 441—subrule 75.11(2) shall be followed when determining whether a lawfully admitted alien child is eligible to participate in the HAWK-I program.

a. The citizenship or alien status of the parents or other responsible person shall not be considered when determining the eligibility of the child to participate in the program.

b. As a condition of eligibility for HAWK-I:

(1) All applicants shall attest to their citizenship status by signing the application form, which contains a citizenship declaration. EXCEPTION: Applicants applying pursuant to subrule 86.3(6) shall instead complete and sign Form 470-2549, Statement of Citizenship Status.

(2) When a child under the age of 19 is not living independently, the child's parent or other responsible person with whom the child lives shall be responsible for attesting to the child's citizenship or alien status and for providing any required proof of the status.

c. Except as provided in 441—paragraph 75.11(2)“*f*,” applicants or enrollees for whom an attestation of United States citizenship has been made pursuant to paragraph 86.2(7)“*b*” shall present satisfactory documentation of citizenship or nationality as defined in 441—paragraphs 75.11(2)“*d*,” “*e*,” “*g*,” and “*h*.”

d. An applicant or enrollee shall have a reasonable period to obtain and provide proof of citizenship and nationality. For the purposes of this requirement, the “reasonable period” begins on the date a written request to obtain and provide proof is issued to an applicant or enrollee and continues to the date the proof is provided or to the sixtieth calendar day from the date the written request was issued.

e. Eligibility for HAWK-I shall not be approved for applicants until acceptable documentary evidence is provided.

f. Failure to provide acceptable documentary evidence by the sixtieth calendar day from the date the written request was issued pursuant to paragraph 86.2(7)“*d*” shall be the basis for denial of coverage under HAWK-I for the child.

g. Failure to provide acceptable documentary evidence for a child shall not affect the eligibility of other children in the family for whom acceptable documentary evidence has been provided.

86.2(8) *Dependents of state of Iowa employees.* The child shall not be eligible for the HAWK-I program if the child is eligible for health insurance coverage as a dependent of a state of Iowa employee unless the state contributes only a nominal amount toward the cost of dependent coverage. “Nominal amount” shall mean \$10 or less per month.

86.2(9) *Inmates of nonmedical public institutions.* The child shall not be an inmate of a nonmedical public institution as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

86.2(10) *Inmates of institutions for mental disease.* At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental disease as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

86.2(11) *Preexisting conditions.* The child shall not be denied eligibility based on the presence of a preexisting medical or dental condition.

86.2(12) *Furnishing a social security number.*

a. As a condition of eligibility, a social security number or proof of application for the number if the number has not been issued or is not known must be furnished for a child for whom coverage under HAWK-I is being requested or received.

(1) When proof of application for a social security number has been provided, the number must be reported upon receipt.

(2) The requirement to provide a social security number does not apply if the person refuses to obtain a social security number because of well-established religious objections. The term “well-established religious objections” means that the person is a member of a recognized religious sect or a division of a recognized religious sect and adheres to the tenets or teachings of the sect or division, and for that reason is conscientiously opposed to applying for or using a national identification number.

b. Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of a social security number when the applicant or enrollee is cooperating in providing information necessary for issuance of the number.

c. The mother of a newborn child shall have until the second month following the mother’s discharge from the hospital to apply for a social security number for the child.

d. A social security number may be requested for a person in the family for whom coverage under HAWK-I is not being requested or received, but provision of the number shall not be a condition of eligibility for the applicant or enrollee.

[ARC 7770B, IAB 5/20/09, effective 7/1/09; ARC 7881B, IAB 7/1/09, effective 7/1/09; ARC 8109B, IAB 9/9/09, effective 10/14/09; ARC 8127B, IAB 9/9/09, effective 9/1/09; ARC 8280B, IAB 11/18/09, effective 1/1/10; ARC 8281B, IAB 11/18/09, effective 12/23/09; ARC 8478B, IAB 1/13/10, effective 3/1/10]

441—86.3(514I) Application process.

86.3(1) *Who may apply.* Each person wishing to do so shall have the opportunity to apply without delay. When the request is made in person, the requester shall immediately be given an application form. When a request is made that the application form be mailed, it shall be sent in the next outgoing mail.

a. Child lives with parents. When the child lives with the child’s parents, including stepparents and adoptive parents, the parent shall file the application on behalf of the child unless the parent is unable to do so.

If the parent is unable to act on the child’s behalf because the parent is incompetent or physically disabled, another person may file the application on behalf of the child. The responsible person shall be a family member, friend or other person who has knowledge of the family’s financial affairs and circumstances and a personal interest in the child’s welfare or a legal representative such as a conservator, guardian, executor or someone with power of attorney. The responsible person shall sign the application form and assume the responsibilities of the incompetent or disabled parent in regard to the application process and ongoing eligibility determinations.

b. Child lives with someone other than a parent. When the child lives with someone other than a parent (e.g., another relative, friend, guardian), the person who has assumed responsibility for the care of the child may apply on the child’s behalf. This person shall sign the application form and assume responsibility for providing all information necessary to establish initial and ongoing eligibility for the child.

c. Child lives independently or is married. When a child under the age of 19 lives in an independent living situation or is married, the child may apply on the child’s own behalf, in which case, the child shall be responsible for providing all information necessary to establish initial and ongoing eligibility. If the child is married, both the child and the spouse shall sign the application form.

86.3(2) *Application form.* An application for the HAWK-I program shall be submitted on Comm. 156, HAWK-I Application, or on Form 470-4016, HAWK-I Electronic Application Summary and Signature, unless the family applies for the Medicaid program first.

a. When an application has been filed for the Medicaid program in accordance with the provisions of rule 441—76.1(249A) and Medicaid eligibility does not exist in accordance with the provisions of rule 441—75.1(249A), or the family must meet a spenddown in accordance with the provisions of 441—subrule 75.1(35) before the child can attain eligibility, the Medicaid application shall be used to

establish eligibility for the HAWK-I program in lieu of the HAWK-I Application, Comm. 156, or Form 470-4016, HAWK-I Electronic Application Summary and Signature.

b. Applications may be obtained by telephoning the toll-free telephone number of the third-party administrator or by accessing the Web site at www.hawk-i.org.

86.3(3) *Place of filing.* An application for the HAWK-I program shall be filed with the third-party administrator responsible for making the eligibility determination. Any local or area office of the department of human services, disproportionate share hospital, federally qualified health center, other facilities in which outstationing activities are provided, school nurse, Head Start, maternal and child health center, WIC office, or other entity may accept the application. However, all applications shall be forwarded to the third-party administrator.

86.3(4) *Date and method of filing.* The application is considered filed on the date an identifiable application is received by the third-party administrator or the department. An identifiable application is an application containing a legible name, address, and signature.

a. Medicaid applications referred to the HAWK-I program. When the family has applied for Medicaid first and the department makes a referral to the third-party administrator, the date the Medicaid application was originally filed with the department shall be the filing date.

b. Electronic applications. When an application is submitted electronically to the third-party administrator, the application is considered filed on the date the third-party administrator receives Form 470-4016, HAWK-I Electronic Application Summary and Signature, containing a legible signature.

86.3(5) *Right to withdraw application.* After an application has been filed, the applicant may withdraw the application at any time prior to the eligibility determination. Requests for voluntary withdrawal of the application shall be documented, and the applicant shall be sent a notice of decision confirming the request.

86.3(6) *Application not required.*

a. An application shall not be required when a child becomes ineligible for Medicaid and the local office of the department makes a referral to the HAWK-I program.

(1) A referral to the HAWK-I program pursuant to subrule 86.4(3) or 86.4(4) shall be accepted in lieu of an application.

(2) The original Medicaid application or the last review form that is on file in the local office of the department, whichever is more current, shall suffice to meet the signature requirements.

b. A new application shall not be required when an eligible child is added to an existing HAWK-I eligible group.

86.3(7) *Information and verification procedure.* The decision with respect to eligibility shall be based primarily on information furnished by the applicant, enrollee, or person acting on behalf of the applicant or enrollee.

a. The third-party administrator shall notify the applicant, enrollee, or person acting on behalf of the applicant or enrollee in writing of additional information or verification that is required to establish eligibility. The third-party administrator shall provide this notice personally, by mail, or by facsimile.

b. Failure to supply the information or verification or refusal to authorize the third-party administrator to secure the information shall serve as a basis for rejection of the application or cancellation of coverage.

c. The applicant, enrollee, or person acting on behalf of the applicant or enrollee shall have ten working days to supply the information or verification requested by the third-party administrator. The third-party administrator may extend the deadline for a reasonable period when the applicant, enrollee, or person acting on behalf of the applicant or enrollee is making every effort but is unable to secure the required information or verification from a third party.

86.3(8) *Time limit for decision.* The third-party administrator shall make a decision regarding the applicant's eligibility to participate in the HAWK-I program within ten working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed within the period for a reason that is beyond the control of the third-party administrator.

a. EXCEPTION: When the application is referred for a Medicaid eligibility determination and Medicaid eligibility is denied, the third-party administrator shall determine HAWK-I eligibility no later than ten working days from the date the administrator receives the notice of Medicaid denial unless additional verification is needed.

b. “Day one” of the ten-day period shall mean the first working day following the date of receipt of a completed application and all necessary information and verification.

86.3(9) Applicant cooperation. An applicant must cooperate with the third-party administrator in the application process, which may include providing verification or signing documents. Failure to cooperate with the application process shall serve as basis for a denial of the application.

86.3(10) Waiting lists. When the department has established that all of the funds appropriated for this program are obligated, the third-party administrator shall deny all subsequent applications for HAWK-I coverage unless Medicaid eligibility exists.

a. The third-party administrator shall mail a notice of decision. The notice shall state that:

(1) The applicant meets the eligibility requirements but that no funds are available and that the applicant will be placed on a waiting list, or

(2) The person does not meet eligibility requirements. In which case, the applicant shall not be put on a waiting list.

b. Prior to an applicant’s being denied or placed on the waiting list, the third-party administrator shall refer the application to the Medicaid program for an eligibility determination. If Medicaid eligibility exists, the department shall approve the child for Medicaid coverage in accordance with 441—86.4(514I).

c. The third-party administrator shall enter applicants on the waiting list on the basis of the date an identifiable application form specified in subrule 86.3(2) is date-stamped by the third-party administrator. An identifiable application is an application containing a legible name, address, and signature.

(1) In the event that more than one application is received on the same day, the third-party administrator shall enter applicants on the waiting list on the basis of the day of the month of the oldest child’s birthday, the lowest number being first on the list.

(2) The third-party administrator shall decide any subsequent ties by the month of birth of the oldest child, January being month one and the lowest number.

d. If funds become available, the third-party administrator shall select applicants from the waiting list based on the order in which their names appear on the list and shall notify them of their selection.

e. After being notified of the availability of funding, the applicant shall have 15 working days to confirm the applicant’s continued interest in applying for the program and to provide any information necessary to establish eligibility. If the applicant does not confirm continued interest in applying for the program and does not provide any additional information necessary to establish eligibility within 15 working days, the third-party administrator shall delete the applicant’s name from the waiting list and shall contact the next applicant on the waiting list.

86.3(11) Falsification of information. Rescinded IAB 11/19/08, effective 1/1/09.

86.3(12) Applications pended due to unavailability of a plan. When there is no participating health plan in the applicant’s county of residence, the application shall be held until a plan is available. The application shall be processed when a plan becomes available and coverage shall be effective the first day of the month the plan becomes available.

441—86.4(514I) Coordination with Medicaid.

86.4(1) HAWK-I applicant appears eligible for Medicaid. At the time of initial application, if it appears the child may be eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), a referral shall be made by the third-party administrator to the department for a determination of Medicaid eligibility as follows:

a. The original Healthy and Well Kids in Iowa (HAWK-I) Application, Form 470-3526, or Form 470-4016, HAWK-I Electronic Application Summary and Signature Page, and copies of any accompanying information and verification shall be forwarded to the department within 24 hours, or

the next working day, whichever is sooner. The third-party administrator shall maintain a copy of all documentation sent to the department and a log to track the disposition of all referrals.

b. The third-party administrator shall notify the family that the referral has been made. The third-party administrator shall return to the family any original verification and information that was submitted with the application and retain a copy in the file record.

c. The referral shall be considered an application for Medicaid in accordance with the provisions of rule 441—76.1(249A). The time limit for processing the referred application begins with the date the Healthy and Well Kids in Iowa (HAWK-I) Application, Form 470-3526, or Form 470-4016, HAWK-I Electronic Application Summary and Signature Page, is date-stamped as being received by the third-party administrator.

86.4(2) *HAWK-I enrollee appears eligible for Medicaid.* At the time of the annual review, if it appears the child may be eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the third-party administrator shall make a referral to the department for a determination of Medicaid eligibility as stated in subrule 86.4(1) above. However, the child shall remain eligible for the HAWK-I program pending the Medicaid eligibility determination unless the 12-month certification period expires first.

86.4(3) *Medicaid applicant not eligible.* If a child is not eligible for Medicaid under the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), or is voluntarily excluded from the Medicaid eligible group under the provisions of 441—75.59(249A) and meets the criteria specified at 86.2(5), the department shall make a referral to the third-party administrator for an eligibility determination under the HAWK-I program as follows:

a. The department worker shall submit an electronic referral to the HAWK-I program or complete Form 470-3563, Referral to HAWK-I, and send the form and a copy of the Medicaid notice of decision to the third-party administrator.

b. The third-party administrator shall date-stamp Form 470-3563 with the date the completed form is received.

c. The third-party administrator shall notify the family of the referral and proceed with an eligibility determination under the HAWK-I program.

d. The period for processing the referral begins with the day on which:

(1) Form 470-3563, Referral to HAWK-I, is date-stamped as received by the third-party administrator; or

(2) The third-party administrator receives the electronic referral file.

86.4(4) *Medicaid member becomes ineligible.* If a child becomes ineligible for Medicaid under the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), or is voluntarily excluded from the Medicaid eligible group under the provisions of rule 441—75.59(249A) and meets the criteria specified at subrule 86.2(5), the department shall make a referral to the third-party administrator for an eligibility determination under the HAWK-I program as follows:

a. The department worker shall submit an electronic referral to the HAWK-I program or complete Form 470-3563, Referral to HAWK-I, and send the form and a copy of the Medicaid notice of decision to the third-party administrator.

b. The third-party administrator shall:

(1) Date-stamp Form 470-3563 with the date the completed form is received;

(2) Notify the family of the referral; and

(3) Proceed with an eligibility determination under the HAWK-I program.

c. The period for processing the referral begins with the day on which:

(1) Form 470-3563, Referral to HAWK-I, is date-stamped as received by the third-party administrator; or

(2) The third-party administrator receives the electronic referral file.

441—86.5(514I) Effective date of coverage.

86.5(1) Initial application. Coverage for children who are determined eligible for the HAWK-I program on the basis of an initial application for either HAWK-I or Medicaid shall be effective the first day of the month following the month in which the application is filed, regardless of the day of the month the application is filed, or when a plan becomes available in the applicant's county of residence. However, a one-month waiting period shall be imposed for a child who is subject to a monthly premium pursuant to paragraph 86.8(2) "c" when the child's health insurance coverage ended in the month of application. EXCEPTIONS: A waiting period shall not be imposed if any of the following conditions apply:

- a. The child is moving from Medicaid to HAWK-I.
- b. The child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.
- c. The cost of health insurance coverage for the child exceeds 5 percent of the family's gross income. The cost of health insurance for the child shall be the difference between the premium for coverage with and without the child.
- d. The health insurance was provided through an individual plan.
- e. The child's health insurance coverage was lost due to:
 - (1) Domestic violence.
 - (2) Divorce or death of a parent.
 - (3) An involuntary loss of employment that qualified the parent for dependent coverage, including but not limited to layoff, business closure, reduction in hours, or termination.
 - (4) A job change to a new employer that does not offer the parent dependent coverage or that requires a waiting period before children can be enrolled in dependent coverage.
 - (5) Utilization of the maximum lifetime coverage amount.
 - (6) Expiration of coverage under COBRA.
 - (7) Discontinuation of dependent coverage by the parent's employer.
 - (8) A reason beyond the control of the parent, such as a serious illness of the parent, fire, flood, or natural disaster.

86.5(2) Referrals from Medicaid.

a. *Cancellation of Medicaid.* Coverage for children who are determined eligible for the HAWK-I program on the basis of a referral from Medicaid due to cancellation of Medicaid benefits shall be effective the first day of the month after Medicaid eligibility is lost, regardless of the date of the referral, in order to ensure that there is no break in coverage. However, when such a child does not meet the provisions of paragraph 86.2(4) "a," coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

b. *Denial of Medicaid.* Coverage for children who are determined eligible for the HAWK-I program on the basis of a referral from Medicaid due to denial of Medicaid benefits shall be effective no earlier than the first day of the month following the month in which the Medicaid application was received in accordance with 441—subrule 76.1(2). However, when such a child does not meet the provisions of paragraph 86.2(4) "a," coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

86.5(3) Annual renewals. Coverage for children who are determined eligible for the HAWK-I program on the basis of an annual renewal shall be effective the first day of the month following the month in which the previous enrollment period ended.

86.5(4) Children added to an existing HAWK-I enrollment period. Coverage for children who are determined eligible for the HAWK-I program on the basis of a request from the family to add the child to an existing enrollment period shall be effective the first day of the month following the month in which the request was made. However, if the child does not meet the provisions of paragraph 86.2(4) "a," coverage shall be effective the first day of the month following the month in which health insurance coverage is lost unless the child is subject to a one-month waiting period in accordance with paragraph 86.2(4) "b."

441—86.6(514I) Selection of a plan. At the time of initial application, if there is more than one participating health or dental plan available in the child's county of residence, the applicant shall select the health or dental plan in which the applicant wishes to enroll as part of the eligibility process. The enrollee may change plans only at the time of the annual review unless the provisions of subrule 86.7(1) or paragraph 86.6(2) "a" apply. The applicant may designate the plan choice verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose but is not required.

86.6(1) Coverage in another county's health plan. If a child traditionally travels to another county to receive medical care, the applicant may choose to participate in the health plan available in the county in which the child receives medical care.

86.6(2) Period of enrollment. Once enrolled in a health or dental plan, the child shall remain enrolled in the selected health or dental plan for a period of 12 months unless:

a. There is a substantial change in the provider panel of the health or dental plan originally chosen, as determined by the board. A substantial change means, but is not limited to, loss of a contracted hospital or provider group. When there is another participating health or dental plan available in the child's county of residence, the child may disenroll from the current health or dental plan and enroll in the other health or dental plan.

b. The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the health or dental plan and subsequently reapplies before the end of the original 12-month enrollment period, the child shall be enrolled in the health or dental plan from which the child was originally disenrolled unless the provisions of subrule 86.7(1) apply.

c. The child is added to an existing enrollment. When a family requests to add an eligible child, the child shall be enrolled for the months remaining in the current enrollment period.

86.6(3) Failure to select a health or dental plan. When more than one health or dental plan is available, if the applicant fails to select a health or dental plan within ten working days of the written request to make a selection, the third-party administrator shall select the health or dental plan and notify the family of the enrollment. The third-party administrator shall select the plan on a rotating basis to ensure an equitable distribution between participating health and dental plans.

a. If the third-party administrator has assigned a child a health or dental plan, the family has 30 days to request enrollment into another participating health or dental plan. All changes shall be made prospectively and shall be effective on the first day of the month following the month of the request.

b. If the family has not requested a change of enrollment into another available health or dental plan within 30 days, the provisions of 86.6(2) shall apply.

86.6(4) Child moves from the service area. The child may be disenrolled from the health or dental plan when the child moves to an area of the state in which the health or dental plan does not have a provider network established. If the child is disenrolled, the child shall be enrolled in a participating health or dental plan in the new location. The period of enrollment shall be the number of months remaining in the original certification period.

86.6(5) Change at annual review. If more than one health or dental plan is available at the time of the annual review of eligibility, the family may designate another plan either verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose. The child shall remain enrolled in the current health or dental plan if the family does not notify the third-party administrator of a new health or dental plan choice by the end of the current 12-month enrollment period.

[ARC 8478B, IAB 1/13/10, effective 3/1/10]

441—86.7(514I) Cancellation. The child's eligibility for the HAWK-I program shall be canceled before the end of the 12-month enrollment period for any of the following:

86.7(1) Child moves from the service area. Rescinded IAB 1/13/10, effective 3/1/10.

86.7(2) Age. The child shall be canceled from the HAWK-I program as of the first day of the month following the month in which the child attained the age of 19.

86.7(3) Nonpayment of premiums. The child shall be canceled from the program as of the first day of the month in which premiums are not paid in accordance with the provisions of subrules 86.8(3) and 86.8(5).

86.7(4) Iowa residence abandoned. The child shall be canceled from the program as of the first day of the month following the month in which the child relocated to another state. Eligibility shall not be canceled when the child is temporarily absent from the state in accordance with the provisions of subrule 86.2(6).

86.7(5) Eligible for Medicaid. The child shall be canceled from the program as of the first day of the month following the month in which the third-party administrator is notified of Medicaid eligibility. If there are months during which the child is covered by both the Medicaid and HAWK-I programs, the HAWK-I program shall be the primary payor and Medicaid shall be the payor of last resort.

86.7(6) Enrolled in other health insurance coverage. The child shall be canceled from the program as of the first day of the month following the month in which the third-party administrator is notified that the child has other health insurance coverage. If there are months during which the child is covered by both another insurance plan and the HAWK-I program, the other insurance plan shall be the primary payor and HAWK-I shall be the payor of last resort.

86.7(7) Admission to a nonmedical public institution. The child shall be canceled from the program as of the first day of the month following the month in which the child enters a nonmedical public institution unless the temporary absence provisions of paragraph 86.2(3) “d” apply.

86.7(8) Admission to an institution for mental disease. The child shall be canceled from the program if the child is a patient in an institution for mental disease at the time of annual review.

86.7(9) Employment with the state of Iowa. The child shall be canceled from the HAWK-I program as of the first day of the month in which the child’s parent became eligible to participate in a health or dental plan available to state of Iowa employees.

[ARC 8478B, IAB 1/13/10, effective 3/1/10]

441—86.8(514I) Premiums and copayments.

86.8(1) Income considered. The countable income considered in determining the premium amount shall be the family’s gross countable income minus 20 percent of the family’s earned income.

86.8(2) Premium amount. Except as specified for supplemental dental-only coverage in subrule 86.20(4), premiums under the HAWK-I program shall be assessed as follows:

a. No premium is charged if:

- (1) The eligible child is an American Indian or Alaskan Native; or
- (2) The family’s countable income is less than 150 percent of the federal poverty level for a family of the same size.

b. If the family’s countable income is equal to or exceeds 150 percent of the federal poverty level for a family of the same size but does not exceed 200 percent of the federal poverty level for a family of that size, the premium is \$10 per child per month with a \$20 monthly maximum per family.

c. If the family’s countable income is equal to or exceeds 200 percent of the federal poverty level for a family of the same size, the premium is \$20 per child per month with a \$40 monthly maximum per family.

86.8(3) Due date.

a. *Payment upon initial application.* “Initial application” means the first program application or a subsequent application that is not a renewal. Upon approval of an initial application, the first month for which a premium is due is the third month following the month of decision. The due date of the first premium shall be the tenth day of the second month following the month of decision.

b. *Payment upon renewal.* “Renewal” means any application used to establish ongoing eligibility, without a break in coverage, for any enrollment period subsequent to an enrollment period established by an initial application.

(1) Upon approval of a renewal, the first month for which a premium is due is the first month of the enrollment period. The premium for the first month of the enrollment period shall be due by the tenth day of the month before the month of coverage or the tenth business day following the date of decision, whichever is later.

(2) All premiums due must be paid before the child will be enrolled for coverage. When the premium is received, the third-party administrator shall notify the health and dental plans of the enrollment.

c. Subsequent payments. All subsequent premiums are due by the tenth day of each month for the next month's coverage and must be postmarked no later than the last day of the month before the month of coverage. Failure to pay the premium by the last day of the month before the month of coverage shall result in cancellation from the program. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

86.8(4) Reinstatement. A child may be reinstated once per enrollment period when the family fails to pay the premium by the last day of the month for the next month's coverage. If the premium is subsequently received, coverage will be reinstated if the premium was postmarked or otherwise paid in the calendar month immediately following disenrollment.

86.8(5) Method of premium payment. Premiums may be submitted in the form of cash, personal checks, automatic bank account withdrawals, or other methods established by the third-party administrator.

86.8(6) Failure to pay premium. Failure to pay the premium in accordance with subrules 86.8(3) and 86.8(5) shall result in cancellation from the program unless the reinstatement provisions of subrule 86.8(4) apply. Once a child is canceled from the program due to nonpayment of premiums, the family must reapply for coverage.

86.8(7) Copayment. There shall be a \$25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition.

EXCEPTION: A copayment shall not be imposed when family income is less than 150 percent of the federal poverty level for a family of the same size or when the child is an eligible American Indian or Alaskan Native.

[ARC 7770B, IAB 5/20/09, effective 7/1/09; ARC 8478B, IAB 1/13/10, effective 3/1/10]

441—86.9(514I) Annual reviews of eligibility. All eligibility factors shall be reviewed at least every 12 months to establish ongoing eligibility for the program. "Month one" shall be the first month in which coverage is provided.

86.9(1) Review form. The third-party administrator shall send the family Form 470-3526, Healthy and Well Kids in Iowa (HAWK-I) Application, on which the answers, except for income, have been completed based on the information on file. The family shall review the completed information for accuracy and fill in the income section of the form. The family shall be required to provide verification of current income and sign and date the form attesting to its accuracy as part of the review process.

86.9(2) Failure to provide information. The child shall not be enrolled for the next 12-month period if the family fails to provide information and verification of income or otherwise fails to cooperate in the annual review process.

86.9(3) Change in plan. Rescinded IAB 1/13/10, effective 3/1/10.
[ARC 8478B, IAB 1/13/10, effective 3/1/10]

441—86.10(514I) Reporting changes. Changes that may affect eligibility shall be reported timely to the third-party administrator. "Timely" shall mean no later than ten working days after the change occurred. "Day one" of the ten-day period shall mean the first working day following the date of the change. The parent, guardian, or other adult responsible for the child shall report the change. If the child is emancipated, married, or otherwise in an independent living situation, the child shall be responsible for reporting the change.

86.10(1) Pregnancy. The pregnancy of a child shall be reported when the pregnancy is diagnosed.

86.10(2) Entry to a nonmedical public institution. The entry of a child into a nonmedical public institution, such as a penal institution, shall be reported following entry to the institution.

86.10(3) Iowa residence is abandoned. The abandonment of Iowa residence shall be reported following the move from the state.

86.10(4) Other insurance coverage. Enrollment of the child in other health insurance coverage shall be reported.

86.10(5) *Employment with the state of Iowa.* The employment of the child's parent with the state of Iowa shall be reported.

86.10(6) *Decrease in income.* If the family reports a decrease in income, the third-party administrator shall ascertain whether the change affects the premium obligation of the family. If the change is such that the family is no longer required to pay a premium in accordance with the provisions of rule 441—86.8(514I), premiums will no longer be charged beginning with the month following the month of the report of the change.

86.10(7) *Failure to report changes.* Rescinded IAB 11/19/08, effective 1/1/09.

86.10(8) *Information reported by a third party.* Information reported by a third party shall not be acted upon until the information is verified in accordance with subrule 86.3(7).

86.10(9) *Cooperation.* The provisions of subrule 86.3(7) shall apply when a request for information or verification is made due to a change. In addition, failure of the enrollee or of the person acting on behalf of the enrollee to provide requested information or verification that may affect eligibility for the program shall result in cancellation and recoupment of all payments made by the department on behalf of the enrollee during the period in question.

86.10(10) *Effective date of change in eligibility.*

a. When a change in circumstances has a positive effect on eligibility, the change in eligibility shall be effective no earlier than the month following the month in which the change in circumstances was reported, regardless of when the change was reported.

b. When a change in circumstances has an adverse effect on eligibility, the change in eligibility shall be effective no earlier than the month following the issuance of a timely notification, in accordance with the provisions of rule 441—86.11(514I). When the change in circumstances was not reported timely, as defined in this rule, benefits shall be recouped beginning with the month following the month in which the change occurred.

c. When an anticipated change in circumstances is reported before the change occurs, no action shall be taken until the change actually occurs and is verified in accordance with the provisions of subrule 86.3(7).

441—86.11(514I) Notice requirements. The applicant shall be provided an adequate written notice of the decision of the third-party administrator regarding the applicant's eligibility for the HAWK-I program. The enrollee shall be notified in writing of any decision that adversely affects the enrollee's eligibility or the amount of benefits. The notice shall be timely and adequate as provided in 441—subrule 7.7(1).

441—86.12(514I) Appeals and fair hearings. If the applicant or enrollee disputes a decision by the third-party administrator to reduce, cancel or deny participation in the HAWK-I program, the applicant or enrollee may appeal the decision in accordance with 441—Chapter 7.

441—86.13(514I) Third-party administrator. The third-party administrator shall have the following responsibilities:

86.13(1) *Determination of eligibility.* The third-party administrator shall determine eligibility in accordance with the provisions of rule 441—86.2(514I).

86.13(2) *Dissemination of application forms and information.* The third-party administrator shall disseminate the following:

a. Rescinded IAB 10/17/01, effective 12/1/01.

b. Outreach materials, application forms, or other materials developed and produced by the department to any organization or individual making a request for the materials. If the request is for quantities exceeding ten, the third-party administrator shall forward the request to Iowa prison industries for dissemination.

c. Participating health and dental plan information.

d. Other materials as specified by the department.

86.13(3) Toll-free dedicated customer services line. The third-party administrator shall maintain a toll-free multilingual dedicated customer service line in accordance with the requirements of the department.

86.13(4) HAWK-I program web site. The third-party administrator shall work in cooperation with the department to maintain a web site providing information about the HAWK-I program.

86.13(5) Application process. The third-party administrator shall process applications in accordance with the provisions of rule 441—86.3(514I).

a. Processing applications and mailing of approvals and denials shall be completed within ten working days of receipt of the application and all necessary information and verification unless the application cannot be processed within this period for a reason beyond the control of the third-party administrator.

b. Original verification information shall be returned to the applicant or enrollee upon completion of review.

86.13(6) Tracking of applications. The third-party administrator shall track and maintain applications. This includes, but is not limited to, the following procedures:

a. Date-stamping all applications with the date of receipt.

b. Screening applications for completeness and requesting in writing any additional information or verification necessary to establish eligibility. All information or verification of information attained shall be logged.

c. Entering all applications received into the data system with an identifier status of pending, approved, or denied.

d. Referring applications to the county office of the department, when appropriate, and receiving application referrals from the department.

e. Rescinded IAB 7/9/03, effective 7/1/03.

f. Notifying the health and dental plans when the number of enrollees who speak the same non-English language equals or exceeds 10 percent of the number of enrollees in the health or dental plan.

86.13(7) Effective date of coverage. The third-party administrator shall establish effective date of coverage in accordance with the provisions of rule 441—86.5(514I).

86.13(8) Selection of health or dental plan. The third-party administrator shall provide participating health and dental plan information to families of eligible children by telephone or mail and, if necessary, offer unbiased assistance in the selection of a health or dental plan in accordance with the provisions of rule 441—86.6(514I).

86.13(9) Enrollment. The third-party administrator shall notify participating health and dental plans of enrollments.

86.13(10) Disenrollments. The third-party administrator shall disenroll an enrollee when the enrollee's eligibility for the HAWK-I program is canceled in accordance with the provisions of rule 441—86.7(514I). The third-party administrator shall notify the participating health and dental plans when an enrollee is disenrolled.

86.13(11) Annual reviews of eligibility. The third-party administrator shall annually review eligibility in accordance with the provisions of rules 441—86.2(514I) and 441—86.9(514I).

86.13(12) Acting on reported changes. The third-party administrator shall ensure that all changes reported by the HAWK-I enrollee in accordance with rule 441—86.10(514I) are acted upon no later than ten working days from the date the change is reported.

86.13(13) Premiums. The third-party administrator shall:

a. Calculate premiums in accordance with the provisions of rule 441—86.8(514I).

b. Collect HAWK-I premium payments. The funds shall be deposited into an interest-bearing account maintained by the department for periodic transmission of the funds and any accrued interest to the HAWK-I trust fund in accordance with state accounting procedures.

c. Track the status of the enrollee premium payments and provide the data to the department.

d. Mail a reminder notice to the family if the premium is not received by the due date.

86.13(14) Notices to families. The third-party administrator shall develop and provide timely and adequate approval, denial, and cancellation notices to families that clearly explain the action being taken in regard to an application or an existing enrollment. Denial and cancellation notices shall clearly explain the appeal rights of the applicant or enrollee. All notices shall be available in English and Spanish.

86.13(15) Records. The third-party administrator shall at a minimum maintain the following records:

- a. All records required by the department and the department of inspections and appeals.
- b. Records which identify transactions with or on behalf of each enrollee by social security number or other unique identifier.
- c. Application, case and financial records.
- d. All other records as required by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

86.13(16) Confidentiality. The third-party administrator shall protect and maintain the confidentiality of HAWK-I applicants and enrollees in accordance with 441—Chapter 9.

86.13(17) Reports to the department. The third-party administrator shall submit reports as required by the department.

86.13(18) Systems. The third-party administrator shall maintain data files that are compatible with the department's and the health plans' data files and shall make the system accessible to department staff. [ARC 8478B, IAB 1/13/10, effective 3/1/10]

441—86.14(514I) Covered services. The benefits provided under the HAWK-I program shall meet a benchmark, benchmark equivalent, or benefit plan that complies with Title XXI of the federal Social Security Act.

86.14(1) Required medical services. The participating health plan shall cover at a minimum the following medically necessary services:

- a. Inpatient hospital services (including medical, surgical, intensive care unit, mental health, and substance abuse services).
- b. Physician services (including surgical and medical, and including office visits, newborn care, well-baby and well-child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits).
- c. Outpatient hospital services (including emergency room, surgery, lab, and x-ray services and other services).
- d. Ambulance services.
- e. Physical therapy.
- f. Nursing care services (including skilled nursing facility services).
- g. Speech therapy.
- h. Durable medical equipment.
- i. Home health care.
- j. Hospice services.
- k. Prescription drugs.
- l. Rescinded IAB 1/13/10, effective 3/1/10.
- m. Hearing services.
- n. Vision services (including corrective lenses).

86.14(2) Abortion. Payment for abortion shall only be made under the following circumstances:

- a. The physician certifies that the pregnant enrollee suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the enrollee in danger of death unless an abortion is performed.
- b. The pregnancy was the result of an act of rape or incest.

86.14(3) Required dental services. Participating dental plans shall cover at a minimum the following necessary dental services:

- a. Diagnostic and preventive services.

- b. Routine and restorative services.
- c. Endodontic services.
- d. Periodontal services.
- e. Cast restorations.
- f. Prosthetics.

[ARC 8478B, IAB 1/13/10, effective 3/1/10]

441—86.15(514I) Participating health and dental plans.

86.15(1) *Licensure.* The participating health or dental plan must:

- a. Be licensed by the division of insurance of the department of commerce to provide health or dental care coverage in Iowa; or
- b. Be an organized delivery system licensed by the director of public health to provide health or dental care coverage.

86.15(2) *Services.* The participating health or dental plan shall provide coverage for the services specified in rule 441—86.14(514I) to all children determined eligible by the third-party administrator.

- a. The participating health or dental plan shall make services it provides to HAWK-I enrollees at least as accessible to the enrollees (in terms of timeliness, duration and scope) as those services are accessible to other commercial enrollees in the area served by the health or dental plan.
- b. Participating health plans shall ensure that emergency services (inpatient and outpatient) are available for treatment of an emergency medical condition 24 hours a day, seven days a week, either through the health plan's own providers or through arrangements with other providers.
- c. If a participating health or dental plan does not provide statewide coverage, the health or dental plan shall participate in every county within the region in which the health or dental plan has contracted to provide services in which it is licensed and in which a provider network has been established. Regions are specified in rule 441—86.1(514I).

86.15(3) *Premium tax.* Premiums paid to participating health and dental plans by the third-party administrator are exempt from premium tax.

86.15(4) *Provider network.* The participating health or dental plan shall establish a network of providers. Providers contracting with the participating health or dental plan shall comply with HAWK-I requirements, which shall include collecting copayments, if applicable.

86.15(5) *Identification cards.* Identification cards shall be issued by the participating health or dental plan to the enrollees for use in securing covered services.

86.15(6) *Marketing.*

a. Participating health and dental plans may not distribute directly or through an agent or independent contractor any marketing materials.

b. All marketing materials require prior approval from the department.

c. At a minimum, participating health and dental plans must provide the following material in writing or electronically:

(1) A current member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to the HAWK-I enrollees. At a minimum the handbook shall include covered services, network providers, exclusions, emergency services procedures, 24-hour toll-free number for certification of services, daytime number to call for assistance, appeal procedures, enrollee rights and responsibilities, and definitions of terms.

(2) All health and dental plan literature and brochures shall be available in English and any other language when enrollment in the health or dental plan by enrollees who speak the same non-English language equals or exceeds 10 percent of all enrollees in the health or dental plan and shall be made available to the third-party administrator for distribution.

d. All health and dental plan literature and brochures shall be approved by the department.

e. The participating health and dental plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

f. The participating health or dental plan may make marketing presentations at the discretion of the department.

86.15(7) Appeal process. The participating health or dental plan shall have a written procedure by which enrollees may appeal issues concerning the health or dental care services provided through providers contracted with the health or dental plan and which:

- a. Is approved by the department prior to use.
- b. Acknowledges receipt of the appeal to the enrollee.
- c. Establishes time frames which ensure that appeals be resolved within 60 days, except for appeals which involve emergency medical conditions, which shall be resolved within time frames appropriate to the situations.
- d. Ensures the participation of persons with authority to take corrective action.
- e. Ensures that the decision be made by a physician, dentist, or clinical peer not previously involved in the case.
- f. Ensures the confidentiality of the enrollee.
- g. Ensures issuance of a written decision to the enrollee for each appeal which shall contain an adequate explanation of the action taken and the reason for the decision.
- h. Maintains a log of the appeals which is made available to the department at its request.
- i. Ensures that the participating health or dental plan's written appeal procedures be provided to each newly covered enrollee.
- j. Requires that the participating health or dental plan make quarterly reports to the department summarizing appeals and resolutions.

86.15(8) Appeals to the department. Rescinded IAB 1/13/99, effective 1/1/99.

86.15(9) Records and reports. The participating health and dental plans shall maintain records and reports as follows:

a. The health or dental plan shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition, the health or dental plan or subcontractor of the health or dental plan, as appropriate, must maintain a medical or dental records system that:

- (1) Identifies each medical or dental record by HAWK-I enrollee identification number.
- (2) Maintains a complete medical or dental record for each enrollee.
- (3) Provides a specific medical or dental record on demand.
- (4) Meets state and federal reporting requirements applicable to the HAWK-I program.
- (5) Maintains the confidentiality of medical or dental records information and releases the information only in accordance with established policy below:

1. All medical and dental records of the enrollee shall be confidential and shall not be released without the written consent of the enrollee or responsible party.

2. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, other practitioners, or facilities that are providing services to enrollees under a subcontract with the health or dental plan. This provision also applies to specialty providers who are retained by the health or dental plan to provide services which are infrequently used, which provide a support system service to the operation of the health or dental plan, or which are of an unusual nature. This provision is also intended to waive the need for written consent for department staff and the third-party administrator assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the health or dental plan itself, and other subcontractors which require information as described under numbered paragraph "5" below.

3. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, or facilities providing emergency care pursuant to paragraph 86.15(2) "b."

4. Written consent is required for the transmission of the medical or dental records information of a former enrollee to any physician or dentist not connected with the health or dental plan.

5. The extent of medical or dental records information to be released in each instance shall be based upon a test of medical or dental necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

6. Medical and dental records maintained by subcontractors shall meet the requirements of this rule.

EXCEPTION: Written consent is required for the transmission of medical records relating to substance abuse, HIV, or mental health treatment in accordance with state and federal laws.

b. Each health or dental plan shall provide at a minimum reports and plan information to the third-party administrator as follows:

- (1) A list of providers of services under the plan.
- (2) Encounter data on a monthly basis as required by the department.
- (3) Other information as directed by the department.

c. Each health or dental plan shall at a minimum provide reports and health or dental plan information to the department as follows:

- (1) Information regarding the plan's appeal process.
- (2) A plan for a health improvement program.
- (3) Periodic financial, utilization and statistical reports as required by the department.
- (4) Time-specific reports which define activity for child health care, appeals and other designated activities which may, at the department's discretion, vary among plans, depending on the services covered or other differences.

- (5) Other information as directed by the department.

86.15(10) Systems. The participating health or dental plan shall maintain data files that are compatible with the department's and third-party administrator's systems.

86.15(11) Payment to the participating health or dental plan.

a. In consideration for all services rendered by a health or dental plan, the health or dental plan shall receive a payment each month for each enrollee. This capitation rate represents the total obligation of the department with respect to the costs of medical or dental care and services provided to the enrollees.

b. The capitation rate shall be actuarially determined by the department July of 2000 and each fiscal year thereafter using statistics and data assumptions and relevant experience derived from similar populations.

c. The capitation rate does not include any amounts for the recoupment of losses suffered by the health or dental plan for risks assumed under the current or any previous contract. The health or dental plan accepts the rate as payment in full for the contracted services. Any savings realized by the health or dental plan due to lower utilization from a less frequent incidence of health or dental problems among the enrolled population shall be wholly retained by the health or dental plan.

d. If an enrollee has third-party coverage or a responsible party other than the HAWK-I program available for purposes of payment for medical or dental expenses, it is the right and responsibility of the health or dental plan to investigate these third-party resources and attempt to obtain payment. The health or dental plan shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

86.15(12) Quality assurance. The health or dental plan shall have in effect an internal quality assurance system.

[ARC 8478B, IAB 1/13/10, effective 3/1/10]

441—86.16(514I) Clinical advisory committee. Members of the clinical advisory committee established in accordance with the provisions of 441—paragraph 1.10(2)“c” shall be appointed to three-year terms. Members may be appointed for more than one term. No more than one-third of the membership of the committee shall rotate off the committee in any given calendar year.

441—86.17(514I) Use of donations to the HAWK-I program. If an individual or other entity makes a monetary donation to the HAWK-I program, the department shall deposit the donation into the HAWK-I trust fund. The department shall track all donations separately and shall not commingle the donations with other moneys in the trust fund. The department shall report the receipt of all donations to the HAWK-I board.

86.17(1) If the donor specifically identifies the purpose of the donation, regardless of the amount, the donation shall be used as specified by the donor as long as the identified purpose is permissible under state and federal law.

86.17(2) If the donation is less than \$5,000 and the donor does not specifically identify how it is to be used, the department shall use the moneys in the following order:

- a. For the direct benefit of enrollees (e.g., premium payments).
- b. For outreach activities.
- c. For other purposes as determined by the HAWK-I board.

86.17(3) If the donation is more than \$5,000 and the donor does not specify how the funds are to be used, the HAWK-I board shall determine how the funds are to be used.

441—86.18(505) Health insurance data match program. All carriers, as defined in Iowa Code section 514C.13, shall enter into an agreement with the department to provide data necessary to allow the department to comply with the mandate of Iowa Code section 505.25. Each carrier shall either:

1. Enter into and maintain an agreement with the department on Form 470-4435, HAWK-I Data Use Agreement; or
2. Provide proof of an existing agreement with the department or the department's designee.

441—86.19(514I) Recovery.

86.19(1) Definitions.

“Administrative error” means an action attributed to the department or to the HAWK-I third-party administrator that results in incorrect payment of benefits, including premiums paid to a health or dental plan, due to one or more of the following circumstances:

1. Misfiled or lost form or document.
2. Error in typing or copying.
3. Computer input error.
4. Mathematical error.
5. Failure to determine eligibility correctly when all essential information was available to the HAWK-I third-party administrator.
6. Failure to request essential verification necessary to make an accurate eligibility determination.
7. Failure to make timely revision in eligibility following a change in policy requiring application of the policy change as of a specific date.
8. Failure to issue timely notice to cancel benefits that results in benefits continuing in error.
9. Failure of the department to provide correct information to the HAWK-I third-party administrator regarding a child's Medicaid eligibility.

“Client error” means an intentional or negligent action attributed to the enrollee that results in incorrect payment of benefits, including premiums paid to a health or dental plan, because the enrollee or the enrollee's representative:

1. Failed to disclose information or gave a false or misleading statement, oral or written, regarding income or another eligibility factor; or
2. Failed to timely report a change as defined in rule 441—86.10(514I).

86.19(2) Amount subject to recovery from the enrollee or representative. The department may recover from the enrollee or the enrollee's representative the amount of premiums incorrectly paid to a health or dental plan on behalf of the enrollee due to client error, minus any premium payments made by the enrollee, in accordance with 441—Chapter 11.

- a. Premiums incorrectly paid to a health or dental plan on behalf of an enrollee due to an administrative error are not subject to recovery from the enrollee.
- b. Payments made by a health or dental plan to a provider of medical or dental services are not subject to recovery from the enrollee regardless of the cause of the error.

86.19(3) Notification. The enrollee shall be promptly notified when it is determined that funds were incorrectly paid due to a client error. Notification shall include:

- a. The name of the person for whom funds were incorrectly paid;

- b. The period during which the funds were incorrectly paid;
- c. The amount subject to recovery; and
- d. The reason for the incorrect payment.

86.19(4) Recovery.

a. Recovery shall be made:

(1) From the enrollee when the enrollee completed the application and had responsibility for reporting changes, or

(2) From the enrollee's representative (i.e., the parent, guardian, or other responsible person acting on behalf of an enrollee who is under the age of 19) when the representative completed the application and had responsibility for reporting changes.

b. The enrollee or representative shall repay to the department the funds incorrectly expended on behalf of the enrollee.

c. Recovery may come from income, income tax refunds, lottery winnings, or other resources of the enrollee or representative.

86.19(5) Appeals. The enrollee shall have the right to appeal a decision to recover benefits under the provisions of 441—Chapter 7.

[ARC 8478B, IAB 1/13/10, effective 3/1/10]

441—86.20(514I) Supplemental dental-only coverage.

86.20(1) Definition.

“*Supplemental dental-only coverage*” means dental care coverage provided to a child who meets the eligibility requirements for the HAWK-I program except that the child is covered by health insurance through an individual or group health plan.

86.20(2) Eligibility. Unless otherwise specified, eligibility for supplemental dental-only coverage shall be determined in accordance with the provisions of rules 441—86.1(514I) through 441—86.12(514I), 441—86.18(514I), and 441—86.19(514I).

86.20(3) Premiums. Premiums for participation in the supplemental dental-only plan are assessed as follows:

a. No premium is charged to families who meet the provisions of paragraph 86.8(2) “a.”

b. If the family's gross countable income is equal to or exceeds 150 percent of the federal poverty level but does not exceed 200 percent of the federal poverty level for a family of the same size, the premium is \$5 per child per month with a \$10 monthly maximum per family.

c. If the family's gross countable income exceeds 200 percent of the federal poverty level but does not exceed 250 percent of the federal poverty level for a family of the same size, the premium is \$10 per child per month with a \$15 monthly maximum per family.

d. If the family's gross countable income exceeds 250 percent of the federal poverty level but does not exceed 300 percent of the federal poverty level for a family of the same size, the premium is \$15 per child per month with a \$20 monthly maximum per family.

e. If the family includes uninsured children who are eligible for both medical and dental coverage under HAWK-I and insured children who are eligible only for dental coverage, the premium shall be assessed as follows:

(1) The total premium shall be no more than the amount that the family would pay if all the children were eligible for both medical and dental coverage.

(2) If the family has one child eligible for both medical and dental coverage and one child eligible for dental coverage only, the premium shall be the total of the health and dental premium for one child and the dental premium for one child.

(3) If the family has two or more children eligible for both medical and dental coverage, no additional premium shall be assessed for dental-only coverage for the children who do not qualify for medical coverage under HAWK-I because they are covered by health insurance.

86.20(4) *Waiting lists.* Before the provisions of subrule 86.3(10) are implemented, all children enrolled in supplemental dental-only coverage shall be disenrolled from the program.
[ARC 8478B, IAB 1/13/10, effective 3/1/10]

These rules are intended to implement Iowa Code chapter 514I as amended by 2009 Iowa Acts, Senate File 389.

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TITLE XIV
GRANT/CONTRACT/PAYMENT ADMINISTRATION

CHAPTER 150
PURCHASE OF SERVICE

[Prior to 7/1/83, Social Services[770] Ch 145]
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[Prior to 2/11/87, Human Services[498]]

DIVISION I
TERMS AND CONDITIONS FOR IOWA PURCHASE OF SOCIAL SERVICES AGENCY AND
INDIVIDUAL CONTRACTS, IOWA PURCHASE OF ADMINISTRATIVE SUPPORT, AND
IOWA DONATIONS OF FUNDS CONTRACT AND PROVISIONS FOR PUBLIC ACCESS TO CONTRACTS

441—150.1(234) Definitions.

“Accounting year” means a 12 consecutive month period for which accounting records are maintained. It can be either a calendar year or another designated fiscal year.

“Accrual basis accounting” means the accounting basis which shows all expenses incurred and income earned for a given time even though the expenses may not have been paid or income received in cash during the period.

“Administrative support” means technical assistance, studies, surveys, or securing volunteers to assist the department in fulfilling its administrative responsibilities.

“Agency” means an organization or organizational unit that provides social services.

1. Public agency means a general or special-purpose unit of government and organizations administered by that unit to deliver social services, for example, county boards of supervisors, community colleges, and state agencies.

2. Private nonprofit agency means a voluntary agency operated under the authority of a board of directors for purposes other than generating profit and incorporated under Iowa Code chapter 504A. An out-of-state agency must meet requirements of similar laws governing nonprofit organizations in its state.

3. Private proprietary agency means a for-profit agency operated by an owner or board for the operator’s financial benefit.

“Bureau of purchased services” means a bureau of the division of fiscal management, which is responsible for administering the purchase of service system.

“Cash basis accounting” means the accounting basis which records expenses when bills are paid and income when money is received.

“Ceiling” means the maximum limit for payment for a service which has been established by an administrative rule or by the Iowa Code specifically for that service.

“Client” means an individual or family group who has applied for and been found to be eligible for social services from the Iowa department of human services.

“Common ownership” means that relationship existing when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

“Components of service” means the elements or activities that make up a specific service.

“Contract” means formal written agreement between the Iowa department of human services and another legal entity, except for those government agencies whose services are covered under provision of Iowa Code chapter 28E.

“Contractor” means an institution, organization, facility or individual who is a legal entity and has entered into a contract with the department of human services.

“Control” means that relationship existing where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

“Department” means the Iowa department of human services.

“Direct cost” means those expenses which can be identified specifically and solely to a particular program.

“Donor” means a local source of funding (public or private) that enters into an Iowa donation of funds contract.

“Effective date.”

1. Contract effective date for agency contracts means the first day of a month on which the contract shall become in force.

2. Effective date of rate means the date specified in a purchase of service contract on which the specified rate of payment for service provided begins.

“Field staff” means department employees outside of central office reporting to the deputy director of field operations.

“Grant” means an award of funds to develop specific programs or achieve specific outcomes.

“Indirect cost” means those expenses which cannot be related directly to a specific program and are, therefore, allocated to more than one program.

“Project manager” means a department employee who is assigned to assist in developing, monitoring and evaluating a contract and to provide related technical assistance.

“Provider” means an institution, organization, facility, or individual who is a legal entity and has entered into a contract with the department to provide social services to clients of the department.

“Purchase of service system” means the system within the department for contracting and payment for services, including contracts for funding and contracts for technical assistance.

“Related to provider” means that the provider to a significant extent is associated or affiliated with or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

“Relatives” include the following persons: husband and wife, natural parent and child, sibling, adopted child and adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent and grandchild.

“Social services” means a set of actions purposefully directed toward human needs which are socially identified as requiring assistance from others for their resolution.

“Unit of service” means a specified quantity of service or a specific outcome as a result of the service provided.

441—150.2(234) Categories of contracts.

150.2(1) *Iowa purchase of social services contract.* An Iowa purchase of social services contract is a legal contract between the department and a provider for a specified service or services to clients referred by the department. This contract establishes the components of service to be provided, the rate per unit of service, a maximum number of units to be available, and other negotiated conditions. The department has three types of contracts for purchasing social services.

a. An agency contract is a contract written with an agency. Iowa Purchase of Social Services Agency Contract, Form 470-0628, shall be completed prior to services being purchased from the agency.

b. A child care certificate is an agreement written with a licensed child care center, a family day care home, a group day care home, an in-home care provider, or a relative care provider. Policies governing child care certificates may be found in 441—Chapter 170.

c. An individual in-home health-related provider agreement is an agreement written with an individual provider of in-home health services. Policies governing individual in-home health-related provider agreements may be found in 441—Chapter 177.

150.2(2) *Iowa purchase of administrative support contract.* An Iowa purchase of administrative support contract is between the department and a contractor for the provision of administrative support. This contract establishes the support services to be provided, the rate and the method of payment, and other negotiated conditions. A contractor or the division of a contractor who is a multiservice organization holding an administrative support contract may not provide direct client services during the period of the contract.

a. A volunteer contract is the administrative support contract between an individual or agency and the department to secure volunteers to assist the department in service delivery.

b. A general use administrative support contract is between the department and a contractor for the provision of administrative support.

150.2(3) *County board of supervisors’ participation contract.* Rescinded IAB 7/8/92, effective 7/1/92.

150.2(4) Iowa donation of funds contract. The department may accept donated funds.

a. Upon mutual agreement regarding the scope and use of the funds to be donated, the department may negotiate and shall execute a contract between the department and the donor in accordance with department of administrative services rules in 11—Chapters 106 and 107. The contract shall contain specifications concerning amendment, termination, transmittal of funds, accounting, and reversion of unspent funds.

b. Except for restrictions permitted by the contract, all funds shall be donated on an unrestricted basis for use as if they were appropriated funds and shall be under the administrative control of the department. The donor may specify the geographic area to be served and the specific service to be provided.

c. No funds donated and transmitted to the department will be returned to the donor unless specified in the contract.

441—150.3(234) Iowa purchase of social services agency contract.

150.3(1) Initiation of contract proposal. When the department issues a request for proposal to select providers, the process and conditions for approving contract proposals shall be as specified in the request, and the department shall not be required to contract with a provider that is not selected. Otherwise, the following procedures for initiation of contract proposals shall apply.

a. *Right to request a contract.* All potential provider agencies have a right to request a contract.

b. *Initial contact.* The initial contact should be between the potential provider and the service area manager for the service area in which the provider's headquarters is located. In the case of out-of-state providers, this contact can be with the service area manager for either the closest service area or the service area initiating the contact. At the beginning of the process of developing a contract, the bureau of purchased services shall give the provider:

- (1) Information about the contracting process; and
- (2) Instructions on how to access the Purchase of Service Provider Handbook electronically.

c. *Contract proposal development.* When the service area manager determines that a contract is to be developed, a project manager will be assigned who will assist in contract development and processing. The project manager will assist the contractor in completing the contract proposal and fiscal information appropriate to the contract. This information shall include documentation that the conditions of participation are met. Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet, shall be completed at the same time as Form 470-0628, Iowa Purchase of Social Services Agency Contract, or Form 470-0630, Amendment or Renewal of the Iowa Purchase of Social Services Agency Contract, is prepared.

d. *Contract proposal approval or rejection.* Before a contract can be effective, it shall be signed by the following persons within the time frames provided:

- (1) Authorized representative of the provider agency.
- (2) Service area manager, within one week from receipt.
- (3) Rescinded IAB 5/11/05, effective 5/1/05.
- (4) Chief of the bureau of purchased services, within 30 days from receipt.

The provider shall be given a notice and explanation in writing of delays in the process or of rejection of the proposal. Payment cannot be made until the contract is signed by the provider's authorized representative and the chief of the bureau of purchased services.

e. *Criteria for rejection.* The following criteria may cause a proposed contract to be rejected:

- (1) The service is not needed by department clients.
- (2) The service is not in the social services block grant plan for the counties to be served by the program.
- (3) No funds are available for the service being proposed.
- (4) The proposed contract does not meet applicable rules, regulations, or guidelines, including service definition.

f. Contract effective date. When the agreed-upon contract conditions have been met, the effective date of the contract is the first day of an agreed-upon month following signature by the chief of the bureau of purchased services.

150.3(2) Contract administration.

a. Contract management. During the contract period the assigned project manager shall be the contract liaison between the department and the provider. The project manager shall be contacted on all interpretations and problems relating to the contract and shall follow the issues through to their resolution. The project manager shall also monitor performance under the contract and shall provide or arrange for technical assistance to improve the provider's performance, if needed. Report of On-Site Visit, Form 470-0670, may be used to monitor performance under the contract.

b. Contract amendment. The contract shall be amended only upon agreement of both parties. Amendments which affect the cost of services shall include reestablishment of applicable rates. Amendment or Renewal of Iowa Purchase of Social Services Agency Contract, Form 470-0630, shall be used to amend or renew the contract.

c. Contract renewal. A joint decision to pursue renewal of the contract must be made at least 60 days before the expiration date.

(1) Each contract shall be evaluated. The department shall take the results of the evaluation into consideration in making the decision on renewal. This evaluation may involve use of the Monitoring and Evaluation Review Guide, Form 470-2571, or other evaluation tools specified in the contract.

(2) Desk Audit for Civil Rights Contract Compliance, Form 470-2215, shall be completed by the provider.

d. Contract termination. Causes for termination during the period of the contract are:

- (1) Mutual agreement of the parties involved.
- (2) Demonstration that sufficient funds are unavailable to continue the services involved.
- (3) Failure to make required reporting.
- (4) Failure to make financial and statistical records available for review.
- (5) Failure to abide by the provisions of the contract.

150.3(3) Conditions of participation. The provider shall meet the following standards:

a. Licensure, approval, or accreditation. The provider shall have any license, approval, and accreditation required by law, regulation or administrative rules, or standards of operation required by the state or the federal government before the contract can be effective. Out-of-state providers shall meet Iowa licensing standards related to treatment, professional staff to client ratio, and staff qualifications.

b. Signed contract. A contract can be effective only when signed by all parties required in 150.3(1) "d."

c. Civil rights laws. The providers shall be in compliance with all federal, state and local civil rights laws and regulations with respect to equal employment opportunity, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

d. Title VI compliance. The provider shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services, or have a written plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

e. Section 504 compliance. The provider shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, Plan Review Accessibility Checklist, Form 470-0149, and Section 504 Transition Plan: Structural Accessibility, Form 470-0150, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

f. Affirmative action. The provider shall be in compliance with all federal, state, and local laws and regulations regarding affirmative action, or have a written work plan approved by the diversity programs unit to come into compliance. Equal Opportunity Review, Form 470-0148, shall be completed by the provider. Equal Opportunity Review Status Report, Form 470-2194, shall be completed by the diversity programs unit.

g. Abuse reporting. The provider shall have a written policy and procedure approved by the service area manager or designee for reporting abuse or denial of critical care of children or dependent adults.

h. Confidentiality. The provider shall comply with all applicable federal and state laws and regulations on confidentiality including rules on confidentiality contained in 441—Chapter 9. The provider shall have a written policy and procedure approved by the service area manager or designee for maintaining individual client confidentiality including client record destruction.

i. Client appeals and grievances. Clients receiving service through a purchase of service contract have the right to appeal adverse decisions made by the department or the provider. The provider shall have a written policy and procedure approved by the service area manager or designee for handling client appeals and grievances and shall provide information to clients about their rights to appeal.

j. Client reports. The provider shall maintain the following client records:

(1) Provider service plan or individual program plan. Providers shall develop a written service plan or individual program plan for each client within 30 days of service initiation. The plan shall include a concise description of the situation or area which will be the focus of the service; statement of the goals to be achieved through the delivery of services; time limited and measurable objectives which will lead to the attainment of the goal to be achieved; specific service components, frequency, and the assignment of responsibility for the provision of the components; and the month and year when it is estimated the client will be able to achieve the current goals and objectives. The provider service plan shall be updated upon receipt of a new departmental case plan, but at least once every six months.

(2) Quarterly progress reports. Quarterly progress reports shall be sent to the department service worker responsible for the client. The first report shall be submitted to the department three months after service is initiated. Reports shall be submitted quarterly thereafter, unless provided for otherwise in rules for a specific service.

The progress report shall include a description of the specific service components provided, their frequency, and who provided them; the client's progress with respect to the goals and service objectives; and any recommended changes in the service plan or individual program plan. For all placement cases the report shall include interpretation of the client's reaction to placement, a summary of medical or dental services that were provided, a summary of educational or vocational progress and participation, and a summary of the involvement of the family with the client and the services.

Reports for the supervised apartment living service shall also include supporting documentation for service provision. The documentation shall list dates of client and collateral contacts, type of contact, persons contacted, and a brief explanation of the focus of each contact. Each unit of service for which payment is sought should be the subject of a written progress note.

(3) Termination of service summary. A termination of service summary shall be sent to the department service worker responsible for the client within two weeks of service termination. The summary shall include the rationale for service termination and the impact of the service components on the client in relationship to the established goals and objectives.

k. Financial and statistical records. Each provider of service must maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department.

(1) The records shall be available for review at any time during normal business hours by department personnel, the purchase of service fiscal consultant, and state or federal audit personnel.

(2) These records shall be retained for a period of five years after final payment.

l. Reports on financial and statistical records. Reports on financial and statistical records shall be submitted as required. Failure to do so within the required time limits is grounds for termination of the contract.

m. Maintenance of client records. Records for clients served through a purchase of service contract must be retained by the provider for a period of three years after service to the client terminates.

n. Provider charges. A provider shall not charge department clients more than it receives for the same services provided to nondepartmental clients.

o. Special-purpose organizations. A provider may establish a separate, special-purpose organization to conduct certain of the provider's client-related or nonclient-related activities. For example, a development foundation assumes the provider's fund-raising activity. Often, the provider does not own the special-purpose organization (e.g., a nonprofit, nonstock-issuing corporation), and has no common governing body membership. However, a special-purpose organization is considered to be related to a provider if:

(1) The provider controls the organization through contracts or other legal documents that give the provider the authority to direct the organization's activities, management, and policies; or

(2) The provider is, for all practical purposes, the primary beneficiary of the organization's activities. The provider should be considered the special-purpose organization's primary beneficiary if one or more of the following circumstances exist:

The organization has solicited funds on the provider's behalf with provider approval, and substantially all funds so solicited were contributed with intent of benefiting the provider.

The provider has transferred some of its resources to the organization, substantially all of whose resources are held for the benefit of the provider; or

The provider has assigned certain of its functions to a special-purpose organization that is operating primarily for the benefit of the provider.

p. Certification by department of transportation.

(1) If the provider furnishes public transit service as defined in 761—910.1(324A), the provider shall annually submit to the project manager information regarding compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules in 761—Chapter 910. This information shall include:

1. Form 020107, Certification Application for Coordination of Public Transit Services, which the project manager shall submit to the department of transportation; and

2. A copy of an ACORD Certificate of Insurance or similar self-insurance documentation, as applicable.

(2) If a provider believes it does not furnish public transit service as defined in 761—910.1(324A) and therefore is exempt from the requirements in subparagraph (1), the provider shall submit Form 020107 with only Section 1 completed when the provider enters into a new contract.

(3) If a provider that has furnished public transit service as defined in 761—910.1(324A) ceases to do so, the provider becomes exempt from the requirements in subparagraph (1).

(4) If an exempt provider begins to furnish public transit service as defined in 761—910.1(324A), the provider shall inform the project manager within 30 days of the change and shall adhere to the procedures in subparagraph (1).

(5) Failure of the provider to cooperate in obtaining or providing the required documentation for compliance or exemption is grounds for denial or termination of the contract.

q. Services provided. Services provided, as described in Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet, and attachments, shall at a minimum meet the rules found in the Iowa Administrative Code for a particular service or the contract may be terminated.

r. Bonding, indemnity and insurance clauses.

(1) Rescinded IAB 2/3/93, effective 4/1/93.

(2) Indemnity. The provider agrees that it will at all times during the existence of this contract indemnify and hold harmless the department and county against any and all liability, loss, damages, costs or expenses which the provider may hereafter sustain, incur or be required to pay:

1. By reason of any client's suffering personal injury, death or property loss or damages either while participating in or receiving from the provider the care and services to be furnished by the provider under this contract, or while on premises owned, leased, or operated by the provider, or while being

transported in any vehicle owned, operated, leased, chartered, or otherwise contracted for by the provider or any officer, agency, or employee thereof.

2. By reason of any client's causing injury to or damage to another person or property during any time when the provider or any officer, agency or employee thereof has undertaken or is furnishing the care and service called for under this contract.

(3) Insurance. The provider agrees that in order to protect itself as well as the department and county under the indemnity agreement above, it will at all times during the term of the contract have and keep in force a liability insurance policy, verification of which shall accompany Form 470-0663, Iowa Purchase of Social Services Agency Contract Face Sheet. The provider agrees that all employees, volunteers, or any other person, other than employees of the department acting within the scope of their employment in the department, authorized to transport clients in privately owned vehicles, have liability insurance in force.

s. Renegotiation clause. In the event there is a revision of federal or state laws or regulations and this contract no longer conforms to those laws or regulations, both parties will review the contract and renegotiate those items necessary to conform with the new federal or state laws or regulations.

t. Performance measures. The department may require performance measures.

150.3(4) Establishment of rates. The Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, is the basis for establishing the rates to be paid to all providers under an Iowa Purchase of Social Services Agency Contract, Form 470-0628, except as provided below.

a. Injectable contraceptive unit. Rescinded IAB 8/1/07, effective 9/5/07.

b. Out-of-state providers.

(1) Rescinded IAB 9/1/93, effective 11/1/93.

(2) Out-of-state providers of other services shall have rates established using the applicable portions of the Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664.

c. Family-centered flexible supportive services. Rescinded IAB 5/6/09, effective 7/1/09.

150.3(5) Financial and statistical report. The Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, shall be completed by those providers as required in 150.3(4). The reports shall be based on the following rules.

a. Accounting procedures. Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers who are multiple program agencies shall submit a cost allocation schedule prepared in accordance with recognized methods and procedures.

(1) Direct program expense shall include all direct client contact personnel involved in a program including the time of a supervisor of a program, or the apportioned share of the supervisor's time when the supervisor supervises more than one program.

(2) Expenses other than salary and fringe benefits shall be charged as direct program expenses when the expenses are identifiable to a program. They may also be charged as direct program expenses when a method of distribution acceptable to the department is maintained on a consistent basis.

(3) Occupancy expenses shall be allocated to programs on a space utilization formula. The space utilization formula may be used for salaries and fringes of building maintenance and janitorial type personnel.

(4) All expenses which relate jointly to two or more programs shall be allocated to program service costs by utilizing a cost allocation method which fairly distributes costs to the related programs. Any expenses which relate directly to a particular program shall be reflected as such. All maintenance costs shall be charged directly or allocated proportionately to the related programs affected.

(5) Indirect program service costs shall be distributed over all applicable services.

(6) Expenses such as supplies, conferences, and similar expenses that cannot be directly related to a program shall be charged to indirect program service costs.

(7) A multiservice agency shall establish a method acceptable to the department of distributing indirect program service costs.

(8) Income received from fund-raising efforts or donations shall be reported as revenue on the financial and statistical report and used to offset fund-raising costs. Fund-raising costs remaining after the offset shall be an unallowable cost.

All contributions shall be accompanied by a schedule showing the contribution and anticipated designation by the agency. No private moneys contributed to the agency shall be included by the department in its reimbursement rate determination unless these moneys are contributed for services provided to specific individuals for whom the reimbursement rate is established by the department.

If a shelter care provider's actual and allowable costs for a child's shelter care placement exceed the amount the department is authorized to pay and the provider is reimbursed by the child's county of legal settlement for the difference between actual and allowable costs and the amount reimbursed by the department, the amount paid by the county shall not be included by the department in its reimbursement rate determination, as long as the amount paid is not greater than the provider's actual and allowable costs, or the statewide average of actual and allowable costs in May of the preceding year for juvenile shelter care homes, whichever is less.

(9) When an agency has a certified public accounting firm perform an audit of its financial statements, the resulting audit report shall follow one of the uniform audit report formats recommended by the American Institute of Certified Public Accountants. These formats are specified in the industry audit guide series, "Audits of Voluntary Health and Welfare Organizations," prepared by the Committee on Voluntary Health and Welfare Organizations, American Institute of Certified Public Accountants, New York, 1974. A copy of the certified audit report shall be submitted to the department within 60 days of receipt.

(10) All expenses reported on Form 470-0664 shall be supported by an agency's general ledger and documentation on file in the agency's office.

b. Failure to maintain records. Failure to maintain records adequate to support the Financial and Statistical Report for Purchase of Service Contracts, Form 470-0664, may result in termination of the contract. These records include, but are not limited to:

- (1) Reviewable, legible census reports.
- (2) Payroll information.
- (3) Capital asset schedules.
- (4) All canceled checks, deposit slips, invoices (paid and unpaid).
- (5) Audit reports (if any).
- (6) Board of directors' minutes.

c. Submission of reports. The financial and statistical report shall be submitted to the department no later than three months after the close of the provider's established fiscal year. At least one week must be allowed prior to this deadline for the project manager to review the report and transmit it to the bureau of purchased services in central office. Failure to submit the report in time without written approval from the chief of the bureau of purchased services may reduce payment to 75 percent of the current rate. Failure to submit the report within six months of the end of the fiscal year shall be cause for terminating the contract.

d. Rate modification. Modification of rates shall be made when required by changes in licensing requirements, changes in the law, or amendments to the contract. Requests for modification of a rate may be made when changes are because of program expansion or modification and have the approval of the service area where services are provided. Even if there is a modification of the rate, the modified rate is still subject to any maximum established in any law or rule.

e. Payment of new rate. New rates shall be effective for services provided beginning the first day of the second calendar month after receipt by the bureau of purchased services of a report sufficient to establish rates or, by mutual agreement, new rates shall be effective the first day of the month following completion of the fiscal review. Failure to submit a report sufficient to establish a rate will result in the effective date's being delayed. At least one week must be allowed prior to the deadline in paragraph "c" above for the project manager to review the report and transmit it to central office.

f. Exceptions to costs. Exceptions to costs identified by the bureau of purchased services or its fiscal consultant will be communicated to the provider in writing.

g. Accrual basis. Providers not using the accrual basis of accounting shall adjust amounts to the accrual basis when the financial and statistical report is completed. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expenses.

h. Census data. Documentation of units of service provided which identifies the individual client shall be available on a daily basis and summarized on a monthly report. The documentation and reports shall be retained by the provider for review at the time the expenditure report is prepared and reviewed by the department's fiscal consultant.

i. Opinion of accountant. The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

j. Revenues. When the Financial and Statistical Report is completed, revenues shall be reported as recorded in the general books and records adjusted for accruals. Expense recoveries shall be reflected as revenues.

k. Capital asset use allowance (depreciation) schedule. The Capital Asset Use Allowance Schedule shall be prepared using the guidelines for provider reimbursement in the Medicare and Medicaid Guide, December 1981.

l. The following expenses shall not be allowed:

- (1) Fees paid directors and nonworking officers' salaries.
- (2) Bad debts.
- (3) Entertainment expenses.
- (4) Memberships in recreational clubs, paid for by an agency (country clubs, dinner clubs, health clubs, or similar places) which are primarily for the benefit of the employees of the agency.
- (5) Legal assistance on behalf of clients.
- (6) Costs eligible for reimbursement through the medical assistance program.
- (7) Food and lodging expenses for personnel incurred in the city or immediate area surrounding the personnel's residence or office of employment, except when the specific expense is required by the agency and documentation is maintained for audit purposes. Food and lodging expenses incurred as part of programmed activities on behalf of clients, their parents, guardians, or consultants are allowable expenses when documentation is available for audit purposes.
- (8) Business conferences and conventions. Meeting costs of an agency which are not required in licensure.
- (9) Awards and grants to recognize board members and community citizens for achievement. Awards and grants to clients as part of treatment program are reimbursable.
- (10) Survey costs when required certification is not attained.
- (11) Federal and state income taxes.

m. Limited service—without a ceiling. The following expenses are limited for service without a ceiling established by administrative rule or law for that service. This includes services with maximum rates, with the exception of shelter care.

(1) Moving and recruitment are allowed as a reimbursable cost only to the extent allowed for state employees. Expenses incurred for placing advertising for purposes of locating qualified individuals for staff positions are allowed for reimbursement purposes.

(2) and (3) Rescinded IAB 5/18/88, effective May 1, 1988.

(4) Costs for participation in educational conferences are limited to 3 percent of the agency's actual salary costs, less excluded or limited salary costs as recorded on the financial and statistical report.

(5) Costs of reference publications and subscriptions for program-related materials are limited to \$500 per year.

(6) Memberships in professional service organizations are allowed to the extent they do not exceed one-half of 1 percent of the total salary costs less excluded salary costs.

(7) In-state travel costs for mileage and per diem expenses are allowable to the extent they do not exceed the maximum mileage and per diem rates for state employees for travel in the state.

(8) Reimbursement for air travel shall not exceed the lesser of the minimum commercial rate or the rate allowed for mileage in subparagraph (7) above.

(9) The maximum reimbursable salary for the agency administrator or executive director charged to purchase of service is \$40,000 annually.

(10) Annual meeting costs of an agency which are required in licensure are allowed to the extent required by licensure.

n. Limited service—with a ceiling. The following expenses are limited for services with a ceiling established by administrative rule or law for that service. This includes shelter care.

(1) The maximum reimbursable compensation for the agency administrator or executive director charged to purchase of service annually is \$40,000.

(2) Annual meeting costs of an agency which are required for licensure are allowed to the extent required by licensure.

o. Establishment of ceiling and reimbursement rate.

(1) The maximum allowable rate ceiling applicable to each service is found in the rules for that particular service.

(2) When a ceiling exists, the reimbursement rate shall be established by determining on a per unit basis the allowable cost plus the current cost adjustment subject to the maximum allowable cost ceiling.

p. Rate limits. Interruptions in service programs will not affect the rate. If an agency assumes the delivery of service from another agency, the rate shall remain the same as for the former agency.

(1) The combined service and maintenance reimbursement rate paid to a shelter care provider shall be based on the financial and statistical report submitted to the department. For the fiscal year beginning July 1, 2008, the maximum reimbursement rate shall be \$92.36 per day, based on a 365-day year. If the department reimburses the provider at less than the maximum rate, the department shall adjust the provider's reimbursement rate to the provider's actual and allowable cost plus the inflation factor or to the maximum reimbursement rate, whichever is less.

(2) Effective for the period from January 1, 2010, to June 30, 2010, the reimbursement rates for services provided under a purchase of social service agency contract for supervised apartment living shall be decreased by 5 percent of the rates in effect on December 1, 2009.

(3) The initial reimbursement rate for any new service shall be based upon actual and allowable costs. A new service does not include a new building or location or other changes in method of service delivery for a service currently provided under the contract.

1. For shelter care, if the provider is currently offering shelter care under social services contract, the only time the provider shall be considered to be offering a new service is if the provider adds a service other than shelter care.

2. For supervised apartment living, the only time a provider shall be considered to be offering a new service is when the agency adds a cluster site or a scattered site for the first time. If, for example, the agency has a supervised apartment living cluster site, the addition of a new site does not constitute a new service.

3. If the department defines, in administrative rule, a new service as a social service that may be purchased, this shall constitute a new service for purposes of establishment of a rate. Once the rate for the new service is established for a provider, the rate will be subject to any limitations established by administrative rule or law.

(4) If a social service provider loses a source of income used to determine the reimbursement rate for the provider, the provider's reimbursement rate may be adjusted to reflect the loss of income, provided that the lost income was used to support actual and allowable costs of a service purchased under a purchase of service contract.

q. Related party costs. Direct and indirect costs applicable to services, facilities, equipment, and supplies furnished to the provider by organizations related to the provider are includable in the allowable cost of the provider at the cost to the related organization. All costs allowable at the provider level are also allowable at the related organization level, unless these related organization costs are duplicative of provider costs already subject to reimbursement.

(1) Allowable costs shall be all actual direct and indirect costs applying to any service or item interchanged between related parties, such as capital use allowance (depreciation), interest on borrowed money, insurance, taxes, and maintenance costs.

(2) When the related party's costs are used as the basis for allowable rental or supply costs, the related party shall supply documentation of these costs to the provider. The provider shall complete a schedule displaying amount paid to related parties, related party cost, and total amount allowable. The resulting costs shall be allocated according to policies in 150.3(5) "a"(3) to (7).

Financial and statistical records shall be maintained by the related party under the provisions in 150.3(3) "k."

(3) Tests for relatedness shall be those specified in rule 441—150.1(234) and 150.3(3) "o." The department or the purchase of service fiscal consultant shall have access to the records of the provider and landlord or supplier to determine if relatedness exists. Applicable records may include financial and accounting records, board minutes, articles of incorporation, and list of board members.

r. Day care increase. Rescinded IAB 7/7/93, effective 7/1/93.

s. Interest on unpaid invoices. Any invoice that remains unpaid after 60 days following the receipt of a valid claim is subject to the payment of interest. The rate of interest is 1 percent per month beyond the 60-day period, on a simple interest basis. A separate claim for the interest is to be generated by the agency. If the original claim was paid with both federal and state funds, only that portion of the original claim paid with state funds will be subject to interest charges.

t. Interest as an allowable cost. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) "Interest" is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably required to operate a program, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

u. Rate formula. Paragraph 150.3(5) "p" notwithstanding, when rates are determined based on cost of providing the service involved, they will be calculated according to the following mathematical formula:

$$\frac{\text{Net allowable expenditures}}{\text{Effective utilization level}} \times \text{Reimbursement factor} = \text{Base Rate}$$

(1) Net allowable expenditures are those expenditures attributable to service to clients which are allowable as set forth in subrule 150.3(5), paragraphs "a" to "t."

(2) Effective utilization level shall be 80 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

(3) Inflation factor is the percentage which will be applied to develop payment rates consistent with current policy and funding of the department. The inflation factor is intended to overcome the time lag between the time period for which costs were reported and the time period during which the rates will be in effect. The inflation factor shall be the amount by which the Consumer Price Index for all urban consumers increased during the preceding calendar year ending December 31.

(4) Base rate is the rate which is developed independent of any limits which are in effect. Actual rates paid are subject to applicable limits or maximums.

v. Rescinded IAB 5/13/92, effective 4/16/92.

150.3(6) Client eligibility and referral.

a. Program eligibility. To receive services through the purchase of service system, clients shall be determined eligible and be formally referred by the department.

(1) The department shall not make payment for services provided before the client's application, eligibility determination, and referral. See "b" below for an exception to this requirement.

(2) Except as provided in paragraph “c,” the department shall use the following forms to authorize services:

1. Form 470-0622, Referral of Client for Purchase of Social Services.
2. Form 470-0719, Placement Agreement: Child Placing or Child Caring Agency (Provider).

b. When a court orders foster care and the department has no responsibility for supervision or placement of the client, the department will pay the rate established by these rules for maintenance and service provided by the facility.

c. Family-centered services. For family-centered services, the provisions in rule 441—172.3(234) relating to approval, authorization, and referral shall apply.

150.3(7) Client fees. The provider shall agree not to require any fee for service from departmental clients unless a fee is required by the department and is consistent with federal regulation and state policy. Rules governing client fees are found in 441—130.4(234).

The provider shall collect fees due from clients. The provider shall maintain records of fees collected, and these 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. When the second notice of nonpayment is sent, the provider shall send a copy of the notice to the department worker.

150.3(8) Billing procedures. At the end of each month the provider agency shall prepare Form 470-0020, Purchase of Service Provider Invoice, for contractual services provided by the agency during the month.

Separate invoices shall be prepared for each county from which clients were referred, each service, and each funding source involved in payment. Complete invoices shall be sent to the departmental county office responsible for the client for approval and forwarding for payment.

More frequent billings may be permitted on an exception basis with the written approval of the service area and the chief of the bureau of purchased services.

a. Time limit for submitting vouchers, invoices, or claims. The time limit for submission of original vouchers, invoices, or claims shall be three months from the date of service.

b. Resubmittals of rejected claims. Valid claims which were originally submitted within the time limit specified in paragraph “a” but were rejected because of an error shall be resubmitted without regard to time frames.

150.3(9) Reviews of departmental actions. A provider who is adversely affected by a departmental decision may request a review. A review request may cause the action to be stopped pending the outcome of the review, except in cases where it can be documented that to do so would be detrimental to the health and welfare of clients. The procedure for review is:

a. The provider shall send a written request for review to the project manager responsible for the contract within ten days of receipt of the decision in question. This request shall document the specific area in question and the remedy desired. The project manager shall provide a written response within ten days.

b. When dissatisfied with the response, the provider shall submit to the service area manager within ten days the original request, the response received, and any additional information desired. The service area manager shall study the concerns and the action taken, and render a decision in writing within 14 days. A meeting with the provider may be held to clarify the situation.

c. If still dissatisfied, the provider may within ten days request a review by the chief of the bureau of purchased services. The request for review should include copies of material from paragraphs “a” and “b” above. The bureau chief shall review the issues and positions of the parties involved and provide a written decision within 14 days. A meeting may be held with the provider, project manager, and service area manager or designee.

d. The provider may appeal this decision within ten days to the director of the department, who will issue the final department decision within 14 days.

150.3(10) Review of financial and statistical reports. Authorized representatives of the department or state or federal audit personnel shall have the right to review the general financial records of a provider.

The purpose of the review is to determine if expenses reported to the department have been handled as required under 150.3(5). Representatives shall provide proper identification and shall use generally accepted auditing principles. The reviews may include an on-site visit to the provider, the provider's central accounting office, the offices of the provider's agents, a combination of these, or, by mutual decision, to other locations.

150.3(11) Rescinded, effective 3/1/87.

This rule is intended to implement Iowa Code section 234.6.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 8447B, IAB 1/13/10, effective 1/1/10]

441—150.4(234) Iowa purchase of social services contract—individual providers.

150.4(1) *Individual child day care provider agreement.* Rules governing individual child day care provider agreements may be found in 441—Chapter 170.

150.4(2) *Individual in-home health-related provider agreement.* Rules governing individual in-home health-related provider agreements may be found in 441—Chapter 177.

441—150.5(234) Iowa purchase of administrative support.

150.5(1) *Initiation of contract proposal.*

a. Right to request a contract. All potential contractors have a right to request a contract.

b. Initial contact.

(1) Volunteer contract. The initial contact for a volunteer contract may be between the potential contractor and the service area manager of the service area in which the individual or the contractor agency's headquarters is located or the contract may be between the potential contractor and the director of the state volunteer program in the central office of the department. If so, the director will communicate with the service area.

(2) General use administrative support contract. The initial contact for a general use administrative support contract may be between the potential contractor and the service area manager of the service area in which the individual or contractor organization's headquarters is located or the contract may be between the potential contractor and the chief of the bureau of purchased services, who will communicate with the service area.

c. Contract proposal development. When the service area manager determines that a contract is to be developed, a project manager will be assigned who will assist in contract development and processing. The project manager will assist the contractor in completing the contract proposal and fiscal information appropriate to the contract. This includes documentation that the conditions of participation required below are met.

d. Contract proposal approval or rejection. Before a contract can be effective it shall be signed by the following persons within the time frames provided:

(1) Volunteer contract.

Individual contractor or authorized representative of the contractor agency.

Service area manager within one week from receipt.

Director of the state volunteer program within 30 days from receipt.

(2) General use administrative support contract.

Individual contractor or authorized representative of the contractor agency.

Service area manager within one week from receipt.

Chief of the bureau of purchased services within two weeks from receipt.

Administrator of the division of fiscal management within two weeks from receipt.

The contractor shall be notified of delays in the process or of rejection of the proposal. This notification along with an explanation shall be in writing. The applicant has a right to have the decision reviewed by the director of the state volunteer program, or chief of the bureau of purchased services.

e. Criteria for rejection. The following criteria may cause a proposed contract to be rejected.

(1) The proposed activity is not needed by the department.

(2) No funds are available for the activity being proposed.

(3) The proposed contract does not meet applicable rules, regulations, or guidelines.

f. Contract effective date. If the agreed-upon contract conditions have been met, the effective date of the contract is the first day of an agreed-upon month following signature by the director of the state volunteer program, or the chief of the bureau of purchased services.

150.5(2) Contract administration.

a. Contract management. During the contract period, the assigned project manager shall be the liaison between the department and the contractor. The project manager shall be contacted on all interpretations and problems related to the contract and shall follow issues through to their resolution. The project manager shall also monitor performance under the contract and will provide or arrange for technical assistance to improve the contractor's performance, if needed.

b. Contract amendments. The contract shall be amended only upon agreement of both parties. Amendments which affect the cost of providing the volunteer services must include reestablishment of amounts to be paid.

c. Contract renewal. A joint decision to pursue renewal of the contract must be made at least 60 days prior to the expiration date. Each contract shall be evaluated. The results of the evaluation shall be taken into consideration in the decision on renewal. This evaluation may involve use of evaluation tools specified in the contract.

d. Contract termination. Causes for termination during the period of the contract are:

- (1) Mutual agreement of the parties involved.
- (2) Demonstration that sufficient funds are unavailable to continue the service(s) involved.
- (3) Failure to make reports required by the contract.
- (4) Failure to make financial, statistical, and program records available.
- (5) Failure to abide by the provisions of the contract.

150.5(3) Conditions of participation. The contractor shall meet the following standards:

a. Licensure, approval, or accreditation. The contractor shall have any license, approval, and third-party accreditation required by law, regulation, or administrative rules, or shall meet standards of operation required by state or federal regulation. This requirement must be met before the contract can be effective.

b. Signed contract. A contract can be effective only when signed by all parties required in 150.5(1) "d."

c. Civil rights laws. The contractors shall be in compliance with all federal, state, and local civil rights laws and regulations with respect to equal employment opportunity, or have a written work plan approved by the diversity programs unit to come into compliance.

d. Title VI compliance. The contractors shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services, or have a written plan approved by the diversity programs unit to come into compliance.

e. Section 504 compliance. The contractors shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations, or have a written work plan approved by the diversity programs unit to come into compliance.

f. Affirmative action. The contractors shall be in compliance with all federal, state, and local laws and regulations regarding affirmative action, or have a written work plan approved by the diversity programs unit to come into compliance.

g. Abuse reporting. The contractor shall have an approved policy and procedure for reporting abuse or denial of critical care of children or dependent adults.

h. Confidentiality. The contractor shall comply with all applicable federal and state laws and regulations on confidentiality.

i. Financial and statistical records. Each contractor of service shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department.

(1) The records shall be available for review at any time during normal business hours by department personnel, the purchase of service fiscal consultant, or state or federal audit personnel.

(2) These records shall be retained for a period of five years after final payment.

j. Certification by department of transportation. Each contractor who supplies transportation services shall submit Form 020107, Certification Application for Coordination of Public Transit Services, and a copy of “Certificate of Insurance” (an ACORD form or similar or self-insurance documentation) to the applicable project manager annually showing information regarding compliance with, or exemption from, public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910.

Failure to provide the required documentation for compliance or exemption is grounds for denial or termination of the contract.

150.5(4) *Establishing amounts to be paid.* The amounts to be paid under purchase of administrative support contracts are actual approved expenses as negotiated in the contract. Approved items of cost are based on submission of a proposed budget listing those items necessary for provision of the volunteer coordination or technical assistance to be delivered. At the termination of the contract a statement of actual expenses incurred shall be submitted by the contractor.

150.5(5) *Billing procedures.* At the end of each month, or as otherwise provided in the contract, the contractor shall prepare a claim on Form GAX, General Accounting Expenditure, for expenses for which reimbursement is permitted in the contract. The claim shall be sent to the office of the department that administers the contract for approval and forwarding for payment.

a. Time limit for submitting claims. The time limit for submission of original claims shall be within 90 days of the provision of service.

b. Resubmittals of rejected claims. Valid claims which were originally submitted within this time limit but were rejected because of an error must be resubmitted, but without regard to time frames.

150.5(6) *Reviews of department actions.* A contractor who is adversely affected by a department decision may request a review. A review request may cause the action to be stopped pending the outcome of the review process, except in cases where it can be documented that to do so would be detrimental to the health and welfare of clients. The procedure for review is:

a. Within ten days of receipt of the decision in question the contractor shall send a written request for review to the project manager responsible for the contract. This request shall document the specific area in question and the remedy desired. A written response from the project manager shall be provided within ten days.

b. When dissatisfied with the response, the contractor shall submit the original request, the response received, and any additional information desired to the service area manager within ten days. The service area manager shall study the concerns, the action taken and render a decision in writing within 14 days. A meeting with the contractor may be held to clarify the situation.

c. If still dissatisfied, the contractor may within ten days request a review by the chief of the bureau of purchased services. The request for review should include copies of material from paragraphs “*a*” and “*b*” above. The bureau chief shall review the issues and positions of the parties involved and provide a written decision within 14 days. A meeting with the contractor, project manager, and service area manager or designee may be held.

d. The contractor may appeal this decision within ten days to the director of the department, who will issue the final department decision within 14 days.

150.5(7) *Reviews.* Authorized representatives of the department or state or federal audit personnel have the right to review the general financial records of a contractor. The purpose of the review is to determine if expenses reported to the department have been handled as required under 150.5(4). Representatives shall provide proper identification and shall use generally accepted auditing principles. The reviews may be on the basis of an on-site visit to the contractor, the contractor’s central accounting office, the offices of the contractor’s agents, a combination of these, or, by mutual decision, to other locations.

This rule is intended to implement Iowa Code sections 234.6 and 324A.5, subsection 3, paragraph “*c*.”

441—150.6(234) County board of supervisors participation contract. Rescinded IAB 7/8/92, effective 7/1/92.

441—150.7(234) Iowa donation of funds contract. Rescinded IAB 12/3/08, effective 2/1/09.

441—150.8(234) Provider advisory committee. Rescinded IAB 12/3/08, effective 2/1/09.

441—150.9(234) Public access to contracts. Subject to applicable federal and state laws and regulations on confidentiality including 441—Chapter 9, all material submitted to the department of human services pursuant to this chapter shall be considered public information.

These rules are intended to implement Iowa Code section 234.6 and 2001 Iowa Acts, House File 732, section 31, subsection 6, and Senate File 537, section 1, subsection 1, paragraph “d.”

441—150.10 to 150.20 Reserved.

DIVISION II
PURCHASE OF SOCIAL SERVICES CONTRACTING ON BEHALF OF COUNTIES FOR
LOCAL PURCHASE SERVICES FOR ADULTS WITH MENTAL ILLNESS,
MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES
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CHAPTER 152
FOSTER GROUP CARE CONTRACTING

PREAMBLE

This chapter sets forth the contracting process used for providers of foster group care services, including standards for rate-setting, payment mechanisms, and provider monitoring, audits, and sanctions. The term of the contract is limited to no more than six years pursuant to 11—Chapters 106 and 107. The rules also establish provider qualifications, service authorization procedures, documentation requirements, and service termination and appeal procedures associated with foster group care services. Refer to 441—Chapter 156 for additional program requirements.

441—152.1(234) Definitions.

“*Affiliates*” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

“*Authorized representative*,” within the context of rule 441—152.9(234), means that person appointed to carry out audit procedures, including an assigned auditor, fiscal consultant, or agent contracted for a specific audit or audit procedure.

“*Child*” means a person under 18 years of age or a person 18 or 19 years of age who meets the criteria in Iowa Code section 234.1.

“*Claim*” means each record the department receives that tells the amount of requested payment and the service rendered by a provider to a child and family.

“*Client*” means a child who has been found to be eligible for foster group care services through the Iowa department of human services.

“*Confidence level*” means the probability that an overpayment or underpayment rate determined from a random sample of charges is less than or equal to the rate that exists in the universe from which the sample was drawn.

“*Contract*” means a formal written agreement between the Iowa department of human services and a provider of foster group care services.

“*Contract monitor*” means a department employee who is assigned to assist in developing, monitoring, and evaluating a contract and to provide related technical assistance.

“*Department*” means the Iowa department of human services.

“*Extrapolation*” means that the total dollars of overpayment or underpayment will be estimated by using sample data meeting the confidence level requirement.

“*Family*,” for purposes of child welfare service delivery, shall include the following:

1. The natural or adoptive parents, stepparents, and children who reside in the same household.
2. A child who lives with an adult related to the child within the fourth degree of consanguinity and the adult relatives within the fourth degree of consanguinity in the child’s household who are responsible for the child’s supervision. Relatives within the fourth degree of consanguinity include: full or half siblings, aunts, uncles, great-aunts, great-uncles, nieces, great-nieces, nephews, great-nephews, grandparents, great-grandparents, great-great-grandparents, and first cousins.
3. A child who lives alone or who resides with a person or persons not legally responsible for the child’s support.

“*Fiscal record*” means a tangible and legible history that documents the criteria established for financial and statistical records as set forth in subrule 152.2(7).

“*Grant*” means an award of funds to develop specific programs or achieve specific outcomes.

“*Host area*” means:

1. The department service area where the provider’s corporate office is located, or
2. The service area designated by the chief of the bureau of purchased services when the provider’s corporate office is out of state.

“*Juvenile court officer*” means a person appointed as a juvenile court officer or chief juvenile court officer under Iowa Code chapter 602.

“*Level of care*” means a type of foster group care service that is differentiated by the ratio of staff to children. There are three levels of foster group care services:

1. Community-level group care (service code D1), which requires a minimum staff-to-client ratio of 1 to 8 during prime programming time.
2. Comprehensive-level group care (service code D2), which requires a minimum staff-to-client ratio of 1 to 5 during prime programming time.
3. Enhanced comprehensive-level group care (service code D3), which requires a minimum staff-to-client ratio during prime programming time as follows:
 - 1 staff person for facilities serving up to 4 children.
 - 2 staff persons for facilities serving 5 to 7 children.
 - 3 staff persons for facilities serving 8 to 10 children.
 - 4 staff persons for facilities serving 11 to 13 children.
 - 5 staff persons for facilities serving 14 to 16 children.
 - 6 staff persons for facilities serving 17 to 19 children.
 - 1 staff person for every 3 children for facilities serving 20 or more children.

“*Nonprime programming time*” means any period of the day other than prime programming time and sleeping time.

“*Overpayment*” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to foster group care services and results in a payment greater than that to which the provider is entitled.

“*Prime programming time*” means any period of the day when special attention, supervision, or treatment is necessary (for example, upon awakening of the clients in the morning until their departure for school, during meals, after school, during transition between activities, evenings and bedtime, and on nonschool days such as weekends, holidays, and school vacations).

“*Probation*” means a specified period of conditional participation in the provision of foster group care services.

“*Provider*” means any natural person, company, firm, association, or other legal entity that is seeking a contract or is under contract with the department pursuant to this chapter.

“*Random sample*” means a systematic (or every “nth” unit) sample for which each item in the universe has an equal probability of being selected.

“*Referral worker*” means the department worker or juvenile court officer who refers the case to a provider and who is responsible for carrying out the follow-up activities of determining client eligibility and ensuring that the service authorization is completed.

“*Service authorization*” means the process of determining service necessity and the level of care and number of units of service to be provided to a child.

“*Service record*” means an individual, tangible, and legible file that records service-related activities set forth in subrule 152.2(6).

“*Site*” means a location from which services are delivered or where staff report or records are kept. In the foster group care programs, each separately licensed location is a site.

“*Sleeping time*” means any period of the day during which clients are normally sleeping.

“*Suspension of payments*” means the withholding of all payments due a provider until resolution of the matter in dispute between the provider and the department.

“*Underpayment*” means any payment or portion of a payment not made to a provider for services delivered to eligible recipients according to the laws and rules applicable to the foster group care services program and to which the provider is entitled.

“*Unit of service*” means one day.

“*Universe*” means all items (claims) submitted by a specific provider for payment during a specific period, from which a random sample will be drawn.

“*Withholding of payments*” means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted claims for purposes of offsetting overpayments previously made to the provider.

[ARC 7741B, IAB 5/6/09, effective 7/1/09]

441—152.2(234) Conditions of participation.

152.2(1) Provider licensure. The department shall enter into a contract with a provider for foster group care services only when the provider's facility has achieved full licensure as follows:

- a. A facility providing community-level group care shall be licensed:
 - (1) As a community residential facility pursuant to 441—Chapter 114;
 - (2) As a comprehensive residential facility pursuant to 441—Chapter 115; or
 - (3) Under comparable standards by the state in which the facility is located.
- b. A facility providing comprehensive-level group care shall be licensed:
 - (1) As a comprehensive residential facility pursuant to 441—Chapter 115; or
 - (2) Under comparable standards by the state in which the facility is located.
- c. A facility providing enhanced comprehensive-level group care shall be licensed:
 - (1) As a comprehensive residential facility pursuant to 441—Chapter 115; or
 - (2) Under comparable standards by the state in which the facility is located.

152.2(2) Provider staffing. At a minimum, all providers shall meet the requirements for staff qualifications, training, and number of staff pursuant to 441—Chapter 114 or as identified in appendices to Form 470-3052, Foster Group Care Services Contract.

a. All foster group care programs shall provide an appropriate number of hours of prime programming time sufficient to meet the child welfare service needs of the children served in the program.

b. Staffing during prime programming time, nonprime programming time, and sleeping time shall be sufficient to meet the group care maintenance needs of the children served in the program.

152.2(3) Services provided. The provider shall comply with the requirements for services to be provided, as described on Form 470-3051, Foster Group Care Services Contract Face Sheet, and appendices to Form 470-3052, Foster Group Care Services Contract. These services shall at a minimum meet the requirements found in 441—Chapter 156 and in 441—Chapter 114 or 441—Chapters 114 and 115, as applicable, or the contract may be terminated.

152.2(4) Provider charges. A provider shall not charge departmental clients more than it receives for the same foster group care services provided to nondepartmental clients. The provider shall agree not to require any fee from departmental clients unless a fee is required by the department and is consistent with federal regulation and state policy.

152.2(5) Compliance with the law. The provider and its employees, agents, and subcontractors shall comply with all applicable federal, state, and local laws, rules, ordinances, regulations, and orders when performing services under the contract.

a. *Drug-free workplace.* The provider shall operate a drug-free workplace.

b. *Use of funds.* The provider shall:

(1) Agree that federally appropriated funds shall not be paid on behalf of the department or provider to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with:

- 1. The awarding of any federal contract,
- 2. The making of any federal grant,
- 3. The making of any federal loan,
- 4. The entering into of any cooperative agreement, or
- 5. The extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

(2) Ensure that no funds received or expended will be used in any way to promote or oppose unionization.

152.2(6) Maintenance of service records. A provider shall maintain complete and legible records as required in this subrule. A provider's client service records and case files for foster group care services shall comply with the requirements of this subrule and with the record-keeping requirements related to licensure pursuant to 441—Chapter 114.

a. The provider shall establish and maintain confidential, individual service records for each client receiving foster group care services. The service records must adequately support the provision of child welfare services and group care maintenance as defined in rule 441—156.1(234). The service record shall include, at a minimum, those items identified in rule 441—114.11(237) and the following:

- (1) Additional reports, if requested by the referral worker;
- (2) Form 470-3055, Referral and Authorization for Child Welfare Services;
- (3) Daily documentation of billed per diem services as defined in paragraph “b”; and
- (4) Notes indicating the child’s general progress in regard to the child’s care plan, entered no less than every seven calendar days.

b. Daily documentation of billed per diem services shall include:

- (1) The child’s first and last name;
- (2) The month, day, and year service was provided;
- (3) The first and last names of the persons who provided the service;
- (4) A clear description of the specific service rendered, including interventions, actions, and activities performed which support the provision of child welfare services; and
- (5) Any problem areas or unusual behavior for the child.

c. If individual case files include service records for services other than foster group care services, the provider has the responsibility to maintain the client records in compliance with all applicable rules.

d. The provider shall retain service records for clients receiving foster group care services for a period of not less than five years following the date of final payment or completion of any required audit or review, whichever is later. If any litigation, claim, negotiation, audit, review, or other action involving the records has been started before the expiration of the five-year period, the records must be retained until the later of:

- (1) The completion of the action and resolution of all issues which arise from it, or
- (2) The end of the regular five-year period.

e. Failure to maintain records or failure to make records available to the department or to its authorized representatives upon request may result in a notice of violation and recoupment of payments, pursuant to rules 441—152.9(234) and 441—152.10(234).

152.2(7) Maintenance of financial and statistical records. The provider shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department. The records shall be available for review at any time during normal business hours by department personnel, the department's fiscal consultant, and state or federal audit personnel.

a. At a minimum, financial and statistical records shall include all revenue and expenses supported by a provider’s general ledger and documentation on file in the provider’s office. These records include, but are not limited to:

- (1) Payroll information.
- (2) Capital asset schedules.
- (3) All canceled checks, deposit slips, and invoices (paid and unpaid).
- (4) Audit reports (if any).
- (5) The board of directors' minutes (if applicable).
- (6) Loan agreements and other contracts.
- (7) Reviewable, legible census reports and documentation of units of service provided to departmental clients that identify the individual client and are kept on a daily basis and summarized in a monthly report.

(8) For nondepartmental clients, sufficient documentation of utilization to establish a complete unit of service count.

b. The provider shall maintain the following documentation for each program.

- (1) A list of all staff and supervisors providing foster group care services and their qualifications.
- (2) The number of staff hired and terminated in the year to date.

c. The documentation prepared by the provider shall be retained for use when any financial report is prepared and for review by the department's fiscal consultant. Financial records must be retained for five years from the date of report submission or final payment for services.

d. Independent audits. When a provider has an audit conducted, a firm not related to the provider shall conduct the audit. The provider shall submit a copy of the independent audit report to the department within 30 days of receipt of the report. The bureau of purchased services shall maintain the report and provide a copy of the report to the fiscal consultant.

152.2(8) *Special-purpose organizations.* A provider may establish a separate, special-purpose organization to conduct certain client-related or non-client-related activities on behalf of the provider. (For example, a provider may establish a development foundation to assume the provider's fund-raising activity.) Even if the provider does not own the special-purpose organization (e.g., a nonprofit, non-stock-issuing corporation) and has no common governing body membership, a separate special-purpose organization shall be considered a related party for purposes of this chapter when one of the following applies:

a. The provider controls the organization through contracts or other legal documents that give the provider the authority to direct the organization's activities, management, and policies.

b. For all practical purposes, the provider is the primary beneficiary of the organization's activities. The provider shall be considered the special-purpose organization's primary beneficiary if one or more of the following circumstances exist:

(1) The organization has solicited funds on the provider's behalf with provider approval, and substantially all funds so solicited were contributed with the intent of benefiting the provider.

(2) The provider has transferred some of its resources to the organization, substantially all of whose resources are held for the benefit of the provider.

(3) The provider has assigned certain of its functions to a special-purpose organization that is operating primarily for the benefit of the provider.

152.2(9) *Certification by department of transportation.*

a. If the provider furnishes public transit service as defined in rule 761—910.1(324A), the provider shall annually submit to the contract monitor information regarding compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules in 761—Chapter 910. This information shall include:

(1) Form 020107, Certification Application for Coordination of Public Transit Services, which the contract monitor shall submit to the department of transportation; and

(2) A copy of an ACORD Certificate of Insurance or similar self-insurance documentation, as applicable.

b. If a provider believes it does not furnish public transit service as defined in rule 761—910.1(324A) and, therefore, is exempt from the requirements in paragraph "a," the provider shall submit Form 020107 with only Section 1 completed when the provider enters into a new contract.

c. If a provider that has furnished public transit service as defined in rule 761—910.1(324A) ceases to do so, the provider becomes exempt from the requirements in paragraph "a."

d. If an exempt provider begins to furnish public transit service as defined in rule 761—910.1(324A), the provider shall inform the contract monitor within 30 days of the change and shall adhere to the procedures in paragraph "a."

e. Failure of the provider to cooperate in obtaining or providing the required documentation of compliance or exemption is grounds for denial or termination of the contract.

152.2(10) *Copyright and patents.* The activities and results of contract activity may be published subject to confidentiality requirements.

[ARC 7741B, IAB 5/6/09, effective 7/1/09]

441—152.3(234) *Determination of rates.* Rates for foster group care services effective on or after November 1, 2006, shall be based on the historical payment rate negotiated between the provider and the department and shall be calculated based on rule 441—156.9(234).

152.3(1) *Negotiation of rates.* Rates for foster group care services effective on or after November 1, 2006, must be established in accordance with this subrule, except as provided in subrule 152.3(4).

a. All historical rate negotiations made under the former rehabilitative treatment and supportive services program on or after February 1, 1998, remain true and valid.

b. The scope of negotiations is limited solely to the rate to be paid for each service.

c. No other items, such as, but not limited to, changes in staff qualifications, service definition, required components, allowable costs or any licensing or other contractual requirements, shall be the subject of negotiations or be used as a basis for changing rates.

d. The service area manager of the host area is responsible for the negotiation of rates for each provider whose contract for foster group care services is administered by the host area, regardless of where the services are provided. Only the service area manager of the host area may approve the rates negotiated for a provider, except as provided in subrule 152.3(4).

(1) The service area manager of the host area shall take into consideration the other service areas served by a provider when negotiating a rate for a service provided in multiple service areas.

(2) When a service is provided only in a nonhost area, the two service area managers shall determine which one will negotiate the rate for that service.

e. The service area manager of the host area and the provider are mutually responsible for initiating the rate negotiation process. Negotiations may be conducted in a manner acceptable to both parties, but shall be conducted face to face upon the request of either party.

f. At the initiation of the rate negotiation process, the provider must disclose all relevant subcontractual and related-party relationships involved in the provision of foster group care services.

g. Negotiated rates shall not exceed any rate ceiling established or authorized by the legislature.

h. Once a negotiated rate is established, it shall not be changed or renegotiated, except in the following circumstances:

(1) Rates may be changed when funds are appropriated for an across-the-board increase.

(2) Rates may be changed by mandated across-the-board decreases. Effective for the period from January 1, 2010, to June 30, 2010, the negotiated reimbursement rates for foster group care shall be decreased by 5 percent of rates in effect on December 31, 2009.

152.3(2) *New service.* When a prospective provider contracts to provide a foster group care service or an existing provider adds a new foster group care service on or after November 1, 2006, the rate for the new service shall be established based on a payment rate negotiated with the provider.

a. The starting point for negotiated rates shall be the weighted average for each service as of July 1, 1997, as previously established in accordance with 441—subrule 185.109(1), in effect at that time, and further calculated based on rule 441—156.9(234). These rates shall become the established weighted average rates for each service code as described in 441—Chapter 156 and in the appendices of the foster group care contract.

(1) The rate for community-level group care child welfare service is \$8.43 per unit of service.

(2) The rate for community-level group care maintenance is \$50.16 per unit of service.

(3) The rate for comprehensive-level group care child welfare service is \$10.13 per unit of service.

(4) The rate for comprehensive-level group care maintenance is \$60.31 per unit of service.

(5) The rate for enhanced comprehensive-level group care child welfare service is \$13.36 per unit of service.

(6) The rate for enhanced comprehensive-level group care maintenance is \$79.55 per unit of service.

b. In the event the department and a new provider or an existing provider adding a new foster group care service are unable to reach agreement on a rate for a service within 60 days of initiating rate negotiations, a rate resolution process may be used. If no rate is agreed upon within 60 days of initiation of a rate resolution process, no rate shall be established and the services in question shall not be part of any approved contract for foster group care services.

152.3(3) *Interruptions in a program.*

a. The rate for a new provider shall remain the same as the rate established for the former provider if:

- (1) A provider assumes the delivery of a program from a related-party provider, or
- (2) The difference between the former provider and the new provider is a change in name or a change in the legal form of ownership (i.e., a change from partnership to corporation).

b. If a provider ceases to contract for and provide a foster group care service on or before October 31, 2006, and before the calculation of new rates according to rule 441—156.9(234), the rate in effect when the contract ceased shall be used to calculate the new rates to be used as the starting point in negotiations.

c. If a provider ceases to contract for and provide a foster group care service after a rate has been established in accordance with rule 441—156.9(234) and then decides to again contract for and provide the foster group care service, the rate shall be established at the rate in effect when the service was interrupted.

152.3(4) *Exception to rate policy.* When a provider not located in Iowa has been granted an exception to these rules based upon another state's requirement that its providers be paid the same rate they are paid for clients from that state, the exception shall continue in effect as written for the life of the contract.

152.3(5) *Across-the-board cuts.* Payment under the contract may be subject to across-the-board cuts pursuant to Iowa Code section 8.31.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 8449B, IAB 1/13/10, effective 1/1/10]

441—152.4(234) *Initiation of contract proposal.* All potential providers have a right to request a contract.

152.4(1) *Initial contact.* The initial contact shall be between the potential provider and the bureau of purchased services.

a. At the beginning of the contract development process, the bureau shall give the potential provider:

- (1) Information about the contracting process; and
- (2) Instructions on how to access the foster group care services provider handbook electronically.

b. The provider shall sign Form 470-3057, Verification of Receipt, at the end of the contract development process to verify receipt of information on how to access the handbook.

152.4(2) *Contract proposal development.* When the bureau of purchased services determines that a new contract is to be developed, a contract monitor shall be assigned to assist in contract development and processing. The contract monitor shall assist the applicant in the completion of the contract proposal and required fiscal information. The contract proposal shall include all of the following:

a. Form 470-3051, Foster Group Care Services Contract Face Sheet.

b. Form 470-3404, Foster Group Care Services Negotiated Rate Establishment Amendment. This form need not be completed until the completion of the rate negotiation process, but the contract proposal will not be acted upon until the form is completed and attached to the contract proposal.

c. Form 470-3052, Foster Group Care Services Contract, or Form 470-3053, Amendment to Foster Group Care Services Contract.

152.4(3) *Contract proposal approval.* The department shall review all complete proposed contracts for compliance with state and federal requirements.

a. The applicant shall submit four copies of the contract proposal to the assigned contract monitor 60 calendar days in advance of the desired effective date of the contract.

b. Submission within the time frame does not ensure the effective date of the contract. The department shall give the applicant notice and explanation in writing of any delay in the approval process.

c. The contract monitor shall forward four signed copies of the contract proposal to the bureau of purchased services within four weeks of receipt.

d. Before the contract can be effective, it shall be approved and signed by the following persons:

- (1) An authorized representative of the provider.
- (2) The service area manager, who shall make a decision within one week of receipt.
- (3) The director of the department or the director's designee, who shall make a decision within 15 days of receipt.

152.4(4) Rejection of contract proposal. The department shall give the applicant notice and explanation in writing of the reasons for rejection of the contract proposal within ten working days of the decision. The following criteria may cause a proposed contract or proposed contract amendment to be rejected:

- a. The proposed contract does not meet applicable rules, regulations, or guidelines.
- b. The applicant has falsified any information required as a condition of participation.
- c. Licenses submitted as a condition of participation in the contract process have never been approved or have been revoked or suspended.
- d. The provider fails to provide notification within seven days of any changes that may significantly affect the licenses submitted as a condition of contracting.
- e. The department and the provider fail to reach agreement on negotiated rates.

[ARC 7741B, IAB 5/6/09, effective 7/1/09]

441—152.5(234) Contract. All providers shall enter into a contract with the department using Form 470-3052, Foster Group Care Services Contract.

152.5(1) Contract effective date. When the agreed-upon contract conditions have been met, the effective date of a new contract, a renewed contract, or an amendment to add a new service code to the contract is the day following signature of the director of the department or the director's designee, unless the provider and the department agree to a later specified date.

- a. The contract shall be effective only after the provider is licensed to provide foster group care services as described in subrule 152.2(1).
- b. The contract shall be effective only when signed by all parties as required by paragraph 152.4(3) "d."

152.5(2) Liability for payment. The department shall not be liable for payment for any programs or services before:

- a. The contract effective date, or
- b. The effective date of the rate for the program or service.

152.5(3) Term of contract. Pursuant to the provisions of 11—Chapters 106 and 107, the term of the contract is limited to no more than six years from the effective date of the contract.

[ARC 7741B, IAB 5/6/09, effective 7/1/09]

441—152.6(234) Client eligibility and referral.

152.6(1) Determination of eligibility. The department shall determine a child's eligibility for foster group care services. The department shall not make payment for foster group care services provided before the child's eligibility determination and service authorization.

152.6(2) Court order. If a child and family have been referred to the department and the department has not authorized foster group care services, but the services have been ordered by the juvenile court, the department shall make payment subject to availability of authorized funds.

152.6(3) Service authorization. Any change in the level of care or increase in the number of units or duration of foster group care services shall be authorized by the department.

[ARC 7741B, IAB 5/6/09, effective 7/1/09]

441—152.7(234) Billing procedures. At the end of each month, the provider shall prepare Form 470-0020, Purchase of Service Provider Invoice, for contractual services provided during the month for which the provider has documentation of the billed per diem services as described in subrule 152.2(6). Separate invoices shall be prepared for each county from which clients were referred. Each invoice shall contain claims for only one month of service. A separate invoice is required for each separate month of service if the service spans more than one month.

152.7(1) Submission of invoices. Complete invoices shall be sent to the department local office responsible for the client for approval and forwarding for payment. The time limit for submission of original invoices shall be 90 days from the date of service, except at the end of the state fiscal year when claims for services through June 30 shall be submitted by August 10.

152.7(2) Resubmittal of rejected claims. Valid claims that were originally submitted within the time limit specified in subrule 152.7(1) but were rejected because of an error shall be resubmitted as soon as corrections are made.

152.7(3) Payment. The invoices shall be subject to audit and adjustment by the department. Within 60 days of the date of receipt of a valid invoice, the department shall make payment in full of all claims concerning foster group care services rendered to clients.

[ARC 7741B, IAB 5/6/09, effective 7/1/09]

441—152.8(234) Contract management. During the contract period, the assigned contract monitor designated in the contract shall be the contract liaison between the department and the provider.

152.8(1) The provider shall contact the contract monitor about all interpretations and problems relating to the contract, and the contract monitor shall follow the issues through to their resolution.

152.8(2) The contract monitor shall also monitor performance under the contract and shall provide or arrange for technical assistance to improve the provider's performance if needed. Form 470-0670, Report of On-Site Visit, shall be used to monitor performance under the contract.

152.8(3) The contract monitor shall make at least one on-site visit to each provider during the term of the provider's contract. The on-site visit shall be coordinated with on-site visits scheduled to fulfill requirements for provider reviews, licensing, or other on-site visits required by the department. Site visits to out-of-state providers shall be made at the discretion of the service area responsible for administration of the contract.

[ARC 7741B, IAB 5/6/09, effective 7/1/09]

441—152.9(234) Provider reviews. The department may review any provider at its discretion at any time. Records generated and maintained by the department or its fiscal agent may be used by reviewers and in all proceedings of the department.

152.9(1) Review of provider records. The department shall have the authority to conduct a scheduled or an unannounced site visit to evaluate the adequacy of service records in compliance with the policies and procedures for foster group care services.

152.9(2) Purpose. Upon proper identification, authorized representatives of the department shall have the right to review the service and fiscal records of the provider to determine whether:

- a. The department has accurately paid claims for services.
- b. The provider has furnished the services.
- c. The provider has retained service records and fiscal records, as described in subrules 152.2(6) and 152.2(7), that substantiate claims submitted for payment during the review period.
- d. Expenses reported to the department have been handled as required under subrule 152.2(8).

152.9(3) Method. The department shall select the appropriate method of conducting a review and shall protect the confidential nature of the records being reviewed. The provider may be required to furnish records to the department. The provider may select the method of delivering any requested records to the department. Review procedures may include, but are not limited to, the following:

- a. Comparing service and fiscal records with each claim.
- b. Interviewing clients and employees of providers.

152.9(4) Sampling. The department's procedures for reviewing a provider's service records may include the use of random sampling and extrapolation. When these procedures are used, all sampling will be performed within acceptable statistical methods, yielding not less than a 95 percent confidence level.

a. *Findings.* The review findings generated through the review procedure shall constitute prima facie evidence in all department proceedings of the number and amount of requests for payment as submitted by the provider.

b. *Extrapolation.* Findings of the sample will be extrapolated to the universe for the review period. The total of the payments determined to be in error in the review sample shall be divided by the total payments in the reviewed sample to calculate the percentage of dollars paid in error. This percentage shall then be multiplied by the total payments in the review universe to determine the extrapolated overpayment.

c. Disagreement with findings. When the provider disagrees with the department's review findings and the findings have been generated through sampling and extrapolation, the provider may present evidence to show that the sample was invalid. The burden of proof of compliance rests with the provider. The evidence may include a 100 percent review of the universe of provider records used by the department in the drawing of the department's sample. This review shall:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by a certified public accountant.
- (3) Demonstrate that bills and records not reviewed in the department's sample complied with program regulations and requirements.
- (4) Be submitted to the department with all supporting documentation.

152.9(5) Actions based on review findings.

a. The department shall report the results of a review of provider records to concerned parties consistent with the provisions of 441—Chapter 9.

b. When an overpayment is found, the department may do one or more of the following:

- (1) Request repayment in writing.
- (2) Impose sanctions provided for in rule 441—152.10(234).
- (3) Investigate and refer the matter to an agency empowered to prosecute.

[ARC 7741B, IAB 5/6/09, effective 7/1/09]

441—152.10(234) Sanctions against providers. Failure to meet the requirements relevant to provider contracting, financial record keeping, billing and payment, and client record keeping may subject providers to sanctions.

152.10(1) Grounds for sanction. The department may impose sanctions against a provider for committing one or more of the following actions:

a. Failing to provide and maintain the quality of the services to children and families within established standards, including:

- (1) Failing to meet standards required by state or federal law for licensure.
- (2) Failing to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

(3) Engaging in a course of conduct or performing an act that is in violation of state or federal regulations or continuing that conduct following notification that it should cease.

(4) Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions subject to this chapter.

(5) Receiving a formal reprimand or censure by an association of the provider's peers for unethical practices.

(6) Being suspended or terminated from participation in another governmental program such as, but not limited to, workers' compensation or Medicaid remedial services.

(7) Committing a negligent practice resulting in client death or injury.

b. Failing to disclose or make available to the department or its authorized agent records of services provided to a child and family and records of payments made for those services.

c. Engaging in deceptive billing practices, such as:

- (1) Presenting or causing to be presented for payment any false or deceptive claim for services.
- (2) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

d. Submitting or causing to be submitted false information to meet service authorization requirements.

e. Inducing, furnishing or otherwise causing the child or family to receive foster group care services that are not authorized (overutilization of services).

f. Rebating or accepting a fee or portion of a fee or a charge for referrals of a child or family.

g. Failing to repay or arrange for the repayment of identified overpayments or other erroneous payments.

152.10(2) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted.

a. Notification shall set forth:

- (1) The nature of the discrepancies or violations.
- (2) The known dollar value of the discrepancies or violations.
- (3) The method of computing the dollar value.
- (4) Further actions to be taken or sanctions to be imposed by the department.
- (5) Any actions required of the provider.

b. The provider shall have 15 days after the date of the notice and before the department action to show cause why the action should not be taken.

152.10(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in subrule 152.10(1):

- a.* A term of probation for provision of foster group care services.
- b.* Termination from participation in the provision of foster group care services.
- c.* Suspension from provision of foster group care services.
- d.* Suspension or withholding of payments to the provider.
- e.* Review of 100 percent of the provider's claims before payment.
- f.* Referral to the appropriate state licensing board for investigation.
- g.* Referral of the matter to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

h. Suspension of foster group care services licensure.

i. Termination of foster group care services licensure.

152.10(4) *Imposition and extent of sanction.* The department shall determine what sanction to impose. The following factors shall be considered in determining the sanction or sanctions to be imposed:

- a.* Seriousness of the offense.
- b.* Extent of violations.
- c.* History of prior violations.
- d.* Prior imposition of sanctions.
- e.* Prior provision of technical assistance.
- f.* Pattern of failure to follow program rules.
- g.* Whether a lesser sanction will be sufficient to remedy the problem.
- h.* Actions taken or recommended by peer review groups or licensing bodies.

152.10(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider. Each decision to include an affiliate shall be made on a case-by-case basis after giving due regard to all relevant factors and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated when the conduct was committed in the course of official duty or was effectuated with the knowledge or approval of that person.

b. When there are grounds for sanction pursuant to subrule 152.10(1) against a provider facility, campus, or site, the department may suspend or terminate the provision of foster group care services by:

- (1) The provider; or
- (2) The specific facility, campus, or site; or
- (3) Any individual within the provider's organization who is responsible for the violation.

c. No provider shall submit claims for payments to the department for any services provided by any facility, campus, site, or person within the organization that has been suspended or terminated from provision of foster group care services except for those services provided before the suspension or termination.

d. Suspension or termination from provision of foster group care services shall preclude the submission of claims to the department for payment for any services provided after suspension or termination, whether submitted personally or through the provider.

152.10(6) *Suspension or withholding of payments pending a final determination.* When the department has notified a provider of a violation pursuant to paragraph 152.9(5) “b” or subrule 152.10(2) and has demanded repayment of an identified overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. When the department intends to withhold or suspend payments, it shall notify the provider in writing.

152.10(7) *Notice of sanction.* When a provider has been sanctioned, the department shall notify, as appropriate, the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

[ARC 7741B, IAB 5/6/09, effective 7/1/09]

441—152.11(234) Appeals of departmental actions. Providers may appeal decisions of the department, other than rate determinations, according to rules in 441—Chapter 7.

[ARC 7741B, IAB 5/6/09, effective 7/1/09]

These rules are intended to implement Iowa Code section 234.6.

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[Filed Emergency ARC 8449B, IAB 1/13/10, effective 1/1/10]

CHAPTER 153
FUNDING FOR LOCAL SERVICES
[Prior to 7/1/83, see Social Services[770] Ch 131]
[Previously appeared as Ch 131—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
SOCIAL SERVICES BLOCK GRANT

PREAMBLE

This division sets forth the requirements for reporting required for receipt of federal social services block grant (SSBG) funds and service availability and allocation methodology related to those funds.

441—153.1(234) Definitions.

“*Direct services*” means services provided by staff of the department of human services to clients. This includes the administrative support necessary to maintain and oversee services. Direct services are funded with state and federal dollars.

“*State purchase services*” means those services the department purchases in every county statewide. State purchase services are funded with state and federal funds.

441—153.2(234) Development of preexpenditure report.

153.2(1) The department of human services shall develop the social services block grant preexpenditure report on an annual basis. The report shall be developed in accordance with the Code of Federal Regulations, Title 45, Part 96, Subpart G, as amended to July 20, 2000. The report shall describe the services to be funded, in what areas services are available and the amount of funding available. The plan shall also indicate the source of funding.

153.2(2) The department shall issue a proposed preexpenditure report before publication of the final report. The proposed report shall be available for public review and comment:

a. In each local office where a service area manager is based during regular business hours for a two-week period; and

b. On the department’s Internet Web site, www.dhs.iowa.gov.

153.2(3) The time and scope of public review will be announced each year. The announcement will indicate the time the proposed report can be viewed. The department:

a. Shall make this information available on the department’s Internet Web site, www.dhs.iowa.gov, and post signs in each local human services office; and

b. May publish advertisements in each service area listing the time of review.

153.2(4) The department shall accept comments about the preexpenditure report during the specified public review and comment period. Individuals or groups may submit written comments to the service area manager or to the Division of Fiscal Management, Iowa Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114. The service area manager may arrange public hearings where testimony will be accepted.

153.2(5) The department shall consider the public comment when developing the final preexpenditure report.

153.2(6) A copy of the final preexpenditure report will be available:

a. In each local office where a service area manager is based; and

b. On the department’s Internet Web site, www.dhs.iowa.gov.

441—153.3(234) Amendment to preexpenditure report.

153.3(1) The preexpenditure report may be amended throughout the year. The department may file an amendment changing the kind, scope or duration of a service. Decisions to change a direct service or state purchase service will be made by the department.

Prior to filing an amendment the department and the county boards of supervisors will evaluate available funds and the effect any change will have on clients.

153.3(2) An amendment in the preexpenditure report will be posted in the local offices affected by the amendment at least 30 days prior to the effective date of the change. However, in the event funding for the service has been exhausted, an amendment shall be posted immediately notifying the public that the service will no longer be available. The service area manager will, whenever possible, give advance notice of a service termination made necessary because funds have been exhausted. When a service is added or extended, an amendment may be posted immediately and a 30-day posting period is not required.

153.3(3) Individuals or groups may submit written comments to the service area manager or to the Division of Fiscal Management, Iowa Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

153.3(4) Nothing in this rule will supersede the requirement for notifying clients of adverse action as provided in 441—130.5(234).

441—153.4(234) Service availability.

153.4(1) A client shall apply for services in the appropriate office of the Iowa department of human services.

a. The department shall determine eligibility according to 441—130.3(234).

b. The department shall develop a case plan to monitor the client's progress toward achieving goals as identified in 441—130.7(234).

153.4(2) An eligible client shall receive a service for which the client is eligible, subject to the provisions of 441—Chapter 130, when the service is listed in the geographic area in which the client resides. The geographic area for direct and state purchase is the state.

153.4(3) To the extent federal law prohibits use of federal funds for provision of social service block grant services to persons the department has defined as eligible, state funds shall be used to pay for these services.

441—153.5(234) Allocation of block grant funds.

153.5(1) The department shall follow a cost allocation plan for determining the appropriate administrative costs to be funded with block grant money.

153.5(2) Funding for services shall be allocated in accordance with the annual budgeting process. The department's annual budget is available for review on the department's Internet Web site at www.dhs.iowa.gov. Costs may be shifted in and between service areas to ensure continued statewide availability of services.

441—153.6(234) Local purchase planning process. Rescinded IAB 7/8/92, effective 7/1/92.

441—153.7(234) Advisory committees. Rescinded IAB 3/6/02, effective 7/1/02.

441—153.8(234) Expenditure of supplemental funds. When supplemental funds are issued through the social services block grant as emergency disaster relief, the department shall administer the funds in compliance with the terms of the federal award rather than the provisions of this division.

[ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—153.9 and 153.10 Reserved.

These rules are intended to implement Iowa Code section 234.6.

DIVISION II
DECATEGORIZATION OF CHILD WELFARE AND JUVENILE JUSTICE FUNDING

PREAMBLE

Decategorization of child welfare and juvenile justice funding is an initiative intended to establish systems of delivering human services based upon client needs that replace systems based upon a multitude of categorical funding programs and funding sources, each with different service definitions

and eligibility requirements. Decategorization is designed to redirect child welfare and juvenile justice funding to services that are more preventive, family-centered, and community-based in order to reduce use of restrictive approaches that rely on institutional, out-of-home, and out-of-community care.

441—153.11(232) Definitions. For the purposes of this division, the following definitions apply:

“*Budget accountability*” means that expenditures for decategorization services from a decategorization project’s funding pool during the state fiscal year do not exceed the total amount of funding available in the funding pool for the state fiscal year.

“*Carryover funding*” means moneys designated for a project’s decategorization services funding pool that remain unencumbered or unobligated at the close of the state fiscal year.

“*Chief juvenile court officer*” mean the judicial department official responsible for managing and supervising juvenile court services operations within one of the eight judicial districts.

“*Decategorization*” means an initiative established pursuant to Iowa Code section 232.188 that is designed to redirect child welfare and juvenile justice funding to services that are more preventive, family-centered, and community-based in order to reduce use of more restrictive approaches.

“*Decategorization agreement*” means the agreement entered into among representatives of the department of human services, juvenile court services, and the county government in one or more counties to implement a decategorization project in accordance with the requirements of Iowa Code Supplement section 232.188 and this division.

“*Decategorization project*” means the county or counties that have entered into a decategorization agreement to implement the decategorization initiative in the county or multicounty area covered by the agreement.

“*Decategorization services funding pool*” or “*funding pool*” means the funding designated for a decategorization project from all sources.

“*Department*” means the department of human services.

“*Governance board*” means a decategorization governance board, which is the group that enters into and implements a decategorization agreement.

“*Service area manager*” means the department official responsible for managing the department’s programs, operations, and child welfare budget within one of the eight department service areas.

“*Unencumbered or unobligated*” means funding within a decategorization services funding pool that is not spent by the project’s governance board for a specific program or purpose by the close of the state fiscal year.

441—153.12(232) Implementation requirements. The decategorization initiative shall be implemented through the creation and operation of decategorization projects. One or more counties may jointly agree to form a decategorization project to implement the initiative. The decategorization initiative shall be implemented in accordance with the following requirements:

153.12(1) *Decategorization agreement.* Representatives from the department, juvenile court services, and county government within the county or counties interested in forming a decategorization project shall develop a written agreement to work together to implement decategorization.

153.12(2) *Department approval.* A decategorization project must request and receive approval from the department director.

153.12(3) *Governance board.* A decategorization project shall be implemented by a decategorization governance board.

a. The department director shall ensure that each decategorization project has an operating governance board that includes:

(1) Representatives designated by administrators of the department and of juvenile court services; and

(2) Officials with the authority to represent county government in the affected county or counties.

b. Decategorization projects may choose to expand their governance boards to include representatives from other entities.

153.12(4) Department information. The service area manager shall provide the governance board with:

a. Information concerning the department service area's funding allocation for department-administered child welfare service programs; and

b. A copy of the service area's child welfare and juvenile justice annual plan.

153.12(5) Juvenile justice information. The chief juvenile court officer shall provide the governance board with information on the judicial district's allocation of funding for juvenile justice service programs.

153.12(6) Support and coordination. The department service area manager and the chief juvenile court officer shall:

a. Work with the governance board throughout each state fiscal year to coordinate planning and to target resources most effectively.

b. Regularly provide the governance board with available data concerning child welfare and juvenile justice needs, service trends and expenditures, child welfare and juvenile justice outcomes, and other relevant issues.

c. Work with the governance board to:

(1) Support board planning and service development; and

(2) Promote effective alignment of available financial resources to enhance preventive, family-centered, and community-based services.

441—153.13(232) Role and responsibilities of decategorization project governance boards. The governance board of a decategorization project shall have the following authority and responsibilities:

153.13(1) Rules of operation. The governance board shall establish and adopt written rules of operation that are available to the public.

153.13(2) Open meetings and records. The governance board shall adhere to statutory requirements for government bodies concerning open meetings and open records procedures as specified in Iowa Code chapters 21 and 22.

153.13(3) Coordination. The governance board shall coordinate project planning, decategorization service decisions, and budget planning activities with the service area manager and the chief juvenile court officer for the county or counties comprising the project.

153.13(4) Right to services. The governance board shall implement the decategorization initiative in a manner that does not limit the legal rights of children and families to receive services.

153.13(5) Community service planning. The governance board shall undertake community planning activities within the county or counties comprising the project. These activities shall be designed to develop services that are more preventive, family-centered, and community-based.

a. As part of decategorization community planning, the governance board shall partner with other community stakeholders to develop service alternatives that provide less restrictive levels of care for children and families within the project area. The governance board shall involve community representatives, including representatives for families and youth and for county organizations, in the development of specific and quantifiable short-term and long-term plans for:

(1) Enhancing preventive, family-centered, and community-based services; and

(2) Reducing reliance on out-of-community care and restrictive interventions.

b. In community planning, the governance board may use information from federal reviews of Iowa's child welfare system and indicators and outcomes from other community planning efforts. The governance board shall coordinate its community planning efforts as much as possible with those of other planning entities in the community, such as but not limited to:

(1) Communities of promise;

(2) Community empowerment;

(3) United Way;

(4) Community partnerships for protecting children;

(5) Comprehensive school improvement planning;

(6) Comprehensive substance abuse agency planning; and

(7) Substance-abuse-free environment (SAFE) program planning.

153.13(6) Annual service plan. The governance board shall oversee the development and submission of an annual child welfare and juvenile justice services plan that meets the requirements of rule 441—153.18(232). The governance board shall involve community representatives and county organizations in the development of the plan for the use of the decategorization services funding pool.

153.13(7) Fiscal management. The governance board shall manage and have authority over the project's decategorization services funding pool.

a. The governance board shall develop a plan to maintain budget accountability by ensuring during each state fiscal year that there is ongoing accountability for results, fiscal monitoring, and oversight of expenditures from the decategorization services funding pool.

b. Budget planning and decategorization services funding decisions shall be coordinated with the affected service area managers and chief juvenile court officers or their designees throughout each state fiscal year.

c. The governance board shall ensure that expenditures do not exceed the amount of funding available within the funding pool.

d. If necessary, the governance board shall approve actions to reduce expenditures, discontinue programs, or take other action to manage expenditures within the available decategorization services funding pool during each state fiscal year.

153.13(8) Annual report. The governance board shall oversee the development and submission of an annual progress report for the decategorization project that meets the requirements of rule 441—153.19(232).

441—153.14(232) Realignment of decategorization project boundaries. If a governance board votes to change the composition of counties participating in the project, the governance board shall send a letter to the department director that describes the nature of the proposed project realignment and is signed by each board member who supports the proposed realignment.

153.14(1) If the realignment request involves the move of one or more counties from one decategorization project to another, the governance board of the project receiving the county or counties shall send a letter to the department director expressing support for the realignment.

153.14(2) The department director shall review the request and within 30 days shall provide a written decision to the project governance boards involved.

a. In evaluating the request, the department director shall consider the reasons expressed for the proposed realignment and the community and budgetary impacts of the realignment.

b. The director may consult with governance board representatives and others before making a decision.

441—153.15(232) Decategorization services funding pool.

153.15(1) Creation and composition of pool. The department shall create the decategorization services funding pool for a project by combining funding resources that may be made available to the project from one or more of the following funding sources:

a. The project's allocation of any funding designated for decategorization in a state appropriation. When the general assembly designates a portion of the department's child welfare appropriation specifically for decategorization services, the designated funds shall be allocated to decategorization project services funding pools. Unless otherwise specified by legislation, the designated funds shall be allocated among decategorization projects based solely on each project's share of the population of children under the age of 18.

b. Child welfare and juvenile justice services funds that are:

(1) Specifically designated and committed in writing to the project by the service area manager; and

(2) Accepted by the project's governance board.

c. Any juvenile justice program funds that are:

(1) Specifically designated and committed in writing to the decategorization project by a chief juvenile court officer; and

(2) Accepted by the project's governance board.

d. Any carryover funds available to the project from funding transfers and from operation of decategorization services during the previous state fiscal year.

e. Funds made available to the project from any other funding source, such as another state agency or a grant awarded to the project. Funds awarded to the project under this provision may be subject to specific conditions, reporting requirements, and expenditure limits specified by the entity that awards funding.

153.15(2) *Use of funding pool.* A governance board shall use the funding pool in accordance with the following requirements:

a. The funding pool shall be used to provide services that meet at least one of the following criteria:

(1) Services are flexible;

(2) Services are individualized;

(3) Services are family-centered;

(4) Services are preventive;

(5) Services are community-based;

(6) Services are comprehensive; or

(7) Services promote coordinated service systems for children and families in order to reduce the use of restrictive approaches that rely on institutional, out-of-home, and out-of-community care.

b. The governance board may use the funding pool for enhancements to the child welfare and juvenile justice service systems within the project.

c. The funding pool shall not be used for any of the following services:

(1) Institutional services;

(2) Out-of-home services; or

(3) Out-of-community services.

d. The funding pool shall be expended in accordance with statutes and rules regarding vendor solicitation and service contracting, including Iowa Code chapter 8 and department of administrative services rules at 11—Chapters 106 and 107, Iowa Administrative Code.

153.15(3) *Designation and transfer of department funds.* A service area manager may choose during each state fiscal year to designate and transfer a portion of the service area's child welfare and juvenile justice service allocation to a decategorization project's funding pool. When designating funds, the service area manager and the governance board shall follow these procedures:

a. The service area manager shall provide written notification of any funding designations to the governance boards within the service area by June 1 of the state fiscal year. The service area manager shall specify any special terms and conditions of the funding designation in the written notification to the governance board.

b. The governance board shall consider the offer of designated funding and provide written notification of acceptance or rejection to the service area manager by June 30 of the state fiscal year.

c. If the governance board accepts the designated funding, the funds shall:

(1) Be transferred to the project's decategorization services funding pool; and

(2) Be under the sole management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

d. Any funding from such transfers that remains unencumbered or unobligated at the close of the state fiscal year shall be carryover funding in accordance with subrule 153.15(5).

153.15(4) *Designation and transfer of juvenile justice funds.* A chief juvenile court officer may choose to designate and transfer a portion of the judicial district's juvenile justice program funding to a decategorization project's services funding pool. When designating funds, the chief juvenile court officer and the governance board shall follow these procedures:

a. The chief juvenile court officer shall provide written notification of any funding designations to the governance boards within the judicial district by June 1 of the state fiscal year. The chief juvenile

court officer shall specify any special terms and conditions of the funding designation in the written notification to the governance board.

b. The governance board shall consider the offer of funding and shall provide the chief juvenile court officer with written notification of acceptance or rejection of the funding by June 30 of the state fiscal year.

c. If the governance board accepts the designated funding, the funds shall:

(1) Be transferred to the project's decategorization services funding pool; and

(2) Be under the sole management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

d. Any funding from such transfers that remains unencumbered or unobligated at the close of the state fiscal year shall be carryover funding in accordance with subrule 153.15(5).

153.15(5) Carryover funding. Funds allocated to a decategorization project from a legislative appropriation for decategorization services and funds designated and transferred to a decategorization project's funding pool that remain unencumbered or unobligated at the close of a state fiscal year are referred to as "carryover funding." The following procedures shall apply to the determination and use of decategorization carryover funding:

a. Upon the close of a state fiscal year, the department shall determine the exact amount of funding that is unencumbered or unobligated in each project's decategorization services funding pool. The department shall collaborate with governance boards to reconcile expenditure records and determine the amount of carryover funding for each decategorization project.

b. Before December 15 of each state fiscal year, the department shall provide each governance board with written notification of the official amount of carryover funding available from the previous state fiscal year.

c. Carryover funding shall not revert to the state general fund but shall remain available to the governance board until the close of the succeeding state fiscal year.

d. Carryover funding shall be under the authority of the project's governance board. These funds shall be available for expenditure for child welfare and juvenile justice systems enhancements and other purposes of the project as determined by the governance board.

e. Any carryover funding not expended by a decategorization project by the close of the succeeding state fiscal year shall revert to the fiscal authority of the department. The department shall return these funds to the state general fund.

441—153.16(232) Relationship of decategorization funding pool to other department child welfare funding. With the exception of any portion of the service area's child welfare allocation that is allocated by law for decategorization services, each service area's child welfare allocation shall be managed under the authority of the respective service area manager as follows:

153.16(1) Allocation. Each service area manager receives an allocation from the state appropriation for child welfare and juvenile justice services funding to meet child welfare and juvenile justice needs within all counties comprising the service area. The service area manager is responsible for meeting service needs throughout the service area within that allocation.

153.16(2) Budgeting. The service area manager may establish internal child welfare and juvenile justice services budget targets for the counties comprising the service area. Based on budget monitoring and changes in circumstances, the service area manager may revise the child welfare and juvenile justice budget targets within the service area to provide for the safety, permanency, and well-being of children served in the child welfare and juvenile justice systems.

153.16(3) Transfer to project. A service area manager may choose to designate and to transfer a portion of the service area's child welfare allocation to the funding pool of a decategorization project. The service area manager may ask a governance board to accept specific terms and conditions concerning use of this funding. Once funding is transferred to a governance board, the funding is under the management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

153.16(4) *Communication with the governance board.* The service area manager shall regularly communicate with the governance boards within the service area to provide updated data and other information on child welfare and juvenile justice funding amounts, service expenditures and trends, and other issues in order to assist the governance board in service and budget planning.

441—153.17(232) Relationship of decategorization funding pool to juvenile court services funding streams. Funds allocated by the department among the eight judicial districts for the court-ordered services and graduated sanctions programs shall be managed under the authority of the chief juvenile court officer for each judicial district as follows:

153.17(1) *Allocation.* Each chief juvenile court officer receives an allocation from the state appropriation for the court-ordered services and graduated sanction programs. The chief juvenile court officer is responsible for managing needs for these programs throughout the judicial district within that allocation.

153.17(2) *Budgeting.* The chief juvenile court officer may establish internal budget targets for expenditures from the court-ordered services and graduated sanction programs for the counties comprising the judicial district. Based on budget monitoring and changes in circumstances, a chief juvenile court officer may revise the budget targets established within the judicial district to provide programs most effectively for children within the district.

153.17(3) *Transfer to project.* A chief juvenile court officer may choose to designate and to transfer a portion of the judicial district's allocation for court-ordered services and graduated sanction programs to the funding pool of a decategorization project. The chief juvenile court officer may ask a governance board to accept specific terms and conditions concerning use of this funding. Once funding is transferred to a governance board, the funding is under the management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

153.17(4) *Communication with the governance board.* The chief juvenile court officer shall regularly communicate with the governance boards within the judicial district to provide data and other information on juvenile justice program allocation amounts, service expenditures and trends, and other issues that may assist the governance boards in service and budget planning.

441—153.18(232) Requirements for annual services plan. Each decategorization project shall annually develop and submit a child welfare and juvenile justice decategorization services plan.

153.18(1) *Content of plan.* The decategorization services plan shall describe:

a. The project's proposed use of funding from the decategorization services funding pool during the state fiscal year.

b. The community planning and needs assessment process that was used in developing the annual decategorization services plan, including information on:

- (1) The community members and organizations that participated in developing the plan; and
- (2) Efforts to coordinate with other community planning initiatives affecting children and families.

c. The project's specific and quantifiable short-term plans and desired results for the state fiscal year and how these plans align with the project's long-term plans to improve outcomes for vulnerable children and families by enhancing service systems.

d. The methods that the project will use to track results and outcomes during the year.

e. The project's plans for monitoring and maintaining fiscal accountability, which shall include monitoring:

- (1) The performance and results achieved by contractors that receive funding; and
- (2) Expenditures from the decategorization services funding pool throughout the state fiscal year.

f. The project's plans to expend projected carryover funds by the conclusion of the state fiscal year.

153.18(2) *Submission of plan.* The decategorization services plan shall be submitted to the department's child welfare administrator and to the Iowa empowerment board by October 1 of each state fiscal year.

441—153.19(232) Requirements for annual progress report. Each decategorization project shall develop and submit an annual progress report.

153.19(1) Content of report. At a minimum, the progress report shall:

- a. Summarize the project's key activities and the progress toward reaching the project's desired outcomes during the previous state fiscal year.
- b. Describe key activities, outcomes, and expenditures for programs and services that received funding from the governance board during the previous state fiscal year.
- c. Describe any lessons learned and planning adjustments made by the governance board during the previous state fiscal year.

153.19(2) Submission of report. The progress report shall be submitted to the department's child welfare administrator and to the Iowa empowerment board by December 1 of each state fiscal year.

These rules are intended to implement Iowa Code Supplement section 232.188.

441—153.20 to 153.30 Reserved.

DIVISION III
MENTAL ILLNESS, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES—LOCAL SERVICES
[Rescinded IAB 3/6/02, effective 5/1/02]

441—153.31 to 153.50 Reserved.

DIVISION IV
STATE PAYMENT PROGRAM FOR LOCAL MENTAL HEALTH, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES SERVICES TO ADULTS WITHOUT LEGAL SETTLEMENT

PREAMBLE

The state payment program provides 100 percent state funds to pay for local mental health, mental retardation, and developmental disabilities services for eligible adults who have no legal settlement in Iowa. The state payment program is intended to enable all eligible residents to receive services from the county mental health, mental retardation and developmental disabilities services fund through the county central point of coordination, regardless of the resident's legal settlement status.

Three basic principles underlie the state payment program.

First, duration of residency, including legal settlement, is not an eligibility factor for local mental health, mental retardation, and developmental disabilities service programs. The state payment program ensures that each of the local mental health, mental retardation, and developmental disabilities services provided by an Iowa county to residents who have legal settlement is also available to residents of that county who do not have legal settlement.

Second, each state is responsible to provide care and services for its own residents. Iowa provides for residents of Iowa.

Third, one's own family is of primary importance to one's well-being. Thus, the state payment program emphasizes that care and services for a person be provided near the person's own family, unless this is contraindicated or impossible to provide.

441—153.51(331) Definitions.

"Adult" means a person who is 18 years of age or older and is a United States citizen or a qualified alien as defined in 8 U.S.C. §1641.

"Applicant" means a person for whom payment is requested from the state payment program.

"Approved county management plan" means the county plan for mental health, mental retardation, and developmental disabilities services developed pursuant to Iowa Code section 331.439 that has been approved by the department's director.

"Central point of coordination" or *"CPC"* means the administrative entity designated by a county board of supervisors or by the boards of supervisors of a consortium of counties to act as the single entry point to the service system established under an approved county management plan.

“*County of residence*” means the county in Iowa where, at the time an adult applies for or receives services, the adult is living and has established an ongoing presence with the declared, good-faith intention of living permanently or for an indefinite period. The county of residence of an adult who is a homeless person is the county where the adult usually sleeps. “County of residence” does not mean the county where the adult is present for the purpose of:

1. Attending a college or university; or
2. Receiving services in a hospital, a correctional facility, a nursing facility, an intermediate care facility for persons with mental retardation, or a residential care facility.

The county of residence may be transferred using procedures set forth in subrule 153.53(5).

“*Department*” means the Iowa department of human services.

“*Division*” means the division of mental health and disability services of the department of human services.

“*Homeless person*” means a person who lacks a fixed, regular, and adequate nighttime residence and who has a primary nighttime residence that is one of the following:

1. A supervised publicly or privately operated shelter designed to provide temporary living accommodations.
2. An institution that provides a temporary residence for persons intended to be institutionalized.
3. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

“*Legal representative*” means a person recognized by law as standing in the place or representing the interests of another; for example, a guardian, conservator, custodian, parent of a minor, or the executor, administrator or next of kin of a deceased person.

“*Legal settlement*” is a legal status as defined in Iowa Code sections 252.16 and 252.17.

“*Member*” means a person authorized by the division to receive benefits from the state payment program.

“*Provider*” means a provider of mental health, mental retardation, or developmental disabilities services that has a valid contract for the service with a county to provide services under a county management plan.

“*Resident,*” for purposes of division IV of this chapter, means a person who is present in the state and who has established an ongoing presence with the declared, good-faith intention of living in Iowa permanently or for an indefinite period.

441—153.52(331) Eligibility requirements. To be eligible for the state payment program, an applicant must meet all of the following conditions.

153.52(1) *Adult status.* The applicant shall be an adult as defined in 441—153.51(331).

153.52(2) *Residency.* The applicant shall be a resident of Iowa, present in the state and without legal settlement in an Iowa county. The applicant shall not be in Iowa for purposes of a visit or vacation nor be traveling through the state to another destination at the time of application for services.

153.52(3) *Eligibility under county management plan.* The applicant shall meet the eligibility criteria established in the approved county management plan for the applicant’s county of residence.

153.52(4) *Payment source.* The applicant shall have no other political entity, organization, or other source responsible for provision of or payment for the needed services nor be eligible to have the service funded or provided at no additional cost to the state by another state-funded or federally funded facility or program. The department may, on a case-by-case basis, attempt collection from a legally responsible entity.

441—153.53(331) Application procedure.

153.53(1) *Initiation of application.* The county CPC or the CPC’s designee shall be responsible for applying for state payment program funding for any person who may be eligible and whose county of residence is that county.

a. When an applicant is awaiting discharge from a state mental health institute or state resource center, the facility’s social worker shall initiate the application and forward it to the CPC of the applicant’s

county of residence for completion. If the applicant has no clear county of residence, the application shall be forwarded to the county where the applicant intends to establish residency upon discharge. This county may be designated by the applicant's declaration.

b. Applications shall be made only with the knowledge and consent of the applicant or the applicant's legal representative.

153.53(2) Application requirements. The CPC or the CPC's designee shall complete the application, preferably in electronic format. A complete application shall include:

a. A funding request for the applicant showing:

- (1) The services being requested,
- (2) The total monthly dollar amount needed for the services requested, and
- (3) The chart of accounts codes from the county billing system for the requested services.

b. A copy of a legal settlement worksheet that is completed in accordance with provisions of Iowa Code chapter 252 and other applicable laws and rulings of courts; and

c. The client profile report (or equivalent) from a CPC application that contains information necessary for the division to enter the member into the data system used for payment processing.

153.53(3) Application submission. The CPC or the CPC's designee shall:

a. Submit the complete application as defined in subrule 153.53(2) to the division within 15 business days of the date the CPC or designee receives a completed and signed CPC application form containing a properly completed legal settlement worksheet.

b. Generate a delivery receipt for the application, whether sent to the division by E-mail, fax, or certified mail. The division may require the delivery receipt when it is alleged that an application was sent but the division has no record of receiving the application.

153.53(4) Application date.

a. Waiting list not in effect. When a waiting list is not in effect, the application date shall be the latest of the following dates:

- (1) The date on court commitment documents,
- (2) The date on the CPC application form, or
- (3) 60 days before the division receives the complete application, if the complete application is received more than 60 days after the date on the CPC application form.

b. Waiting list in effect. When a waiting list is in effect pursuant to subrule 153.54(5), the date of application shall be:

- (1) The date on court commitment documents, or
- (2) The date the application is moved off the waiting list.

153.53(5) Transfer of county of residence. The designated county of residence for an adult may be transferred when it seems more reasonable for the county in which the person is receiving services to assume management of the services.

a. Examples of situations where transfer may be reasonable include, but are not limited to:

(1) The person receiving services has been in a facility for more than a year; and the person no longer has any connection to the county of residence, such as relatives who live there, and, so far as anyone can tell, has no desire to return to the county of residence.

(2) The person receiving services was in the state and county of residence for such a short time before needing services that no real attachment was established in the county of residence.

(3) The person is a student attending a college or university but lives and works in the community 12 months per year.

b. If the county of residence desires a transfer and the county in which the person is receiving services agrees, the county accepting the transfer shall notify the department's state payment program manager. The new county of residence shall complete the application procedures, if necessary, and maintain responsibility for the person's case.

c. If the county of residence desires a transfer and the county in which the services are being received does not agree, the county of residence may appeal for resolution to the residency team established by the mental health, mental retardation, developmental disabilities, and brain injury

commission. Either county may appeal the decision of the residency team using the procedures in 441—Chapter 7.

[ARC 8319B, IAB 12/2/09, effective 11/1/09; ARC 8486B, IAB 1/13/10, effective 1/1/10]

441—153.54(331) Eligibility determination.

153.54(1) Approval by county.

a. The CPC or the CPC's designee shall determine whether an applicant is eligible for services based on the eligibility guidelines contained in the approved county management plan for the applicant's county of residence.

b. The county shall apply any policies and procedures regarding waiting lists to state payment program applicants in the same manner as it applies them to persons who have legal settlement in that county.

153.54(2) Certification by the department. Within 15 business days after receipt of a complete application as specified in subrule 153.53(2), division staff shall certify the applicant's eligibility for the state payment program to the central point of coordination.

a. The applicant's legal settlement status shall be ascertained in accordance with Iowa Code sections 252.16 and 252.17 and with other applicable laws, rulings of courts and opinions of the Iowa attorney general.

b. An application shall be approved only when funds are available. When funds are insufficient, the application shall be placed on a statewide waiting list pursuant to subrule 153.54(5).

153.54(3) Effective date of eligibility.

a. An applicant's eligibility for state payment program funding shall be effective from the application date as defined in subrule 153.53(4).

b. Each member shall be assigned a payment slot number based on the member's application date and commitment status.

(1) Members under a court-ordered involuntary commitment shall be considered the first priority for payment slot number assignment, in order of oldest commitment date first. The CPC shall notify the department within seven days of the date when the commitment order is released. When the commitment order is released, the member shall be reassigned a payment slot according to subparagraph 153.54(5) "b"(2).

(2) Slot number assignment for members who are not under an involuntary commitment order shall be based on the application date. For a member who was on a commitment order which has been released, the application date is the date of the member's first commitment order or the member's original application date, whichever is earliest. If there are multiple members with the same application date, the members will be prioritized by the birth month and day (earliest birth date first). If there are multiple members with the same birth month and day, the last four digits of the members' social security numbers will be used, with the lowest number being considered first.

153.54(4) Notification of eligibility decisions. The CPC or the CPC's designee shall notify the applicant or member of the following decisions in accordance with CPC requirements and procedures:

a. Certification of the applicant's eligibility.

b. A change in a member's services, including termination of service.

153.54(5) Waiting list. The department shall start a waiting list when analysis of submitted expenditure reports indicates that the amount of funds needed to pay for the currently assigned payment slots exceeds the state payment program appropriation.

a. *Notice of waiting list.* The department shall notify county CPCs:

(1) Before implementing a waiting list, and

(2) Promptly when the department determines a waiting list is no longer required.

b. *Placement on the waiting list.* When a waiting list is in effect, all new applications shall be placed on the waiting list with the exception of applicants who are subject to an involuntary commitment. Applicants who are subject to an involuntary commitment are exempted from waiting list placement for the services listed on the court order when the CPC includes a copy of relevant court orders directing

services under Iowa Code chapter 229 for which payment is sought. If this documentation is not included, the application will be placed on the waiting list.

c. Movement off the waiting list. The department shall review the waiting list every 30 days. As funds are determined available, applications shall be moved off the statewide waiting list. Applicants shall be served on a first-come, first-served basis, as determined by the date and time the complete application is received in the division office.

(1) In cases where applications are received simultaneously, the applicants will be prioritized by the birth month and day (earliest birth date first).

(2) If there are multiple applicants with the same birth month and day, the last four digits of the applicants' social security numbers will be used, with the lowest number being considered first.

d. Notification of applicant status. The department shall notify the CPC of each applicant's status quarterly, unless an application can be removed from the waiting list sooner. When the department notifies the CPC that an application can be removed from the waiting list, the CPC shall:

(1) Verify with the applicant that the services are still needed, and

(2) Notify the applicant that service funding is available for services identified.

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441—153.55(331) Eligible services. Services eligible for reimbursement under the state payment program are the services defined in the approved county management plan of the applicant's county of residence.

153.55(1) Purchased services.

a. Service management may be provided through a county CPC process during the period for which services are paid.

b. The county may pay for services as long as the member is eligible and the following criteria are met:

(1) The member is receiving a service that requires funding from the state payment program.

(2) The service is provided under the approved county management plan of the member's county of residence.

(3) The member's county of residence provides or pays for the service from the county mental health, mental retardation, and developmental disabilities services fund for persons who have legal settlement in the county.

(4) Service providers bill the other payment systems for which the member is eligible before billing the county of residence.

153.55(2) Excluded costs. The following costs are excluded from payment by the state payment program:

a. Services received before the effective date of eligibility.

b. The cost of local services that the member is eligible to have funded by private sources or by other state or federal programs or funds such as medical assistance program services or services provided in a state institution.

c. Scheduled appointments or consultations for which the member did not appear.

d. Service management (county chart of accounts numbers beginning with 22-000) for members eligible for Medicaid targeted case management, unless the Iowa plan contractor decertifies the member for case management services.

e. Services described by the following county chart of accounts codes:

(1) 4x03, information and referral.

(2) 4x04, consultation.

(3) 4x11, direct administrative.

(4) 4x12, purchased administrative.

(5) 4x21-374, case management Medicaid match.

(6) 4x32-328, home/vehicle modification.

[ARC 8486B, IAB 1/13/10, effective 1/1/10]

441—153.56(331) Program administration.**153.56(1) CPC responsibilities.**

a. Financial participation on the part of the member shall be governed by the financial participation provisions of the approved county management plan of the member's county of residence.

b. The CPC or the CPC's designee shall submit to the division's state payment program manager by the fifth business day of each month a report on the eligible services paid for during the previous month. The report shall be submitted electronically and shall include the following data in each record:

- (1) The calendar month and year in which the county made the payment.
- (2) The name of the county submitting the information.
- (3) The member's name.
- (4) The member's state identification number.
- (5) The member's identification number as assigned under subparagraph 153.56(2) "a"(2).
- (6) The member's diagnostic group code.
- (7) The provider's name.
- (8) The chart of accounts code for each service paid.
- (9) The number of units paid (if applicable).
- (10) The beginning date of each service for which the county paid.
- (11) The ending date of each service for which the county paid.
- (12) The dollar amount paid.

c. The CPC or the CPC's designee shall include payments made on behalf of members in the data warehouse annual reports required by 441—Chapter 25, Division IV.

153.56(2) Department responsibilities. As the sponsoring agency, the department shall be responsible for:

a. Enrolling members as necessary to produce payment to the counties, including:

- (1) Maintaining member information in the data system for payment;
- (2) Notifying counties of the member identification number required for billing; and
- (3) Closing data system files on members as directed by the counties, or when the member has not had any payments processed for a six-month period.

b. Verifying receipt of monthly payment report files. Within 15 business days of receipt of each county's monthly payment report file, the department shall:

- (1) Identify the county's payment amount for that month and the number of clients included in the payment; and
- (2) Notify the county of any clients whose costs were denied and the reason for the denial.

c. Generating and reconciling payments to the counties.

d. Receiving and auditing reports of member activity and expenditures from the counties.

153.56(3) Payment to counties. The following policies shall govern payment to counties for services furnished to members:

a. Monthly payment. Beginning in May 2007, the department shall make a monthly payment to each county based on the expense report for the previous month that was submitted by the county pursuant to paragraph 153.56(1) "b." The department shall process monthly payments by the twentieth day of each month.

b. Prospective payment. The department may make a prospective payment to the county for cash flow purposes by July 10 of each year.

(1) The prospective payment shall be based on the sum of the expense reports that the department received from the county in April, May, and June of that year.

(2) For the state fiscal year ending June 30, 2007, the payments made to the county on or before April 1, 2007, shall be considered the prospective payment.

c. Payment reconciliation. The department and counties shall reconcile the total of the prospective payment and monthly payments made to a county with the total actual expenses paid by the county for that same period.

d. Payment adjustment. Beginning in April of each year, the department may adjust the monthly payment to the county to:

- (1) Spend down the balance of the prospective payments previously made; or
- (2) Make additional payment to ensure that the county has sufficient moneys for cash flow purposes.

e. Deductions. For the state fiscal year ending June 30, 2007, moneys that the county received but did not expend, according to the report required by paragraph 153.56(1)“b,” shall be deducted from the county’s subsequent payment.

[ARC 8486B, IAB 1/13/10, effective 1/1/10]

441—153.57(331) Reduction, denial, or termination of benefits. The member’s state payment program benefits may be denied, terminated, or reduced according to the provisions of the approved county management plan of the member’s county of residence.

153.57(1) Termination of eligibility. A member shall remain eligible until:

- a.* Reimbursement for episodic commitment costs has been made to the county if the member was enrolled for commitment costs only;
- b.* The CPC in the county of residence notifies the state payment program manager that the member is no longer eligible;
- c.* No services have been reported for the member for six months; or
- d.* The member is disenrolled pursuant to subrule 153.57(2).

153.57(2) Disenrollment. If instituting a waiting list does not adequately address the funding shortfall, the department shall begin disenrollment of members.

a. Members who are enrolled and receiving services being reimbursed by the state and who are not under court-ordered involuntary commitment shall be disenrolled beginning with the highest payment slot number first.

b. The department shall notify the member and the CPC when a member is to be disenrolled. The department shall give the member at least ten days’ notice of disenrollment pursuant to rule 441—7.7(17A). The department shall give a member receiving any residential service 30 days’ notice of disenrollment from the program consistent with department of inspections and appeals’ rule 481—57.36(135C).

c. Any member who is disenrolled shall be placed on the waiting list as provided in subrule 153.54(5).

[ARC 8486B, IAB 1/13/10, effective 1/1/10]

441—153.58(331) Appeals.

153.58(1) Decisions regarding denial or termination of state payment program eligibility, including disenrollment, may be appealed to the department pursuant to 441—Chapter 7. Continuation of assistance will be granted pursuant to rule 441—7.9(17A).

153.58(2) Decisions (other than eligibility) adversely affecting applicants or members shall be appealed pursuant to the county CPC’s appeal provisions.

[ARC 8319B, IAB 12/2/09, effective 11/1/09; ARC 8486B, IAB 1/13/10, effective 1/1/10]

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- [Filed Emergency ARC 8486B, IAB 1/13/10, effective 1/1/10]

CHAPTER 156
PAYMENTS FOR FOSTER CARE

[Prior to 7/1/83, Social Services[770] Ch 137]
[Previously appeared as Ch 137—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—156.1(234) Definitions.

“*Child welfare services*” means age-appropriate activities to maintain a child’s connection to the child’s family and community, to promote reunification or other permanent placement, and to facilitate a child’s transition to adulthood.

“*Cost of foster care*” means the maintenance and supervision costs of foster family care, the maintenance costs and child welfare service costs of group care, and the maintenance and service costs of supervised apartment living and shelter care. The cost for foster family care supervision and for supervised apartment living services provided directly by the department caseworker shall be \$250 per month. When using this average monthly charge results in unearned income or parental liability being collected in excess of the cost of foster care, the excess funds shall be placed in the child’s escrow account. The cost for supervised apartment living services purchased from a private provider shall be the actual costs paid by the department.

“*Department*” means the Iowa department of human services.

“*Director*” means the director of the child support recovery unit of the department or the director’s designee.

“*Earned income*” means income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from job corps or profit from self-employment.

“*Escrow account*” means an interest bearing account in a bank or savings and loan association which is maintained by the department in the name of a particular child.

“*Family foster care supervision*” means the support, assistance, and oversight provided by department caseworkers to children in family foster care and directed toward achievement of the child’s permanency plan goals.

“*Foster care*” means substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child’s parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care shall include but is not limited to the provision of food, lodging, training, education, supervision and health care.

“*Foster family care*” means foster care provided by a foster family licensed by the department according to 441—Chapter 113 or licensed or approved by the placing state. The care includes the provision of food, lodging, clothing, transportation, recreation, and training that is appropriate for the child’s age and mental and physical capacity.

“*Group care maintenance*” means food, clothing, shelter, school supplies, personal incidentals, daily care, general parenting, discipline, and supervision of children to ensure their well-being and safety, and administration of maintenance items provided in a group care facility.

“*Income*” means earned and unearned income.

“*Mental health professional*” means a person who meets all of the following conditions:

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

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

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

“*Mental retardation professional*” means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the

educational requirements for the profession, as required in the state of Iowa, and has one year of experience working with persons with mental retardation.

“*Parent*” means the biological or adoptive parent of the child.

“*Parental liability*” means a parent’s liability for the support of a child during the period of foster care placement. Liability shall be determined pursuant to 441—Chapter 99, Division I.

“*Physician*” means a licensed medical or osteopathic doctor as defined in rule 441—77.1(249A).

“*Service area manager*” means the department employee or designee responsible for managing department offices within a department service area and for implementing policies and procedures of the department.

“*Special needs child*” means a child with needs for emotional care, behavioral care, or physical and personal care which require additional skill, knowledge, or responsibility on the part of the foster parents, as measured by Form 470-4401, Foster Child Behavioral Assessment. See subrule 156.6(4).

“*Unearned income*” means any income which is not earned income and includes supplemental security income (SSI) and other funds available to a child residing in a foster care placement.

This rule is intended to implement Iowa Code section 234.39.

[ARC 7606B, IAB 3/11/09, effective 5/1/09; ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 8010B, IAB 7/29/09, effective 10/1/09]

441—156.2(234) Foster care recovery. The department shall recover the cost of foster care provided by the department pursuant to the rules in this chapter and the rules in 441—Chapter 99, Division I, which establishes policies and procedures for the computation and collection of parental liability.

156.2(1) Funds shall be applied to the cost of foster care in the following order and each source exhausted before utilizing the next funding source:

- a. Unearned income of the child.
- b. Parental liability of the noncustodial parent.
- c. Parental liability of custodial parent(s).

156.2(2) The department shall serve as payee to receive the child’s unearned income. When a parent or guardian is not available or is unwilling to do so, the department shall be responsible for applying for benefits on behalf of a child placed in the care of the department. Until the department becomes payee, the payee shall forward benefits to the department. For voluntary foster care placements of children aged 18 and over, the child is the payee for the unearned income. The child shall forward these benefits, up to the actual cost of foster care, to the department.

156.2(3) The custodial parent shall assign child support payments to the department.

156.2(4) Unearned income of a child and parental liability of the noncustodial parent shall be placed in an account from whence it shall be applied toward the cost of the child’s current foster care and the remainder placed in an escrow account.

156.2(5) When a child has funds in escrow these funds may be used by the department to meet the current needs of the child not covered by the foster care payments and not prohibited by the source of the funds.

156.2(6) When the child leaves foster care, funds in escrow shall be paid to the custodial parent(s) or guardian or to the child when the child has attained the age of majority, unless a guardian has been appointed.

156.2(7) When a child who has unearned income returns home after the first day of a month, the remaining portion of the unearned income (based on the number of days in the particular month) shall be made available to the child and the child’s parents, guardian or custodian, if the child is eligible for the unearned income while in the home of a parent, guardian or custodian.

This rule is intended to implement Iowa Code section 234.39.

441—156.3(252C) Computation and assessment of parental liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.4(252C) Redetermination of liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.5(252C) Voluntary payment. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.6(234) Rate of maintenance payment for foster family care.

156.6(1) Basic rate. A monthly payment for care in a foster family home licensed in Iowa shall be made to the foster family based on the following schedule effective January 1, 2010, to June 30, 2010:

<u>Age of child</u>	<u>Daily rate</u>
0 through 5	\$15.54
6 through 11	\$16.16
12 through 15	\$17.69
16 or over	\$17.93

156.6(2) Out-of-state rate. A monthly payment for care in a foster family home licensed or approved in another state shall be made to the foster family based on the rate schedule in effect in Iowa, except that the service area manager or designee may authorize a payment to the foster family at the rate in effect in the other state if the child's family lives in that state and the goal is to reunite the child with the family.

156.6(3) Mother and child in foster care. When the child in foster care is a mother whose young child is in placement with her, the rate paid to the foster family shall be based on the daily rate for the mother according to the rate schedule in subrules 156.6(1) and 156.6(4) and for the child according to the rate schedule in subrule 156.6(1). The foster parents shall provide a portion of the young child's rate to the mother to meet the partial maintenance needs of the young child as defined in the case permanency plan.

156.6(4) Difficulty of care payment.

a. For placements made before January 1, 2007, when foster parents provide care to a special needs child, the foster family shall be paid the basic maintenance rate plus \$5 per day for extra expenses associated with the child's special needs. This rate shall continue for the duration of the placement.

b. When a foster family provides care to a sibling group of three or more children, an additional payment of \$1 per day per child may be authorized for each nonspecial needs child in the sibling group.

c. When the foster family's responsibilities in the case permanency plan include providing transportation related to family or preplacement visits outside the community in which the foster family lives, the department worker may authorize an additional maintenance payment of \$1 per day. Expenses over the monthly amount may be reimbursed with prior approval by the worker. Eligible expenses shall include the actual cost of the most reasonable passenger fare or gas.

d. Effective January 1, 2007, when a foster family provides care to a child who was receiving behavioral management services for children in therapeutic foster care in that placement as of October 31, 2006, the foster family shall be paid the basic maintenance rate plus \$15 per day for that child. This rate shall continue for the duration of the placement.

e. Effective January 1, 2007, when a service area manager determines that as of October 31, 2006, a foster family was providing care for a child comparable to behavioral management services for children in therapeutic foster care, except that the placement is supervised by the department and the child's treatment plan is supervised by a physician, mental health professional, or mental retardation professional, the foster family shall be paid the basic maintenance rate plus \$15 per day for that child. This rate shall continue for the duration of the placement.

f. For placements made on or after January 1, 2007, the supervisor may approve an additional maintenance payment above the basic rate in subrule 156.6(1) to meet the child's special needs as identified by the child's score on Form 470-4401, Foster Child Behavioral Assessment. The placement worker shall complete Form 470-4401 within 30 days of the child's initial entry into foster care.

(1) Additional maintenance payments made under this paragraph shall begin no earlier than the first day of the month following the month in which Form 470-4401 is completed and shall be awarded as follows:

1. Behavioral needs rated at level 1 qualify for a payment of \$4.75 per day.
2. Behavioral needs rated at level 2 qualify for a payment of \$9.50 per day.
3. Behavioral needs rated at level 3 qualify for a payment of \$14.25 per day.

(2) The department shall review the child's need for this difficulty of care maintenance payment using Form 470-4401:

1. Whenever the child's behavior changes significantly;
2. When the child's placement changes;
3. After termination of parental rights, in preparation for negotiating an adoption subsidy or pre-subsidy payment; and
4. Before a court hearing on guardianship subsidy.

g. All maintenance payments, including difficulty of care payments, shall be documented on Form 470-0716, Foster Family Placement Contract.

h. Rescinded IAB 1/3/07, effective 1/1/07.

156.6(5) *Payment method.* All foster family maintenance payments shall be made directly to the foster family.

156.6(6) *Return of overpayments.* When a foster family has received payments in excess of those allowed under this chapter, the department caseworker shall ask the foster family to return the overpayment. If the foster family is returning the overpayment to the department, the caseworker will note the monthly amount the foster family agrees to pay in the family's case file. The amount returned shall not be less than \$50 per month.

This rule is intended to implement Iowa Code section 234.38.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 8451B, IAB 1/13/10, effective 1/1/10]

441—156.7(234) Purchase of family foster care services. Rescinded IAB 5/6/09, effective 7/1/09.

441—156.8(234) Additional payments.

156.8(1) *Clothing allowance.* When, in the judgment of the worker, clothing is needed at the time the child is removed from the child's home and placed in foster care, an allowance may be authorized, not to exceed \$237.50, to purchase clothing.

a. Once during each calendar year that the child remains in foster care, the department worker may authorize another clothing allowance, not to exceed \$190 for family foster care and \$100 for all other levels, when:

- (1) The child needs clothing to replace lost clothing or because of growth or weight change, and
- (2) The child does not have escrow funds to cover the cost.

b. When clothing is purchased by the foster family, the foster family shall submit receipts to the worker within 30 days of purchase for auditing purposes, using Form 470-1952, Foster Care Clothing Allowance.

156.8(2) *Supervised apartment living.* When a youth is initially placed in supervised apartment living, the service area manager or designee may authorize an allowance not to exceed \$400 if the youth does not have sufficient resources to cover initial costs.

156.8(3) *Medical care.* When a child in foster care needs medical care or examinations which are not covered by the Medicaid program and no other source of payment is available, the cost may be paid from foster care funds with the approval of the service area manager or designee. Eligible costs shall include emergency room care, medical treatment by out-of-state providers who refuse to participate in the Iowa Medicaid program, and excessive expenses for nonprescription drugs or supplies. Requests for payment for out-of-state medical treatment and for nonprescription drugs or supplies shall be approved prior to the care being provided or the drugs or supplies purchased. Claims shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the service is provided. The rate of payment shall be the same as allowed under the Iowa Medicaid program.

156.8(4) *Transportation for medical care.* When a child in foster family care has expenses for transportation to receive medical care which cannot be covered by the Medicaid program, the expenses may be paid from foster care funds, with the approval of the service area manager. The claim for all the expenses shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the trip. This payment shall not duplicate or supplement payment through the Medicaid

program. The expenses may include the actual cost of meals, parking, child care, lodging, passenger fare, or mileage at the rate granted state employees.

156.8(5) *Funeral expense.* When a child under the guardianship of the department dies, the department will pay funeral expenses not covered by the child's resources, insurance or other death benefits, the child's legal parents, or the child's county of legal settlement, not to exceed \$650.

The total cost of the funeral and the goods and services included in the total cost shall be the same as defined in rule 441—56.3(239,249).

The claim shall be submitted by the funeral director to the department on Form GAX, General Accounting Expenditure, and shall be approved by the service area manager. Claims shall be submitted within 90 days after the child's death.

156.8(6) *School fees.* Payment for required school fees of a child in foster family care or supervised apartment living that exceed \$5 may be authorized by the department worker in an amount not to exceed \$50 per calendar year if the child does not have sufficient escrow funds to cover the cost. Required school fees shall include:

- a. Fees required for participation in school or extracurricular activities; and
- b. Fees related to enrolling a child in preschool when a mental health professional or a mental retardation professional has recommended school attendance.

156.8(7) *Respite care.* The service area manager or designee may authorize respite for a child in family foster care for up to 24 days per calendar year per placement. Respite shall be provided by a licensed foster family. The payment rate to the respite foster family shall be the rate authorized under rule 441—156.6(234) to meet the needs of the child.

156.8(8) *Tangible goods, child care, and ancillary services.* To the extent that a foster child's escrow funds are not available, the service area manager or designee may authorize reimbursement to foster parents for the following:

a. Tangible goods for a special needs child including, but not limited to, building modifications, medical equipment not covered by Medicaid, specialized educational materials not covered by educational funds, and communication devices not covered by Medicaid.

b. Child care services when the foster parents are working, the child is not in school, and the provision of child care is identified in the child's case permanency plan.

(1) Child care services shall be provided by a licensed foster parent or a licensed or registered child care provider when available.

(2) When foster parents elect to become child care providers, they shall be registered pursuant to 441—Chapter 110.

c. Ancillary services needed by the foster parent to meet the needs of a special needs child including, but not limited to, specialized classes when directed by the case permanency plan.

d. Ancillary services needed by the special needs child including, but not limited to, recreation fees, in-home tutoring and specialized classes not covered by education funds.

e. Requests for tangible goods, child care, and ancillary services shall be submitted to the service area manager for approval on Form 470-3056, Request for Tangible Goods, Child Care, and Ancillary Services. Payment rates for tangible goods and ancillary services shall be comparable to prevailing community standards. Payment rates for child care shall be established pursuant to 441—subrule 170.4(7).

f. Prior payment authorization shall be issued by the service area manager before tangible goods, child care, and ancillary services are purchased by or for foster parents.

[ARC 7606B, IAB 3/11/09, effective 5/1/09; ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 8451B, IAB 1/13/10, effective 1/1/10]

441—156.9(234) Rate of payment for foster group care.

156.9(1) *In-state reimbursement.* Effective November 1, 2006, public and private foster group care facilities licensed or approved in the state of Iowa shall be paid for group care maintenance and child welfare services in accordance with the rate-setting methodology in this subrule.

a. A provider of group care services shall maintain at least the minimum staff-to-child ratio during prime programming time as established in the contract. Staff shall meet minimum qualifications as

established in 441—Chapters 114 and 115. The actual number and qualifications of the staff will vary depending on the needs of the children.

b. Additional payment for group care maintenance may be authorized if a facility provides care for a mother and her young child according to subrule 156.9(4).

c. Reimbursement rates shall be adjusted based on the provider's rate in effect on October 31, 2006, to reflect an estimate that group care providers will provide an average of one hour per day of group remedial services and one hour per week of individual remedial services. The reimbursement rate shall be calculated as follows:

(1) Step 1. Annualize the provider's combined daily reimbursement rate for maintenance and service in effect on October 31, 2006, by multiplying that combined rate by 365 days.

(2) Step 2. Annualize the provider's remedial services reimbursement rate for one hour per day of remedial services code 96153 (health and behavioral interventions - group), as established by the Iowa Medicaid enterprise, by multiplying that rate by 365 days.

(3) Step 3. Annualize the provider's remedial services reimbursement rate for one hour per week of remedial services code 96152 (health and behavioral interventions - individual), as established by the Iowa Medicaid enterprise, by multiplying that rate by 52 weeks.

(4) Step 4. Add the amounts determined in Steps 2 and 3.

(5) Step 5. Subtract the amount determined in Step 4 from the amount determined in Step 1.

(6) Step 6. Divide the amount determined in Step 5 by 365 to compute the new combined maintenance and child welfare service per diem rate.

(7) Step 7. Determine the maintenance portion of the per diem rate by multiplying the new combined per diem rate determined in Step 6 by 85.62 percent.

(8) Step 8. Determine the child welfare service portion of the per diem rate by multiplying the new combined per diem rate determined in Step 6 by 14.38 percent.

EXAMPLE: Provider A has the following rates as of October 31, 2006:

- A combined daily maintenance and service rate of \$121.45;
- A Medicaid rate for service code 96153 of \$5.10 per 15 minutes, or \$20.40 per hour;
- A Medicaid rate for service code 96152 of \$19.92 per 15 minutes, or \$79.68 per hour.

Step 1. $\$121.45 \times 365 \text{ days} = \$44,329.25$

Step 2. $\$20.40 \times 365 \text{ days} = \$7,446.00$

Step 3. $\$79.68 \times 52 \text{ weeks} = \$4,143.36$

Step 4. $\$7,446.00 + \$4,143.36 = \$11,589.36$

Step 5. $\$44,329.25 - \$11,589.36 = \$32,739.89$

Step 6. $\$32,739.89 \div 365 \text{ days} = \89.70

Step 7. $\$89.70 \times 0.8562 = \76.80 maintenance rate

Step 8. $\$89.70 \times 0.1438 = \12.90 child welfare service rate

Provider A's rates are \$76.80 for maintenance and \$12.90 for child welfare services.

d. If the Iowa Medicaid enterprise has not made a determination by October 31, 2006, on the need for remedial services for a child who is in group care placement as of that date, the department service area manager may approve a payment from state funds for the estimated daily reimbursement rate for remedial services that was used in the calculation of the provider's reimbursement rate under paragraph 156.9(1) "c." The service area manager shall document the reason for the delay in the decision on the child's need for remedial services.

(1) The service area manager may approve such payment only until the time that the Iowa Medicaid enterprise is anticipated to issue the decision regarding the child's need for remedial services. The service area manager shall not authorize payment from state funds if the Iowa Medicaid enterprise has determined that the child does not need remedial services.

(2) The payment that the service area manager may authorize shall be based on a reimbursement rate calculated as follows:

Step 1. Annualize the provider's reimbursement rate for one hour per day of remedial services code 96153 (health and behavioral interventions - group), as established by the Iowa Medicaid enterprise, by multiplying that rate by 365 days.

Step 2. Annualize the provider's remedial services reimbursement rate for one hour per week of remedial services code 96152 (health and behavioral interventions - individual), as established by the Iowa Medicaid enterprise, by multiplying that rate by 52 weeks.

Step 3. Add the amounts determined in Steps 1 and 2.

Step 4. Determine the provider's estimated daily rate for reimbursement of remedial services by dividing the amount in Step 3 by 365 days.

EXAMPLE: Provider B has the following rates as of October 31, 2006:

- A Medicaid rate for service code 96153 of \$5.10 per 15 minutes, or \$20.40 per hour;
- A Medicaid rate for service code 96152 of \$19.92 per 15 minutes, or \$79.68 per hour.

Step 1. $\$20.40 \times 365 \text{ days} = \$7,446.00$

Step 2. $\$79.68 \times 52 \text{ weeks} = \$4,143.36$

Step 3. $\$7,446.00 + \$4,143.36 = \$11,589.36$

Step 4. $\$11,589.36 \div 365 \text{ days} = \31.75 estimated daily rate for remedial services

156.9(2) *Out-of-state group care payment rate.* The payment rate for maintenance and child welfare services provided by public or private agency group care licensed or approved in another state shall be established using the same rate-setting methodology as that in subrule 156.9(1), unless the director determines that appropriate care is not available within the state pursuant to the following criteria and procedures.

a. Criteria. When determining whether appropriate care is available within the state, the director shall consider each of the following:

- (1) Whether the child's treatment needs are exceptional.
- (2) Whether appropriate in-state alternatives are available.
- (3) Whether an appropriate in-state alternative could be developed by using juvenile court-ordered service fund or wrap-around funds.
- (4) Whether the placement and additional payment are expected to be time-limited with anticipated outcomes identified.
- (5) If the placement has been approved by the service area manager or chief juvenile court officer.

b. Procedure. The service area manager or chief juvenile court officer shall submit the request for director's exception to the Bureau of Policy Analysis, Department of Human Services, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114. This request shall be made in advance of placing the child and should allow a minimum of two weeks for a response. The request shall contain documentation addressing the criteria for director's approval listed in 156.9(2) "a."

c. Appeals. The decision of the director regarding approval of an exception to the rate determination in rule 441—152.3(234) is not appealable.

156.9(3) *Supplemental payments for in-state facilities.* Rescinded IAB 9/1/93, effective 8/12/93.

156.9(4) *Mother-young child rate.* When a group foster care facility provides foster care for a mother and her young child, the maintenance rate for the mother shall include an additional amount to cover the actual and allowable maintenance needs of the young child. No additional amount shall be allowed for service needs of the child.

a. The rate shall be determined according to the policies in rule 441—152.3(234) and added to the maintenance rate for the mother. The young child portion of the maintenance rate shall be limited to the costs associated with food, clothing, shelter, personal incidentals, and supervision for each young child and shall not exceed the maintenance rate for the mother. Costs for day care shall not be included in the maintenance rate.

b. Rescinded IAB 6/8/94, effective 6/1/94.

c. Unless the court has transferred custody from the mother, the mother shall have primary responsibility for providing supervision and parenting for the young child. The facility shall provide services to the mother to assist her to meet her parenting responsibilities and shall monitor her care of the young child.

d. The facility shall provide services to the mother to assist her to:

- (1) Obtain a high school diploma or general education equivalent (GED).
- (2) Develop preemployment skills.

- (3) Establish paternity for her young child whenever appropriate.
- (4) Obtain child support for the young child whenever paternity is established.
- e. The agency shall maintain information in the mother's file on:
 - (1) The involvement of the mother's parents or of other adults.
 - (2) The involvement of the father of the minor's child, including steps taken to establish paternity, if appropriate.
 - (3) A decision of the minor to keep and raise her young child.
 - (4) Plan for the minor's completion of high school or a GED program.
 - (5) The parenting skills of the minor parent.
 - (6) Child care and transportation plans for education, training or employment.
 - (7) Ongoing health care of the mother and child.
 - (8) Other services as needed to address personal or family problems or to facilitate the personal growth and development toward economic self-sufficiency of the minor parent and young child.
- f. The agency shall designate \$35 of the young child rate as an allowance to the mother to meet the maintenance needs of her young child, as defined in her case permanency plan.

This rule is intended to implement Iowa Code sections 234.6 and 234.38.
 [ARC 7741B, IAB 5/6/09, effective 7/1/09]

441—156.10(234) Payment for reserve bed days.

156.10(1) Group care facilities. The department shall provide payment for group care maintenance and child welfare services according to the following policies.

a. *Family visits.* Reserve bed payment shall be made for days a child is absent from the facility for family visits when the absence is in accord with the following:

- (1) The visits shall be consistent with the child's case permanency plan.
- (2) The facility shall notify the worker of each visit and its planned length prior to the visit.
- (3) The intent of the department and the facility shall be for the child to return to the facility after the visit.
- (4) Staff from the facility shall be available to provide support to the child and family during the visit.
- (5) Payment shall be canceled and payments returned if the facility refuses to accept the child back.
- (6) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.
- (7) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.
- (8) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.
- (9) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. *Hospitalization.* Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

- (1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.
- (2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.
- (3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.
- (4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.
- (5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.
- (6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

c. Runaways. Reserve bed payment shall be made for days a child is absent from the facility after the child has run away when the absence is in accord with the following:

(1) The facility shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the facility shall be for the child to return to the facility once the child is found.

(3) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(4) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(7) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

d. Preplacement visits. Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

156.10(2) Foster family care.

a. Family visits. Reserve bed payment shall be made for days a foster child is absent from the foster family home for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home after the visit.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

b. Hospitalization. Reserve bed payment shall be made for days a foster child is absent from the foster family home for hospitalization when the absence is in accord with the following:

(1) The intent of the department and the foster family shall be for the child to return to the foster family home after the hospitalization.

(2) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(3) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(5) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

c. Runaways. Reserve bed payment shall be made for days a foster child is absent from the foster family home after the child has run away when the absence is in accord with the following:

(1) The foster family shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home once the child is found.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

d. Preplacement visits. Reserve bed payment shall be made when a foster child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family home shall be for the child to return to the foster family home.

(3) Payment shall be canceled and payment returned if the foster family home refuses to accept the child back.

(4) Payment shall not exceed two consecutive days.

156.10(3) Shelter care facilities.

a. Hospitalization. Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. Preplacement visits. Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

This rule is intended to implement Iowa Code sections 234.6 and 234.35.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

441—156.11(234) Emergency care.

156.11(1) and **156.11(2)** Rescinded IAB 3/11/09, effective 5/1/09.

156.11(3) Shelter care payment. Public and private juvenile shelter care facilities approved or licensed in Iowa shall be paid according to the rate-setting methodology in 441—paragraph 150.3(5) “p.”

a. Facilities shall bill for actual units of service provided in accordance with 441—subrule 150.3(8). In addition, facilities may be guaranteed a minimum level of payment to the extent determined by the department through a request-for-proposal process.

(1) Guaranteed payment shall be calculated monthly.

(2) The guaranteed level of payment shall be calculated by multiplying the number of beds for which payment is guaranteed by the number of days in the month.

(3) When the actual unit billings for a facility do not equal the guaranteed level of payment for the month, the facility may submit a supplemental billing for the deficiency.

(4) The amount of the supplemental billing shall be determined by multiplying the facility’s unit cost for shelter care by the number of units below the guaranteed level for the month for which the facility was not reimbursed.

b. The total reimbursement to the agency shall not exceed the agency’s allowable costs as defined in 441—subrule 150.3(5). Agencies shall refund any payments which have been made in excess of the agencies’ allowable costs.

c. Shelter contracts for the state fiscal year beginning July 1, 2007, shall provide for the statewide availability of a daily average of 273 guaranteed emergency juvenile shelter care beds during the fiscal year.

This rule is intended to implement Iowa Code section 234.35.

[ARC 7606B, IAB 3/11/09, effective 5/1/09]

441—156.12(234) Supervised apartment living.

156.12(1) Maintenance. When a youth at least aged 16 but under the age of 20 is living in a supervised apartment living situation, the maximum monthly maintenance payment for the youth shall be \$573.90. This payment may be paid to the youth or another payee, other than a department employee, for the youth’s care.

156.12(2) Service. When services for a youth in supervised apartment living are purchased, the service components and number of hours purchased shall be specified by the service worker in the youth’s case permanency plan.

This rule is intended to implement Iowa Code section 234.35.

[ARC 8451B, IAB 1/13/10, effective 1/1/10]

441—156.13(234) Excessive rates. Rescinded IAB 6/9/93, effective 8/1/93.

441—156.14(234,252C) Voluntary placements. When placement is made on a voluntary basis, the parent or guardian shall complete and sign Form 470-0715, Voluntary Placement Agreement.

441—156.15(234) Child’s earnings. Earned income of a child who is not in a supervised apartment living arrangement and who is a full-time student or engaged in an educational or training program shall be reported to the department and its use shall be a part of a plan for service, but the income shall not be used towards the cost of the child’s care as established by the department. When the earned income of children in supervised apartment living arrangements or of other children exceeds the foster care standard, the income in excess of the standard shall be applied to meet the cost of the child’s care. When

the income of the child exceeds twice the cost of maintenance, the child shall be discontinued from foster care.

441—156.16(234) Trust funds and investments.

156.16(1) When the child is a beneficiary of a trust and the proceeds therefrom are not currently available, or are not sufficient to meet the child's needs, the worker shall assist the child in having a petition presented to the court requesting release of funds to help meet current requirements. When the child and responsible adult cooperate in necessary action to obtain a ruling of the court, income shall not be considered available until the decision of the court has been rendered and implemented. When the child and responsible adult do not cooperate in the action necessary to obtain a ruling of the court, the trust fund or investments shall be considered as available to meet the child's needs immediately. When the child or responsible adult does not cooperate within 90 days in making the income available the maintenance payment shall be terminated.

156.16(2) The Iowa department of human services shall be payee for income from any trust funds or investments unless limited by the trust.

156.16(3) Savings accounts from any income and proceeds from the liquidation of securities shall be placed in the child's account maintained by the department and any amount in excess of \$1,500 shall be applied towards cost of the child's maintenance.

This rule is intended to implement Iowa Code section 234.39.

441—156.17(234) Preadoptive homes. Payment for a foster child placed in a preadoptive home shall be limited to the amount negotiated pursuant to rule 441—201.5(600) and shall not exceed the foster care maintenance amount paid in family foster care.

This rule is intended to implement Iowa Code section 234.38.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

441—156.18(237) Foster parent training expenses. Rescinded IAB 7/29/09, effective 10/1/09.

441—156.19(237) Rate of payment for care in a residential care facility. When a child is receiving group care maintenance and child welfare services in a licensed residential care facility and is not eligible for supplemental security income or state supplementary assistance, the department will pay for the group care maintenance and child welfare services in accordance with subrule 156.9(1). When a child receives group care maintenance and child welfare services in a licensed residential care facility and is eligible for supplemental security income or state supplementary assistance, the department will pay for child welfare services in accordance with subrule 156.9(1).

This rule is intended to implement Iowa Code section 237.1(3) "e."

441—156.20(234) Eligibility for foster care payment.

156.20(1) Client eligibility. Foster care payment shall be limited to the following populations.

a. Youth under the age of 18 shall be eligible based on legal status, subject to certain limitations.

(1) Legal status. The youth's placement shall be based on one of the following legal statuses:

1. The court has ordered foster care placement pursuant to Iowa Code section 232.52, subsection 2, paragraph "d," Iowa Code section 232.102, subsection 1, Iowa Code section 232.117, or Iowa Code section 232.182, subsection 5.

2. The child is placed in shelter care pursuant to Iowa Code section 232.20, subsection 1, or Iowa Code section 232.21.

3. The department has agreed to provide foster care pursuant to rule 441—202.3(234).

(2) Limitations. Department payment for group care shall be limited to placements which have been authorized by the department and which conform to the service area group care plan developed pursuant to rule 441—202.17(232). Payment for an out-of-state group care placement shall be limited to placements approved pursuant to 441—subrule 202.8(2).

b. Youth aged 18 and older who meet the definition of child in rule 441—202.1(234) shall be eligible based on age, a voluntary placement agreement pursuant to 441—subrule 202.3(3), and type of placement.

(1) Except as provided in subparagraph 156.20(1)“*b*”(3), payment for a child who is 18 years of age shall be limited to family foster care or supervised apartment living.

(2) Except as provided in subparagraph 156.20(1)“*b*”(3), payment for a child who is 19 years of age shall be limited to supervised apartment living.

(3) Exceptions. An exception to subparagraphs (1) and (2) shall be granted for all unaccompanied refugee minors. The service area manager or designee shall grant an exception for other children when the child meets all of the following criteria. The child’s eligibility for the exception shall be documented in the case record.

1. The child does not have mental retardation. Funding for services for persons with mental retardation is the responsibility of the county or state pursuant to Iowa Code section 222.60.

2. The child is at imminent risk of becoming homeless or of failing to graduate from high school or obtain a general equivalency diploma. “At imminent risk of becoming homeless” shall mean that a less restrictive living arrangement is not available.

3. The placement is in the child’s best interests.

4. Funds are available in the service area’s allocation. When the service area manager has approved payment for foster care pursuant to this subparagraph, funds which may be necessary to provide payment for the time period of the exception, not to exceed the current fiscal year, shall be considered encumbered and no longer available. Each service area’s funding allocation shall be based on the service area’s portion of the total number of children in foster care on March 31 preceding the beginning of the fiscal year, who would no longer be eligible for foster care during the fiscal year due to age, excluding unaccompanied refugee minors.

c. A young mother shall be eligible for the extra payment for her young child living with her in care as set forth in subrule 156.6(4), paragraph “*a*,” and subrule 156.9(4) if all of the following apply:

(1) The mother is placed in foster care.

(2) The mother’s custodian determines, as documented in the mother’s case permanency plan, that it is in her best interest and the best interest of the young child that the child remain with her.

(3) A placement is available.

(4) The mother agrees to refund to the department any child support payments she receives on behalf of the child and to allow the department to be made payee for any other unearned income for the child.

156.20(2) Provider eligibility for payment.

a. Providers of shelter care services and supervised apartment living services shall have a purchase of service contract under 441—Chapter 150 in force.

b. Providers of group care services shall have a foster group care services contract under 441—Chapter 152 in force.

This rule is intended to implement Iowa Code sections 232.143, 234.35 and 234.38.

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CHAPTER 175
ABUSE OF CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 135]
[Previously appeared as Ch 135—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
CHILD ABUSE

[Rescinded IAB 5/6/98, effective 9/1/98]

441—175.1 to 175.20 Reserved.

DIVISION II
CHILD ABUSE ASSESSMENT

PREAMBLE

The purpose of this division is to implement requirements established in the Iowa Code which charge the department of human services with accepting reports of child abuse, assessing those reports and taking necessary steps to ensure a reported child's safety. Protection is provided through encouraging the reporting of suspected cases of abuse, conducting a thorough and prompt assessment of the reports, and providing rehabilitative services to abused children and their families. This response to reports of child abuse emphasizes child safety and engagement of a family in services, where necessary. The assessment-based approach recognizes that child protection and strong families are the responsibility not only of the family itself, but also of the larger community (including formal and informal service networks). It is the department's legal mandate to respond to reports of child abuse. The assessment approach shall allow the department to develop divergent strategies when responding to reports of child abuse, adjusting its response according to the severity of abuse, to the functioning of the family, and to the resources available within the child and family's community.

441—175.21(232,235A) Definitions.

"Adequate food, shelter, clothing or other care" means that food, shelter, clothing or other care which, if not provided, would constitute a denial of critical care.

"Allegation" means a statement setting forth a condition or circumstance yet to be proven.

"Assessment" means the process by which the department carries out its legal mandate to ascertain if child abuse has occurred, to record findings, to develop conclusions based upon evidence, to address the safety of the child and family functioning, engage the family in services if needed, enhance family strengths and address needs in a culturally sensitive manner.

"Assessment intake" means the process by which the department receives and records reports of child abuse.

"Caretaker" means a person responsible for the care of a child as defined in Iowa Code section 232.68.

"Case" means a report of child abuse that has been accepted for assessment services.

"Community care," as provided in rule 441—186.1(234), means child- and family-focused services and supports provided to families referred from the department. Services shall be geared toward keeping the children in the family safe from abuse and neglect; keeping the family intact; preventing the need for further intervention by the department, including removal of the child from the home; and building ongoing linkages to community-based resources that improve the safety, health, stability, and well-being of families served.

"Denial of critical care" is the failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing or other care necessary for the child's health and welfare when financially able to do so, or when offered financial or other reasonable means to do so, and shall mean any of the following:

1. Failure to provide adequate food and nutrition to the extent that there is danger of the child suffering injury or death.
2. Failure to provide adequate shelter to the extent that there is danger of the child suffering injury or death.
3. Failure to provide adequate clothing to the extent that there is danger of the child suffering injury or death.
4. Failure to provide adequate health care to the extent that there is danger of the child suffering injury or death. A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child and shall not be placed on the child abuse registry. However, a court may order that medical service be provided where the child's health requires it.
5. Failure to provide the mental health care necessary to adequately treat an observable and substantial impairment in the child's ability to function.
6. Gross failure to meet the emotional needs of the child necessary for normal development.
7. Failure to provide for the proper supervision of the child to the extent that there is danger of the child suffering injury or death, and which a reasonable and prudent person would exercise under similar facts and circumstances.
8. Failure to respond to the infant's life-threatening conditions (also known as withholding medically indicated treatment) by providing treatment (including appropriate nutrition, hydration and medication) which in the treating physician's reasonable medical judgment will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's reasonable medical judgment any of the following circumstances apply: the infant is chronically and irreversibly comatose; the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane.

"Department" means the department of human services.

"Facility providing care to a child" means any public or private facility, including an institution, hospital, health care facility, intermediate care facility for mentally retarded, residential care facility for mentally retarded, or skilled nursing facility, group home, mental health facility, residential treatment facility, shelter care facility, detention facility, or child care facility which includes licensed day care centers, all registered family and group day care homes and licensed family foster homes. A public or private school is not a facility providing care to a child, unless it provides overnight care. Public facilities which are operated by the department of human services are assessed by the department of inspections and appeals.

"Illegal drug" means cocaine, heroin, amphetamine, methamphetamine or other illegal drugs, including marijuana, or combinations or derivatives of illegal drugs which were not prescribed by a health practitioner.

"Immediate threat" means conditions which, if no response were made, would be more likely than not to result in sexual abuse, injury or death to a child.

"Infant," as used in the definition of "Denial of critical care," numbered paragraph "8," means an infant less than one year of age or an infant older than one year of age who has been hospitalized continuously since birth, who was born extremely prematurely, or who has a long-term disability.

"Nonaccidental physical injury" means an injury which was the natural and probable result of a caretaker's actions which the caretaker could have reasonably foreseen, or which a reasonable person could have foreseen in similar circumstances, or which resulted from an act administered for the specific purpose of causing an injury.

"Physical injury" means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition or damage to any bodily tissue which results in the death of the person who has sustained the damage.

“Preponderance of evidence” means evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it.

“Proper supervision” means that supervision which a reasonable and prudent person would exercise under similar facts and circumstances, but in no event shall the person place a child in a situation that may endanger the child’s life or health, or cruelly or unduly confine the child. Dangerous operation of a motor vehicle is a failure to provide proper supervision when the person responsible for the care of a child is driving recklessly, or driving while intoxicated with the child in the motor vehicle. The failure to restrain a child in a motor vehicle does not, by itself, constitute a cause to assess a child abuse report.

“Rejected intake” means a report of child abuse that has not been accepted for assessment.

“Reporter” means the person making a verbal or written statement to the department, alleging child abuse.

“Report of child abuse” means a verbal or written statement made to the department by a person who suspects that child abuse has occurred.

“Subject of a report of child abuse” means any of the following:

1. A child named in a report as having been abused, or the child’s attorney or guardian ad litem.
2. A parent or the attorney for the parent of a child named in a child abuse assessment summary as having been abused.
3. A guardian or legal custodian, or that person’s attorney, of a child named in a child abuse assessment summary as having been abused.
4. A person or the attorney for the person named in a child abuse assessment summary as having abused a child.

“Unduly” shall mean improper or unjust, or excessive.

441—175.22(232) Receipt of a report of child abuse. Reports of child abuse shall be received by local department offices, the central abuse registry, or the Child Abuse Hotline.

175.22(1) Any report made to the department which alleges child abuse as defined in Iowa Code section 232.68 shall be accepted for assessment.

175.22(2) Reports of child abuse which do not meet the legal definition of child abuse shall become rejected intakes.

a. If a report does not meet the legal definition of child abuse, but a criminal act harming a child is alleged, the department shall immediately refer the matter to the appropriate law enforcement agency.

b. If a report constitutes an allegation of child sexual abuse as defined under Iowa Code section 232.68, paragraph “c” or “e,” except that the suspected abuse resulted from the acts or omissions of a person who was not a caretaker, the department shall refer the report to law enforcement orally and, as soon as practicable, follow up in writing within 72 hours of receiving the report.

441—175.23(232) Sources of report of child abuse.

175.23(1) Mandatory reporters. Any person meeting the criteria of a mandatory reporter is required to make an oral report of the child abuse to the department within 24 hours of becoming aware of the abusive incident and make a written report to the department within 48 hours following the oral report. If the person making the report has reason to believe that immediate protection for the child is advisable, that person shall also make an oral report to an appropriate law enforcement agency.

175.23(2) Others required to report. In addition to mandatory reporters which are so designated by the Iowa Code, there are other classifications of persons who are required, either by administrative rule or department policy, to report child abuse when this is a duty identified through the person’s employment. Others required to report include:

- a.* Income maintenance workers.
- b.* Certified adoption investigators.

175.23(3) Permissive reporters. Any person who suspects child abuse may make an oral or written report, or both, to the department. Mandatory reporters may report as permissive reporters when they suspect abuse of a child outside the scope of their professions. A permissive reporter may remain anonymous and is not required by law to report abuse.

441—175.24(232) Child abuse assessment intake process. The primary purpose of intake is to obtain available and pertinent information regarding an allegation of child abuse and determine whether a report of child abuse becomes a case or a rejected intake.

175.24(1) To result in a case, the report of child abuse must include some information to indicate all of the following.

- a. The alleged victim of child abuse is a child.
- b. The alleged perpetrator of child abuse is a caretaker.
- c. The alleged incident falls within the definition of child abuse.

175.24(2) Only mandatory reporters or the person making the report may be contacted during the intake process to expand upon or to clarify information in the report. Any contact with subjects of the report or with nonmandatory reporters, other than the original reporter, automatically causes the report of child abuse to be accepted for assessment.

175.24(3) When it is determined that the report of child abuse fails to constitute an allegation of child abuse, the report of child abuse shall become a rejected intake. Rejected intake information shall be maintained by the department for three years from the date the report was rejected and shall then be destroyed.

175.24(4) The county attorney shall be notified of all reports of child abuse. When a report of child abuse is received which does not meet the requirements to become a case, but has information about illegal activity, the department shall notify law enforcement of the report.

175.24(5) When it is determined that a report of a child needing the assistance of the court fails to meet the definition of “child in need of assistance” in Iowa Code section 232.2(6), the report shall become a rejected child in need of assistance intake. The department shall maintain the report for three years from the date the report was rejected and shall then destroy it.

[ARC 8453B, IAB 1/13/10, effective 3/1/10]

441—175.25(232) Child abuse assessment process. An assessment shall be initiated within 24 hours following the report of child abuse becoming a case. The primary purpose in conducting an assessment is to protect the safety of the child named in the report. The secondary purpose of the assessment is to engage the child’s family in services to enhance family strengths and to address needs, where this is necessary and desired. There are eight tasks associated with completion of the assessment. These are:

175.25(1) *Observing and evaluating the child’s safety.* In instances when there is an immediate threat to the child’s safety, reasonable efforts shall be made to observe the alleged child victim named in the report within one hour of receipt of the report. Otherwise, reasonable efforts shall be made to observe the alleged child victim within 24 hours of the report of child abuse becoming a case. When the alleged perpetrator clearly does not have access to the alleged child victim, reasonable efforts shall be made to observe the alleged child victim within 96 hours of receipt of the report. When reasonable efforts have been made to observe the alleged child victim within the specified time frames and the worker has established that there is no risk to the alleged child victim, the observation of the alleged child victim may be waived with supervisory approval.

175.25(2) *Interviewing the alleged child victim.* The primary purpose of an interview with the child is to gather information regarding the abuse allegation, the child’s immediate safety, and risk of abuse.

175.25(3) *Interviewing subjects of the report and other sources.* Attempts shall be made to conduct interviews with subjects of the report and persons who have relevant information to share regarding the allegations. This may include contact with physicians to assess the child’s condition. The child’s custodial parents or guardians and the alleged perpetrator (if different) shall be interviewed, or offered the opportunity to be interviewed. The court may waive the requirement of the interview for good cause.

175.25(4) *Gathering of physical and documentary evidence.* Evidence shall be gathered from, but not be limited to, interviews, observations, photographs, medical and psychological reports and records, reports from child protection centers, written reports, audiotapes and their transcripts or summaries, videotapes and their transcripts or summaries, or other electronic forms.

175.25(5) *Evaluating the home environment and relationships of household members.* The evaluation may, with the consent of the parent or guardian, include a visit to the home where the child

resides. If permission is refused, the juvenile court may authorize the worker to enter the home to observe or interview the child. An evaluation of the home environment shall be conducted during the course of the child abuse assessment. If protective concerns are identified, the child protection worker shall evaluate the child named in the report and any other children in the same home as the parents or other persons responsible for their care. Each case shall include a full description of information gathered during the assessment process. This description shall provide information which evaluates the safety of the child named in the report. If the child protection worker has concerns about a child's safety or a family's functioning, the worker shall conduct a more intensive assessment until those concerns are addressed. When an assessment is conducted at an out-of-home setting, an evaluation of the environment and relationships where the abuse allegedly occurred shall be conducted.

175.25(6) *Evaluating the information.* Evaluation of information shall include an analysis, which considers the credibility of the physical evidence, observations, and interviews, and shall result in a conclusion of whether or not to confirm the report of child abuse.

175.25(7) *Determining placement on central abuse registry.* A determination of whether the report data and disposition data of a confirmed case of child abuse is subject to placement on the central abuse registry pursuant to Iowa Code Supplement subsection 232.71D(3) shall be made on each assessment.

175.25(8) *Service recommendations and referrals.* During or at the conclusion of a child abuse assessment, the department may recommend information, information and referral, community care referral, or services provided by the department. If it is believed that treatment services are necessary for the protection of the abused child or other children in the home, juvenile court intervention shall be sought.

a. Information or information and referral. Families with children of any age that have confirmed or not confirmed abuse and low risk of abuse shall be provided either information or information and referral when:

- (1) No service needs are identified, and the worker recommends no service; or
- (2) Service needs are identified, and the worker recommends new or continuing services to the family to be provided through informal supports; or
- (3) Service needs are identified, and the worker recommends new or continuing services to the family to be provided through community agencies.

b. Referral to community care. With the exception of families of children with an open department service case, court action pending, or abuse in an out-of-home setting, a referral to community care shall be offered to:

- (1) Families with children whose abuse is not confirmed when there is moderate to high risk of abuse, service needs are identified, and the worker recommends community care.
- (2) Families with children that have confirmed but not founded abuse and moderate or high risk of abuse when service needs are identified and the worker recommends community care.
- (3) Families with children with founded abuse, a victim child six years of age or older, and a low risk of repeat abuse when service needs are identified and the worker recommends community care.

c. Referral for department services. Families with children that have founded abuse and moderate to high risk of abuse and families with victim children under age six that have founded abuse and low risk of abuse shall be offered department services on a voluntary basis.

(1) The worker shall recommend new or continuing treatment services to the family to be provided by the department, either directly or through contracted agencies.

(2) Families that refuse voluntary services shall be referred for a child in need of assistance action through juvenile court.

441—175.26(232) Completion of a child protective assessment summary. The child protection worker shall complete a child protective assessment summary within 20 business days from the date of the report of child abuse becoming a case. In most instances, the child protective assessment summary shall be developed in conjunction with the child and family being assessed. A child protective assessment summary shall consist of two parts as follows:

175.26(1) Report and disposition data. Form 470-3240, Child Protective Services Assessment Summary, shall include report and dispositional data as follows:

a. Allegations: the report of child abuse which caused the assessment to be initiated and additional allegations raised after the report of child abuse becomes a case that have not been previously investigated or assessed.

b. Evaluation of the child's safety: evaluation of the child's safety and the risk for occurrence or reoccurrence of abuse. Criteria to be used in the evaluation of the child's safety include, but are not limited to, the severity of the incident or condition, chronicity of the incident or condition, age of the child, attitude of the person responsible, current treatment services or supports, access of the person responsible for the abuse to the child, and protectiveness of the parent or caretaker who is not responsible for the abuse.

c. Findings and contacts: a description of the child's condition including identification of the nature, extent, and cause of the injuries, if any, to the child named in the report; identification of the injury or risk to which the child was exposed; the circumstances which led to the injury or risk to the child; the identity of the person alleged to be responsible for the injury or risk to the child; the name and condition of other children in the same home as the child named in the report if protective concerns are identified; a list of collateral contacts; and a history of confirmed or founded abuse.

d. Determination regarding the allegations of child abuse: a statement of determination of whether the allegation of child abuse was founded, confirmed but not placed on the central abuse registry, or not confirmed. The statement shall include a rationale for placing or not placing the case on the central abuse registry.

e. Recommendation for treatment services as specified in 175.25(8) and a statement describing whether treatment services are necessary to ensure the safety of the child or to prevent or remedy other identified problems.

(1) The statement shall include the type of treatment services recommended, if any, and whether these treatment services are to be provided by the department, community agencies, informal supports, or another treatment source.

(2) If treatment services are already being provided, the statement shall include a recommendation whether these treatment services should continue.

f. Juvenile court recommendation: a statement describing whether juvenile court action is necessary to ensure the safety of the child; the type of action needed, if any; and the rationale for the recommendation.

g. Criminal court recommendation: a statement describing whether criminal court action is necessary and the rationale for the recommendation.

h. Addendum: An addendum to an assessment summary shall be completed within 20 business days when any of the following occur:

(1) New information becomes available that would alter the finding, conclusion, or recommendation of the summary.

(2) Substantive information that supports the finding becomes available.

(3) A subject who was not previously interviewed requests an interview to address the allegations of the case.

(4) A review or a final appeal decision modifies the summary.

175.26(2) Assessment data. Form 470-4133, Family Risk Assessment, Form 470-4132, Safety Assessment, and Form 470-4461, Safety Plan, if applicable, may be used as part of the child's initial case plan, referenced at 441—subrule 130.7(3), for cases in which the department will provide treatment services.

441—175.27(232) Contact with juvenile court or the county attorney. The child protection worker may orally contact juvenile court or the county attorney, or both, as circumstances warrant.

175.27(1) Report of intake. When a report of child abuse is accepted or rejected for assessment, the county attorney shall be provided Form 470-0607, Child Protective Service Intake, with information about the allegation of child abuse and with identifying information about the subjects of the report.

175.27(2) Report of disposition. The child protection worker shall provide the juvenile court and the county attorney with a copy of Form 470-3240, Child Protective Services Assessment Summary, which pertains to the findings, determinations, and recommendations regarding the report of child abuse.

175.27(3) Report of assessment. The child protection worker shall provide the county attorney and the juvenile court with a copy of Form 470-4133, Family Risk Assessment, and Forms 470-4132, Safety Assessment, and 470-4461, Safety Plan, when any of the following occur:

a. County attorney's or juvenile court's assistance necessary. The worker requires the court's or the county attorney's assistance to complete the assessment process.

b. Court's protection needed. The worker believes that the child requires the court's protection.

c. Child adjudicated. The child is currently adjudicated or pending adjudication under a child in need of assistance petition or a delinquency petition.

d. County attorney or juvenile court requests copy. The county attorney or juvenile court requests a copy of the assessment data. The child protection worker shall document when the assessment data is provided to the county attorney or juvenile court and the rationale provided for the request.

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441—175.28(232) Consultation with health practitioners or mental health professionals. The child protection worker may contact a health practitioner or a mental health professional as circumstances warrant and shall contact a health practitioner or a mental health professional when the worker requires the assistance of the health practitioner or mental health professional in order to complete the assessment process or when the worker requires the opinion or advice of the health practitioner or mental health professional in order to determine if the child requires or should have required medical, health or mental health care as a result of abuse.

441—175.29(232) Consultation with law enforcement. The child protection worker may contact law enforcement as warranted and shall contact law enforcement when the worker believes that:

1. The abuse reported may require a criminal investigation and subsequent prosecution.

2. The child must be separated from the person responsible for the abuse.

3. Contact by the child protection worker with the family will result in a volatile and dangerous response by the child or family members.

441—175.30(232) Information shared with law enforcement. When the department is jointly conducting a child abuse assessment with law enforcement personnel, the department may share information gathered during the assessment process when an assessment is conducted in conjunction with a criminal investigation or the reported abuse has been referred to law enforcement.

441—175.31(232) Completion of required correspondence.

175.31(1) Notification to parents that a child abuse assessment is being conducted. Written notice shall be provided to the parents of a child who is the subject of an assessment within five working days of commencing an assessment unless the assessment is completed within the five working days. Both custodial and noncustodial parents shall be notified, if their whereabouts are known. If it is believed that notification will result in danger to the child or others, an emergency order to prohibit parental notification shall be sought from juvenile court.

175.31(2) Notification of completion of assessment and right to request correction. Written notice shall be provided to all subjects of a child abuse assessment and to the mandatory reporter who made the report of child abuse which indicates that the child abuse assessment is completed. Both custodial and noncustodial parents shall be notified if their whereabouts are known.

a. The notice shall contain information concerning the subject's rights to request correction and appeal rights. The subject may request correction of the information contained within the child protective assessment summary if the subject disagrees with the information.

b. If the child protective assessment results in a determination that abuse is confirmed, the notice shall indicate the type of abuse, name of the child and name of the person responsible for the abuse and whether the report has been placed on the registry.

441—175.32(232,235A) Case records. The assessment case record shall contain the child protective assessment summary as described in 441—175.26(232) and any related correspondence or information which pertains to the assessment or to the child and family. The name of the person who made the report of child abuse shall not be disclosed to the subjects of the report. The child protective assessment summary has two parts.

1. Report and disposition data as described in 175.26(1). Subjects of the report have access to report and disposition data, including, where applicable, confirmation of placement on the central abuse registry for abuse reports meeting the criteria pursuant to Iowa Code subsection 232.71D(3). Form 470-3240, Child Protective Services Assessment Summary, shall be submitted to the central abuse registry only if the abuse is confirmed and determined to meet the criteria pursuant to Iowa Code subsection 232.71D(3).

2. Assessment data as described in 175.26(2). Assessment data shall be available to subjects. Release of assessment data shall be accomplished only when the parent or guardian approves the release as provided through Iowa Code chapter 217, or as specified in Iowa Code section 235A.15. Assessment data shall not be submitted to the central abuse registry.

175.32(1) Assessments where abuse was confirmed but not placed on the central abuse registry. The following conditions apply to case records for assessments in which abuse was confirmed but not placed on the central registry.

a. Access to the report data and disposition data is authorized only to the subjects of the report, the child protection worker, law enforcement officer responsible for assisting in the assessment or for the temporary emergency removal of a child from the child's home, the multidisciplinary team assisting the department in the assessment of the abuse, county attorney, juvenile court, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department or contract personnel necessary for official duties, the department of justice, and the attorney for the department.

b. The child protective assessment summary is retained five years from date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The child protective assessment summary is subject to confidentiality provisions of Iowa Code chapter 217 and 441—Chapter 9. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

175.32(2) Assessments not placed on the central abuse registry where abuse was not confirmed. The following conditions apply to case records for assessments in which abuse was not confirmed and not placed on the central registry:

a. Access to the report data on a child abuse assessment summary where abuse was not determined to have occurred and, therefore, the assessment was not placed on the central abuse registry is authorized only to the subjects of the assessment, the child protection worker, county attorney, juvenile court, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department of justice, and department or contract personnel necessary for official duties.

b. Records are retained five years from date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The child protective assessment summary is subject to confidentiality provisions of Iowa Code chapter 217 and 441—Chapter 9. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

441—175.33(232,235A) Child protection centers. The department may contract with designated child protection centers for assistance in conducting child abuse assessments. When a child who is the subject of an assessment is interviewed by staff at a child protection center, that interview may be used in conjunction with an interview conducted by the child protection worker. Written reports developed by the child protection center shall be provided to the child protection worker and may be included in

the assessment case record. Video or audio records are considered to be part of the assessment process and shall be maintained by the child protection center under the same confidentiality provisions of Iowa Code chapter 217 and 441—Chapter 9.

441—175.34(232) Department-operated facilities. When an allegation of child abuse occurs at a department-operated facility, the allegation shall be referred to the department of inspections and appeals for investigation or assessment.

441—175.35(232,235A) Jurisdiction of assessments. Child protection workers serving the county in which the child's home is located have primary responsibility for completing the child abuse assessment except when the abuse occurs in an out-of-home placement. Circumstances in which the department shall conduct an assessment when another state is involved include the following:

175.35(1) *Child resides in Iowa but incident occurred in another state.* When the child who is the subject of a report of abuse physically resides in Iowa, but has allegedly been abused in another state, the worker shall do all of the following:

- a. Obtain available information from the reporter.
- b. Make an oral report to the office of the other state's protective services agency and request assistance from the other state in completing the assessment.
- c. Complete the assessment with assistance, as available, of the other state.

175.35(2) *Child resides in another state, but is present within Iowa.* When the child who is the subject of a report of abuse is a legal resident of another state, but is present within Iowa, the worker receiving the report shall do all of the following:

- a. Act to ensure the safety of the child.
- b. Contact the child's state of legal residency to coordinate the assessment of the report.
- c. Commence an assessment if the state of legal residency declines to conduct an investigation.

175.35(3) *Child resides in another state and perpetrator resides in Iowa.* When the child who is the subject of a report of abuse resides in another state and the perpetrator resides in Iowa, the worker receiving the report shall do all of the following:

- a. Contact the state where the child resides and offer assistance to that state in its completion of a child abuse assessment. This assistance shall include an offer to interview the person allegedly responsible for the abuse and any other relevant source of information.
- b. Commence an assessment if the child's state of legal residency declines to conduct an investigation.

441—175.36(235A) Multidisciplinary teams. Multidisciplinary teams shall be developed in county or multicounty areas in which more than 50 child abuse cases are received annually. These teams may be used as an advisory group to assist the department in conducting assessments. Multidisciplinary teams consist of professionals practicing in the disciplines of medicine, public health, mental health, social work, child development, education, law, juvenile probation, law enforcement, nursing, and substance abuse counseling. Members of multidisciplinary teams shall maintain confidentiality of cases in which they provide consultation. Rejected intakes shall not be shared with multidisciplinary teams since they are not considered to be child abuse information. During the course of an assessment, information regarding the initial report of child abuse and information related to the child and family functioning may be shared with the multidisciplinary team. After a conclusion is made, only report data and disposition data on confirmed cases of child abuse may be shared with the team members. When the multidisciplinary team is created, all team members shall execute an agreement, filed with the central abuse registry, which specifies:

175.36(1) *Consultation.* The team shall be consulted solely for the purpose of assisting the department in the assessment, diagnosis and treatment of child abuse cases.

175.36(2) *Redissemination.* No team member shall redisseminate child abuse information obtained through the multidisciplinary team. This shall not preclude redissemination of information as authorized

by Iowa Code section 235A.17 when an individual team member has received information as a result of another authorized access provision of the Iowa Code.

175.36(3) *Department not bound.* The department shall consider the recommendation of the team in a specific child abuse case but shall not, in any way, be bound by the recommendation.

175.36(4) *Confidentiality provisions.* Any written report or document produced by the team pertaining to an assessment case shall be made a part of the file for the case and shall be subject to all confidentiality provisions of 441—Chapter 9, unless the assessment results in placement on the central abuse registry in which case the written report or document shall be subject to all confidentiality provisions of Iowa Code chapter 235A.

175.36(5) *Written records.* Any written records maintained by the team which identify an individual assessment case shall be destroyed when the agreement lapses.

175.36(6) *Compensation.* Consultation team members shall serve without compensation.

175.36(7) *Withdrawal from contract.* Any party to the agreement may withdraw with or without cause upon the giving of 30 days' notice.

175.36(8) *Expiration date.* The date on which the agreement will expire shall be included.

441—175.37(232) *Community education.* The department shall conduct a continuing publicity and educational program for the personnel of the department, mandatory reporters, and the general public to encourage recognition and reporting of child abuse, to improve the quality of reports of child abuse made to the department, and to inform the community about the assessment-based approach to child abuse cases.

441—175.38(235) *Written authorizations.* Requests for information from members of the general public as to whether a person is named on the central abuse registry as having abused a child shall be submitted on Form 470-3301, Authorization for Release of Child Abuse Information, to the county office of the department or the central abuse registry. The form shall be completed and signed by the person requesting the information and the person authorizing the check for the release of child abuse information.

441—175.39(232) *Founded child abuse.* Reports of child abuse where abuse has been confirmed shall be placed on the central abuse registry as founded child abuse for ten years under any of the circumstances specified by Iowa Code Supplement subsection 232.71D(3). Reports of denial of critical care by failure to provide adequate clothing or failure to provide adequate supervision and physical abuse where abuse has been confirmed and determined to be minor, isolated, and unlikely to reoccur shall not be placed in the central abuse registry as a case of founded child abuse as specified by Iowa Code Supplement subsections 232.71D(2) and (3). The confirmed abuse shall be placed on the registry unless all three conditions are met. Minor abuse shall be placed on the registry if there is a prior confirmed abuse.

441—175.40(235A) *Retroactive reviews.* Review of child abuse information which is on the central abuse registry as of July 1, 1997, shall be performed using the requirements for child abuse cases to be placed on the central abuse registry as founded child abuse pursuant to Iowa Code Supplement subsections 232.71D(2) and (3). If the review indicates the information should not be placed on the central abuse registry, the information shall be expunged from the registry. The information shall be retained as a service record for five years from the date of intake. The time the report has been placed on the central abuse registry shall count toward the five years' total.

175.40(1) *Eligibility for retroactive reviews.* Eligibility for retroactive reviews is limited to reports which do not meet the criteria for placement in the central abuse registry as a case of founded child abuse specified in Iowa Code Supplement subsection 232.71D(3). The reports eligible for review are reports where the confirmed abuse involved one of the following circumstances:

- a. Physical abuse where the injury was minor and isolated and is unlikely to reoccur.

b. Denial of critical care by failure to provide adequate clothing or failure to provide adequate supervision, where the risk to the child's health and welfare was minor and isolated and is unlikely to reoccur.

175.40(2) *Reviews initiated by subject.* Rescinded IAB 5/6/98, effective 7/1/98.

175.40(3) *Reviews initiated by department.* Reviews shall be performed when the department is reviewing a case for the purpose of one of the following:

a. A record check evaluation is being completed for licensing, registration, or employment or residence in a child care facility. If the department worker completing the record check evaluation determines the case does not meet the criteria specified in Iowa Code subsection 232.71D(3) and, therefore, should be expunged from the central abuse registry, the department worker shall provide copies of the written report and Form 470-2310, Record Check Evaluation, to the bureau of protective services.

(1) Within 30 days the bureau chief shall determine if the report is to be expunged from the central abuse registry and shall notify the service area manager or designee in writing of that decision and the time frame for retention or expungement of the report. The bureau chief or designee shall notify the person on whom the review was completed of the decision to expunge the case from the central abuse registry.

(2) If the department determines that the case is to be expunged from the central abuse registry, no record check evaluation is necessary and the department shall notify the requester.

(3) If the department determines that the case does meet the criteria for placement on the central abuse registry, the department shall proceed with the record check evaluation.

b. Rescinded IAB 8/4/04, effective 7/9/04.

441—175.41(235A) Access to child abuse information. Requests for child abuse information shall include sufficient information to demonstrate that the requesting party has authorized access to the information.

175.41(1) *Written requests.* Requests for child abuse information shall be submitted on Form 470-0643, Request for Child Abuse Information, to the county office of the department, except requests made for the purpose of determining employability of a person in a department-operated facility shall be submitted to the central abuse registry. Subjects of a report may submit a request for child abuse information to the county office of the department on Form 470-0643, Request for Child Abuse Information, or on Form 470-3243, Notice of Child Abuse Assessment: Founded; Form 470-3575, Notice of Child Abuse Assessment: Confirmed Not Registered; or on Form 470-3242, Notice of Child Abuse Assessment: Not Confirmed. The county office is granted permission to release child abuse information to the subject of a report immediately upon verification of the identity and subject status.

175.41(2) *Oral requests.* Oral requests for child abuse information may be made when a person making the request believes that the information is needed immediately and if the person is authorized to access the information. When an oral request to obtain child abuse information is granted, the person approving the request shall document the approval to the central abuse registry through use of Form 470-0643, Request for Child Abuse Information, or Form 470-3243, Notice of Child Abuse Assessment: Founded.

Upon approval of any request for child abuse information authorized by this rule, the department shall withhold the name of the person who made the report of child abuse unless ordered by a juvenile court or district court after a finding that the person's name is needed to resolve an issue in any phase of a case involving child abuse. Written requests and oral requests do not apply to child abuse information that is disseminated to an employee of the department, to a juvenile court, or to the attorney representing the department as authorized by Iowa Code section 235A.15.

175.41(3) *Written authorizations.* Requests for information from members of the general public as to whether a person is named on the central abuse registry as having abused a child shall be submitted on Form 470-3301, Authorization for Release of Child Abuse Information, to the county office of the department or the central abuse registry. The form shall be completed and signed by the person requesting the information and the person authorizing the check for the release of child abuse information.

The department shall not provide requested information when the authorization form is incomplete. Incomplete authorization forms shall be returned to the requester.

441—175.42(235A) Person conducting research. The supervisor of the central abuse registry shall be responsible for determining whether a person requesting child abuse information is conducting bona fide research, whether the research will further the official duties and functions of the central abuse registry, and whether identified information is essential to the research design. A bona fide research design is one which shows evidence of a good-faith, academically objective and sincere intent to add to the body of knowledge about child abuse. To make this determination, the central abuse registry shall require the person to submit credentials and the research design. Additional criteria for approval of a research project may include whether the research involves contact with subjects of child abuse information, and whether contact with department personnel is required to complete the research design. If it is determined that the research will involve use of identified information, the central abuse registry shall also determine under what circumstances and in what format the information is to be used and shall execute an agreement with the researcher which will enable the researcher to obtain access to identified information on subjects of child abuse investigations, as an agent of the central abuse registry. The department will require the researcher to assume costs incurred by the department in obtaining or providing information for research purposes. The department shall keep a public record of persons conducting this research.

175.42(1) *Child abuse factors.* For purposes of conducting research pursuant to Iowa Code sections 235A.15 and 235A.23, official duties and functions of the central abuse registry shall include analysis or identification of child abuse factors in at least one of the following areas:

- a. Causes of abuse—victim, parent and perpetrator characteristics, types of abuse, and correlations to family and environmental factors.
- b. Effects of abuse—immediate and long-term effects of abuse on the individual child victim, the child’s family and the perpetrator, in areas such as family functioning, foster placement, emotional and medical problems, and criminal activity; and effects of abuse on the community and society in general.
- c. Prevention of abuse—intervention, prevention and treatment strategies.
- d. Treatment of abuse—impact of service delivery upon recidivism and maintenance of the family unit.
- e. Reporting of abuse—mandatory and permissive reporter characteristics, training needs, and perception of the department’s protective services to children and families.
- f. Identification of strengths and weaknesses in statute, policy or practice concerning child abuse services.

175.42(2) *Guidelines.* To be accepted by the central abuse registry, a research proposal originating outside the department shall meet the following guidelines:

- a. The proposal shall meet the criteria listed above as “official duties and functions” of the central abuse registry.
- b. The research shall be conducted by a competent researcher, evidenced by affiliation with a recognized human services agency, government body, or academic, social work or medical facility. The researcher shall demonstrate an ability to conduct nonbiased research and present findings in a professional and responsible manner which will benefit the department in providing protective services to children and families.
- c. The proposed research shall not unduly interfere with the ongoing duties and responsibilities of department staff.
- d. When the proposed research includes contact with subjects of child abuse information, the research design shall reflect a plan for initial subject contact by the department, which includes the following:
 - (1) Subjects shall be informed in writing of their right to refuse to participate in the research.
 - (2) Subjects shall receive written assurance that their participation in the research will not affect eligibility for services.
 - (3) Department staff shall be advised of research goals and procedures prior to contact with subjects, in order to answer questions which may arise.

(4) Subjects shall receive written assurance that when identifying information is released by the central abuse registry to research staff, the information will remain confidential and that all child abuse information will be deidentified prior to publication of the research findings.

175.42(3) Approval procedures. Procedures for approval of a research proposal are conducted as follows:

a. The supervisor of the central abuse registry shall designate a person to be the single point of contact (SPOC) for all research proposals requesting child abuse information or involving department staff who provide child protective services. All proposals shall be routed to the SPOC at the Division of Adult, Children and Family Services, Department of Human Services, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Having received a research proposal, the SPOC shall log the date the proposal was received and other identifying information about the researcher and the research design and shall convene a research advisory committee to review the proposal. This committee may consist of:

- (1) The unit supervisor of the child and dependent adult abuse registry, when applicable.
- (2) The unit managers for the programs addressed by the research proposal.
- (3) The research specialist.
- (4) Representatives from the field, including a service area manager or designee and one representative from a service area, appointed by the service area manager, if a specific service area is involved.
- (5) A representative from the department's division of data management, when the proposal involves use of one of the department's computerized data systems.
- (6) A representative of the attorney general's office, when the proposal involves legal questions or issues.
- (7) Other persons whom the SPOC may designate to assist in the review.

c. The SPOC is responsible for ensuring that advisory committee members receive copies of the research proposal.

d. The advisory committee may meet in person or by teleconference.

e. The researcher may, at the discretion of the SPOC, be provided an opportunity to address the advisory committee concerning the research proposal and answer questions about the research design.

f. The committee shall determine the value of the proposed research and formulate recommendations for acceptance of the proposal (with conditions as necessary) or rejection of the proposal (with rationale for the rejection). These recommendations shall be submitted to the SPOC.

g. The SPOC shall transmit the committee's recommendations, with additional comments and recommendations, as needed, to the division administrators for the divisions involved.

h. The division administrators shall review committee recommendations and submit the research proposal to the director or designee for final approval.

i. After review by the director, the proposal shall be returned to the SPOC, who shall notify the researcher of the director's decision, which decision shall be final.

j. If the research proposal is approved, the SPOC shall prepare a written research agreement with the researcher which provides:

- (1) The purpose of the research.
- (2) The research design or methodology.
- (3) The control of research findings and publication rights of all parties, including the deidentification of child abuse information prior to publication.
- (4) The duties of all parties in conducting the research.
- (5) The transfer of funds, if applicable.

k. The SPOC shall be responsible for securing written approval of the research agreement from the attorney general's office, applicable division administrators, and the researcher.

l. The SPOC shall be responsible for maintaining the research agreement throughout the research project and renewing or modifying the agreement when necessary.

441—175.43(235A) Child protection services citizen review panels. The purposes of the child protection services citizen review panels established in this rule are to comply with requirements set forth by the Child Abuse Prevention and Treatment Act and to take advantage of this process to identify strengths and weaknesses of the child protective service system as a whole, including community-based services and agencies. The specific objectives are to clarify expectations for child protective services with current policy; to review consistency of practice with current policy; to analyze trends and recommend policy to address them; and to provide feedback on what is or is not working, and why, and to suggest corrective action if needed.

175.43(1) Establishment of panels. The department shall establish at least three panels, with at least one panel each at the state level, multicounty level, and county level. The department may designate as panels one or more existing entities established under state or federal law, such as multidisciplinary teams, if the entities have the capacity to satisfy the requirements of the function of a citizen review panel set forth in the Child Abuse Prevention and Treatment Act and the department ensures that the entities will satisfy the requirements. The department shall establish procedures to be used for selecting the panels.

175.43(2) Membership of panels. Each panel established shall be composed of a multidisciplinary team of volunteer members who are broadly representative of the community in which the panel is established, including members who possess knowledge and skills related to the diagnosis, assessments, and disposition of child abuse cases, and who have expertise in the prevention and treatment of child abuse. The membership of each panel shall include professionals practicing in the disciplines of medicine, nursing, public health, substance abuse, domestic violence, mental health, social work, child development, education, law, juvenile probation, law enforcement; or representatives from organizations that advocate for the protection of children. The panel shall function under the leadership of a chairperson and vice-chairperson who are elected annually by the membership. Members shall enter into a contract with the department by signing Form 470-3602, Iowa Child Protection System Citizens' Review Panel Contract.

175.43(3) Meetings. Each panel established pursuant to this rule shall meet not less than once every three months.

175.43(4) Functions. Each panel established pursuant to this rule shall:

a. Evaluate the extent to which the department effectively discharges the child protection responsibilities in accordance with: the state plan and the child protection standards under subsection (b) of the Child Abuse Prevention and Treatment Act of 1996; the child protection duties of the department set forth in Iowa Code chapters 232 and 235A; and any other criteria that the panel considers important to ensure the protection of children, including:

(1) A review of the extent to which the child protective services system is coordinated with the foster care and adoption programs established under Part E of Title IV of the Social Security Act (42 USCS 670 et seq.); and

(2) A review of child fatalities and near fatalities.

b. Provide for public outreach and comment in order to:

(1) Assess the impact of current procedures and practices upon children and families in the community; and

(2) Make recommendations to the state and the public on improving the child protective services system at the state and local levels.

175.43(5) Redissemination. No panel member shall redisseminate child abuse information obtained through the citizen review panel. This shall not preclude redissemination of information as authorized by Iowa Code section 235A.17 when an individual panel member has received information as a result of another authorized access provision of the Iowa Code.

175.43(6) Department not bound. The department shall consider the recommendations of the panel but shall not, in any way, be bound by the recommendations.

175.43(7) Confidentiality. Members and staff of a panel may not disclose child abuse information about any specific child abuse case to any person or government official and may not make public any information unless authorized by the Iowa Code to do so.

175.43(8) Reports. Each panel established under this rule shall prepare and make available to the public, on an annual basis, a report containing a summary of the activities of the panel.

175.43(9) Staff assistance. The department shall provide staff assistance to citizen review panels for the performance of their duties, upon request of the panel.

175.43(10) Access to child abuse information. Citizen review panels shall be under contract to carry out official duties and functions of the department and have access to child abuse information according to Iowa Code section 235A.15 [2“e”(2)].

These rules are intended to implement Iowa Code sections 232.67 to 232.77 and Iowa Code chapter 235A.

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¹ Effective date of amendments to subrule 175.8(4), paragraph “a,” subparagraphs (7), (9), and (10); subrule 175.8(5); rules 175.9 and 175.15 delayed 70 days by the Administrative Rules Review Committee.

² Effective date of 175.25(4) “d” delayed 70 days by the Administrative Rules Review Committee at its meeting held January 3, 1996; delay lifted by the Committee at its meeting held February 5, 1996, effective February 6, 1996.

³ Effective date of amendments adopted in ARC 7975A delayed 70 days by the Administrative Rules Review Committee at its meeting held June 9, 1998.

CHAPTER 187
AFTERCARE SERVICES AND SUPPORTS

PREAMBLE

These rules define and structure the aftercare services program, which assists youth leaving foster care in their successful transition to adulthood. The aftercare program, including the preparation for adult living (PAL) component, helps former foster care youth to continue preparing for the challenges and opportunities presented by adulthood while receiving services and supports. The program also offers financial benefits to eligible youth up to the age of 21. All services and supports are voluntary.

DIVISION I
AFTERCARE SERVICES

441—187.1(234) Purpose. The purpose of aftercare services is to provide services and supports to youth aged 18, 19 or 20 who were formerly in foster care. The primary goal of the program is for participants to achieve self-sufficiency and to recognize and accept their personal responsibility for the transition from adolescence to adulthood.

441—187.2(234) Eligibility. To be eligible for aftercare services, a youth must meet the following requirements:

187.2(1) Residence. The youth must reside in Iowa.

187.2(2) Age. The youth must be at least 18 years of age but less than 21 years of age.

187.2(3) Foster care experience.

a. The youth must leave foster care either:

- (1) On or after the youth's eighteenth birthday; or
- (2) Between the ages of 17 ½ and 18 after being in foster care continuously for at least six months.

b. For purposes of this division, "foster care" is defined as 24-hour substitute care for a child who is placed away from the child's parents or guardians and for whom the department or juvenile court services has placement and care responsibility through either court order or voluntary agreement.

c. A placement may meet the definition of foster care regardless of whether:

- (1) The placement is licensed and the state or a local agency makes payments for the child's care;
- (2) Adoption subsidy payments are being made before the finalization of adoption; or
- (3) There is federal matching of any payments made.

d. Foster care may include, but is not limited to, placement in:

- (1) A foster family home;
- (2) A foster home of relatives;
- (3) A group home;
- (4) An emergency shelter;
- (5) A preadoptive home;
- (6) A residential facility; or
- (7) The home of an unlicensed relative or suitable person.

e. Foster care does not include placement in:

- (1) A detention facility;
- (2) A forestry camp;
- (3) A training school; or
- (4) Any other facility operated primarily for the detention of children who are determined to be delinquent.

187.2(4) Responsibility. The youth must:

- a.* Actively take part in developing and participating in a self-sufficiency plan; and

b. Indicate recognition and acceptance of personal responsibility in the transition toward self-sufficiency.

441—187.3(234) Services and supports provided. The aftercare program shall provide the following services and supports to eligible youth:

187.3(1) Individual self-sufficiency plan. Each youth shall have an individual self-sufficiency plan based on an assessment of the youth's strengths and needs. The plan shall identify:

- a. The youth's goals for achieving self-sufficiency;
- b. The target date for reaching the goals; and
- c. The tasks, responsible parties, time frames, and desired outcomes needed to reach the goals.

187.3(2) Life skills services. The program shall provide life skills services to enable youth to maintain a safe, healthy, and stable home.

187.3(3) Vendor payments. The program shall make vendor payments to meet direct expenses of the participant that are necessary in order to meet goals of the participant's self-sufficiency plan.

a. *Need.* To receive a vendor payment, the youth must demonstrate that there are no other means to meet these needs. Youth receiving a PAL stipend are not eligible for a vendor payment.

b. *Scope.* Vendor payments may include but are not limited to:

- (1) Life skills training;
- (2) Transportation assistance;
- (3) Employment and education assistance;
- (4) Clothing; and
- (5) Room and board.

c. *Maximum payment.* The amount available for a 12-month period of service shall not exceed \$1200 per youth.

187.3(4) Follow-up. The program shall maintain individual face-to-face contact with the youth at a frequency as defined in the youth's self-sufficiency plan to ensure that the youth is meeting the goals of the plan.

187.3(5) Ongoing assessment. Ongoing assessment activities shall be directed toward:

- a. Monitoring the progress being made in the youth's ability to achieve self-sufficiency; and
- b. Coordination and evaluation of the services and supports being provided to reach the self-sufficiency goal.

187.3(6) Case management. Case management activities shall include, but not be limited to:

- a. Community involvement services to enable the youth to access community resources; and
- b. Development of support systems, including services to assist the youth in establishing or reestablishing relationships with significant adults.

441—187.4(234) Termination. Aftercare services and supports shall be terminated when any of the following conditions apply:

187.4(1) The youth fails to follow self-sufficiency plan components and expectations as determined by the program administrator.

187.4(2) The youth voluntarily withdraws from aftercare services.

187.4(3) The youth is no longer residing in Iowa.

187.4(4) The youth reaches 21 years of age.

187.4(5) There are insufficient funds to continue the services.

441—187.5(234) Waiting list. The program administrator or designee shall create a waiting list when all funds for the aftercare services program are committed for the fiscal year. Names shall be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible.

441—187.6(234) Administration. The department may contract with another state agency or a private organization to perform the administrative and case management functions necessary to administer this program.

187.6(1) The contractor and any subcontractors shall meet the standards in 441—subrule 150.5(3) and paragraph 150.3(3)“i.”

187.6(2) Agencies providing services or supports shall meet the standards in rules 441—108.2(238) through 441—108.6(238).

441—187.7 to 187.9 Reserved.

These rules are intended to implement Iowa Code section 234.6 and Public Law 106-169, the Foster Care Independence Act of 1999.

DIVISION II
PREPARATION FOR ADULT LIVING (PAL) PROGRAM

441—187.10(234) Purpose. The purpose of the PAL program is to provide financial support to eligible youth who are receiving aftercare services. Youth receiving a PAL stipend are not eligible to receive aftercare vendor payments.

441—187.11(234) Eligibility. A monthly stipend may be provided to a youth receiving aftercare services who left foster care after May 1, 2006, and who meets all of the following criteria:

187.11(1) *Ineligibility for foster care.* The youth must be ineligible for voluntary foster care placement under 441—Chapter 202.

187.11(2) *Foster care experience.* The youth must:

a. Leave foster care paid for by the state under Iowa Code section 234.35 on or after the youth's eighteenth birthday; and

b. Have been in foster care paid for by the state under Iowa Code section 234.35 in at least 6 of the last 12 months before the youth left foster care.

187.11(3) *Living arrangement.* The youth must have a living arrangement other than a parent's home, which may include a former foster family, an apartment, a college dormitory, or another approved arrangement. The program administrator or designee is responsible for approving the living arrangement.

187.11(4) *Activity.* The youth must be engaged in or actively pursuing full-time activity comprised of one or more of the following:

a. Enrollment in a postsecondary educational training program or work training;

b. Employment for an average of 25 hours or more per week; or

c. School or program attendance leading to a high school diploma or GED.

187.11(5) *Financial need.* Initial and ongoing eligibility shall be based on the youth's income and need as determined according to rule 441—187.12(234).

441—187.12(234) Payment. The program administrator or designee shall issue payment to each participant according to the following guidelines:

187.12(1) *Need.* The amount of the PAL stipend shall be based on the needs of the youth as documented in the youth's self-sufficiency plan. Eligibility and the stipend amount shall be based on the best estimate of the youth's income, as determined at least quarterly.

a. All earned and unearned income received by the youth during the 30 days before the determination shall be used to project future income. If the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

b. The youth shall timely report the beginning or ending of earned or unearned income. A report shall be considered timely when made within ten days from the receipt of income or the date income ended.

c. When the youth timely reports a change in income, prospective eligibility and stipend amount for the following month shall be determined based on the change.

d. Recoupment shall be made for any overpayment due to failure to timely report a change in income.

e. Recoupment shall not be made when a youth timely reports a change in income and the change is timely acted upon, but the timely notice policy in rule 441—7.7(17A) requires that the action be delayed until the second calendar month following the month of change.

187.12(2) Amount of monthly stipend. The maximum monthly stipend shall be \$574.

a. The stipend shall be prorated based on the date of entry.

b. Effect of income.

(1) When the monthly unearned income of the youth exceeds the maximum monthly stipend, the youth is not eligible for a stipend.

(2) When the net earnings of the youth exceed the maximum monthly stipend, the stipend shall be reduced the following month by 50 cents for every dollar earned over the maximum monthly stipend.

187.12(3) Payee. The PAL stipend may be paid to the youth, the foster family, or another payee other than a department employee. The payee shall be agreed upon by the parties involved and specified in the self-sufficiency plan under 187.3(1).

187.12(4) Start-up allowance. When a youth is approved for the PAL program, the program administrator or designee may authorize a one-time start-up allowance in addition to the monthly stipend. The start-up allowance:

a. Is intended to assist in covering the initial costs of establishing the youth's living arrangement, such as rental and utility deposits, purchase of food, and purchase of necessary household items.

b. Shall be based on the youth's income and need as determined according to subrule 187.12(1).

c. Shall not exceed the maximum monthly stipend amount.

[ARC 8451B, IAB 1/13/10, effective 1/1/10]

441—187.13(234) Termination of stipend. The PAL stipend shall be terminated when any of the following conditions apply:

187.13(1) The youth reaches the age of 21.

187.13(2) The youth fails to meet work or education eligibility requirements for 30 consecutive days without good cause as determined by the program administrator or designee.

187.13(3) The youth fails to follow self-sufficiency plan components and expectations as determined by the program administrator or designee.

187.13(4) The youth fails to maintain satisfactory progress as defined by the education or training program in which the youth is enrolled. A youth who is not making satisfactory progress may stay in the PAL program by choosing the work option.

187.13(5) The youth chooses to live in a nonapproved setting.

187.13(6) The youth no longer resides in Iowa.

187.13(7) The youth lives with a parent.

187.13(8) There are insufficient funds to continue the stipend.

441—187.14(234) Waiting list. The program administrator or designee shall create a waiting list when all funds for the PAL program are committed for the fiscal year. Names shall be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible.

441—187.15(234) Administration. The department may contract with another state agency or a private organization to perform the administrative functions necessary to administer the PAL program.

187.15(1) The contractor and any subcontractors shall meet the standards in 441—subrule 150.5(3) and paragraph 150.3(3)“i.”

187.15(2) Agencies providing support or services shall meet the standards in rules 441—108.2(238) through 441—108.6(238).

These rules are intended to implement Iowa Code section 234.46.

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CHAPTER 201
SUBSIDIZED ADOPTIONS
[Prior to 7/1/83, Social Services(770), Ch 138]
[Previously appeared as Ch 138—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services(498)]

441—201.1(600) Administration. The Iowa department of human services, through the administrator of the division of child and family services, shall administer the subsidized adoption program, in conformance with the legal requirements for adoption as defined in Iowa Code chapter 600.

441—201.2(600) Definitions.

“*Child*” means a person who has not attained age 18, or a person with a physical or mental disability who has not attained age 21.

“*Escrow account*” means an interest-bearing account in a bank or savings and loan association which is maintained by the department in the name of a particular child.

“*Maintenance subsidy*” means a monthly payment to assist in covering the cost of room, board, clothing, and spending money. The child will also be eligible for medical assistance pursuant to 441—Chapter 75.

“*Mental health professional*” means the same as defined in rule 441—24.1(225C).

“*Mental retardation professional*” means a person who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. A person who holds at least a bachelor’s degree in a human services field including, but not limited to: social work, sociology, special education, rehabilitation counseling, and psychology.

“*Nonrecurring expenses*” means reasonable and necessary adoption fees, court costs, attorney fees and other expenses which are directly related to the legal adoption of a child with special needs. These shall be limited to attorney fees, court filing fees and other court costs.

“*Physician*” means a licensed medical or osteopathic doctor as defined in rule 441—77.1(249A).

“*Presubsidy*” means payment for maintenance or special services for a special needs child who is placed in an adoptive home but whose adoption is not finalized.

“*Special services subsidy*” means payment to a provider or the parent for medical, dental, therapeutic, or other services, equipment or appliances required by a child because of a handicapping condition.

441—201.3(600) Conditions of eligibility or ineligibility.

201.3(1) The child is eligible for subsidy when the department or a private agency has documented that it has been unable to place the child in an appropriate adoptive home without a subsidy and the child is determined to be a child with “special needs” based on one or more of the following reasons:

- a. The child has a medically diagnosed disability which substantially limits one or more major life activities, requires professional treatment, assistance in self-care, or the purchase of special equipment.
- b. The child has been determined by a qualified mental retardation professional to be mentally retarded.
- c. Effective April 20, 2004, or later, the child has been determined by a qualified professional to be at high risk of developing a qualifying medical, mental, or emotional condition as defined in this subrule. A child in this group is eligible for subsidy of nonrecurring expenses only.
- d. The child has been diagnosed by a qualified mental health professional to have a psychiatric condition which impairs the child’s mental, intellectual, or social functioning, and for which the child requires professional services.
- e. The child has been diagnosed by a qualified mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially

from behavior appropriate to the child's age or significantly interferes with the child's intellectual, social and personal adjustment.

- f.* The child is aged eight or over and Caucasian.
- g.* The child is aged two or older and is a member of a minority race or ethnic group or the child's biological parents are of different races.
- h.* The child is a member of a sibling group of three or more who are placed in the same adoptive home.

201.3(2) A child who enters the United States from another country on the basis of a visa classifying the child as an orphan, in accordance with the Immigration and Naturalization Act, for the purpose of adoption by a specific United States family is not eligible for subsidized adoption maintenance payments, medical assistance, or special services except for nonrecurring expenses. A child entering the country for adoption may be eligible for subsidy for nonrecurring expenses, not to exceed \$500, in the following situations:

- a.* Rescinded IAB 8/11/99, effective 10/1/99.
- b.* The child from another country who meets the criteria in subrule 201.3(1) and whose adoption is finalized after June 14, 1989, must file an application on Form 470-0744, Application for Adoption Subsidy, and complete Form 470-0749, Adoption Subsidy Agreement, before or at the time of a final decree of adoption. The claim for reimbursement must be filed on Form GAX, General Accounting Expenditure, within two years of the date of the adoption decree and must include receipts.
- c.* If the adoptive placement disrupts prior to finalization or if the parental rights of the adoptive parents are terminated after the adoption is finalized and the department is named guardian of the child, the child may be eligible for subsidy in another adoptive placement.

201.3(3) Maintenance and child care subsidies for children who were determined to be eligible before January 1, 2004, shall continue unless one of the conditions for termination defined in 441—201.7(600) is present. The child care subsidy payment shall not exceed the applicable reimbursement rate under the child care assistance program as specified in 441—subrule 170.4(7).

201.3(4) The determination of whether a child meets eligibility requirements is made by the Iowa department of human services. An adverse determination may be appealed according to rules in 441—Chapter 7.

201.3(5) The department shall review the subsidy agreement when the child reaches the age of 17½ to determine whether the child is eligible to receive a subsidy through the age of 21 due to the child's physical or mental disability.

- a.* The disability shall be diagnosed by a physician, a qualified mental health professional, or a qualified mental retardation professional.
- b.* The diagnosis shall be current within one year of the child's eighteenth birthday.

441—201.4(600) Application. Application for presubsidy or subsidy shall be made on Form 470-0744, Application for Subsidy, at the time of the adoptive placement of the child, or at any time in the adoptive process before finalization of the adoption.

201.4(1) The prospective adoptive family residing in Iowa who has been studied and approved for adoptive placement or a family residing outside of the state of Iowa studied and approved by a governmental child-placing agency or a licensed child-placing agency in that state, may apply for subsidy for an eligible Iowa child.

201.4(2) Withdrawal of the application for the subsidy shall be reported to the department immediately.

201.4(3) The effective date for the Adoption Subsidy Agreement will be the date the agreement is signed by all parties, which may be the date the child is placed in the adoptive home or any date up to and including the date the adoption is finalized. The agreement shall state the amount of the presubsidy or subsidy, and the frequency and duration of payments.

201.4(4) An application for subsidy cannot be taken after the child is adopted except when there are facts relevant to a child's eligibility that were not presented before the finalizing of the adoption.

a. Upon receiving verification that the child was eligible before the child's adoption, the department may conduct an administrative review of the facts and may determine the child an eligible special needs child. Eligibility will be effective after Form 470-0744, Application for Subsidy, is completed and Form 470-0749, Adoption Subsidy Agreement, is signed by all parties.

b. Requests for determining a child an eligible special needs child after the adoption is finalized shall be forwarded with verification of eligibility to the division of child and family services, adoption program. The division shall conduct an administrative review of eligibility factors and render a written decision regarding the child's eligibility as a special needs child within 30 days of receipt of request and verification materials unless additional verification is requested. If additional verification is requested, a decision shall be reached within 30 days of receipt of additional verification materials.

441—201.5(600) Negotiation of amount of presubsidy or subsidy.

201.5(1) The amount of presubsidy or subsidy shall be negotiated between the department and the adoptive parents and shall be based upon the needs of the child and the circumstances of the family.

a. Each time negotiations are completed, the Adoption Subsidy Agreement, Form 470-0749, shall be completed.

b. Form 470-0762, Agreement to Future Adoption Subsidy, shall be completed and retained in an inactive case record for future reference when:

(1) A child is eligible for subsidy but the child or family does not currently need assistance; or

(2) The child is at risk of being determined a child with special needs according to paragraph 201.3(1) "a," "b," "d," or "e" in the future.

201.5(2) Other services available to the family free of charge to meet the needs of the child, such as other federal, state, and local governmental and private assistance programs, shall be explored and used before the expenditure of subsidy funds.

a. and *b.* Rescinded IAB 5/11/05, effective 5/1/05.

c. Unearned income of the child shall be verified by documentation provided to the department worker by the family from the source of the income.

201.5(3) to 201.5(5) Rescinded IAB 5/3/89, effective 7/1/89.

201.5(6) A maintenance subsidy may be no less than \$10 per month.

201.5(7) An adoptive family may request a review of the subsidy agreement when there is a change in the family's circumstances or the needs of the child.

201.5(8) Maintenance subsidy shall continue under the same rules if the adoptive family moves outside of the state of Iowa.

201.5(9) The maximum monthly maintenance payment for a child in subsidized adoption shall be made pursuant to the foster family care maintenance rates according to the age and special needs of the child as found at 441—subrule 156.6(1) and 441—paragraph 156.6(4) "f."

441—201.6(600) Types of subsidy.

201.6(1) *Special services only.*

a. Reimbursement to the adoptive family or direct payment made to a provider is suspended from January 1, 2010, to June 30, 2010, for any special services negotiated in that period except for nonrecurring expenses as defined in subparagraph (7).

(1) Outpatient counseling or therapy services. Reimbursement for outpatient individual or family services may be provided from a non-Medicaid provider only with approval from the service area manager or designee and when one of the following applies:

1. The services are not available from a Medicaid provider within a reasonable distance from the family.

2. The child and the family were already receiving therapy or counseling from a non-Medicaid provider and it would not be in the child's best interest to disrupt the services.

3. Available Medicaid providers lack experience in working with foster, adoptive, or blended families.

Reimbursement to non-Medicaid providers shall be limited to the Medicaid rate.

(2) Expenses for transportation, lodging, or per diem related to preplacement visits, not to exceed \$2000 per family.

(3) Medical services not covered by the Medicaid program shall be limited to an additional premium amount due to the child's special needs to include the child in the family's health insurance coverage group. An adoption subsidy payment shall not supplement the Medicaid payment rate to a Medicaid provider or a non-Medicaid provider.

(4) Child care, if the family has entered into a presubsidy or subsidy agreement on or before June 30, 2004, that contains a provision for child care reimbursement. Child care subsidy payments shall not exceed the maximum rates established in 441—paragraph 170.4(7)“a” for the child's age and type of care, unless the department grants a waiver under rule 441—1.8(17A,217). Child care services are available through the child care assistance program to families that meet the requirements of 441—Chapter 170.

(5) Medical transportation not covered by Medicaid and the family's lodging and meals, if necessary, when the child is receiving specialized care or the child and family are required to stay overnight as part of a treatment plan.

(6) Supplies and equipment as required by the child's special needs and unavailable through other resources. When a sibling group of three or more are placed together, a one-time-only payment can be made, not to exceed \$500 per child. When home modifications have been authorized to accommodate a child's special needs and the family later sells the house, the family shall repay the department an amount equal to the increase in the equity value of the home attributable to the modifications.

(7) Nonrecurring expenses. Payment for nonrecurring expenses is limited to a total of \$500 per child for attorney fees, court costs and other related legal expenses. Nonrecurring expenses may be paid when the adoptive family has negotiated an Adoption Subsidy Agreement, Form 470-0747, or an Agreement to Future Adoption Subsidy, Form 470-0762.

(8) Funeral benefits at the amount allowed for a foster child in accordance with 441—subrule 156.8(5).

b. The need for special services shall be established by a report in the child's record from the private or public agency which had guardianship of the child, and substantiating information from specialists as defined in rule 441—201.2(600).

c. Any single special service and any special service delivered over a 12-month period costing \$500 or more shall have prior approval from the central office adoption program manager prior to expending program funds.

d. For all Medicaid covered services the department shall reimburse at the same rate and duration as Medicaid as set forth in rule 441—79.1(249A).

201.6(2) Maintenance only. A monthly payment to assist with room, board, clothing and spending money may be provided, as determined under rule 441—201.5(600). The child will also be eligible for medical assistance pursuant to 441—Chapter 75.

201.6(3) Maintenance and special services. For special needs children, a special services subsidy may also be included when a maintenance subsidy is provided.

[ARC 8451B, IAB 1/13/10, effective 1/1/10]

441—201.7(600) Termination of subsidy. Subsidy will terminate when any of the following occur:

201.7(1) The adoptive child no longer meets the definition of child in rule 441—201.1(600).

201.7(2) The child marries.

201.7(3) The adoptive parents are no longer using the maintenance payments to support the child.

201.7(4) Death of the child, or death of the parents of the child (one in a single-parent family and both in a two-parent family).

201.7(5) Upon conclusion of the terms of the agreement.

201.7(6) Upon request of the adoptive parents.

201.7(7) The adoptive parents are no longer legally responsible for the child.

201.7(8) Rescinded IAB 3/12/08, effective 4/16/08.

441—201.8(600) Reinstatement of subsidy. Reinstatement of subsidy will be made when the subsidy was terminated because of reasons in 201.7(3), 201.7(6), or 201.7(7) and the reason for termination no longer exists.

441—201.9(600) New application. New applications will be taken at any time, but processed only so long as funds are available. Maintenance and special services already approved will continue.

441—201.10(600) Medical assistance based on residency. Special needs children eligible for any type of subsidy are entitled to medical assistance as defined in 441—Chapter 75. The funding source for medical assistance is based on the following criteria:

201.10(1) IV-E-eligible children:

a. IV-E-eligible children residing in Iowa from Iowa and from other states shall receive medical assistance from Iowa.

b. IV-E-eligible children from Iowa residing in another state shall receive medical assistance from the family's state of residence, even though medical assistance available in the family's state of residence may vary from Iowa's medical assistance.

201.10(2) Non-IV-E-eligible children:

a. Non-IV-E-eligible children from Iowa residing in Iowa shall be covered by Iowa's medical assistance.

b. Non-IV-E-eligible children from Iowa residing in another state shall be covered by Iowa's medical assistance unless eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act.

c. Non-IV-E-eligible children from another state residing in Iowa shall be covered by Iowa's medical assistance if all of the following conditions are met:

(1) The child is under the age of 21.

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

(3) Another state is currently paying an adoption subsidy for the child pursuant to an adoption assistance agreement in effect for the child with that state.

(4) The state paying the adoption subsidy is a member of the interstate compact on adoption and medical assistance (ICAMA).

(5) The state paying the adoption subsidy provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

201.10(3) When an Iowa child receives medical assistance from another state, Iowa shall discontinue paying any medical costs the month following the move unless additional time is necessary for a timely notice of decision to be provided to the family. An exception shall be made when the initial Iowa subsidy agreement provides for services not covered by the other states.

441—201.11(600) Presubsidy recovery. The department shall recover the cost of presubsidy maintenance and special services provided by the department as follows:

201.11(1) Funds shall be applied to the cost of presubsidy maintenance and special services from the unearned income of the child.

201.11(2) The department shall serve as payee to receive the child's unearned income. The income shall be placed in an account from whence it shall be applied toward the cost of the child's current care and the remainder placed in an escrow account.

201.11(3) When a child has funds in escrow these funds may be used by the department to meet the current needs of the child not covered by the presubsidy payments and not prohibited by the source of the funds.

201.11(4) When the child leaves presubsidy care, funds in the escrow shall be paid to the adoptive parents, or to the child if the child has attained the age of majority.

These rules are intended to implement Iowa Code sections 600.17 to 600.23.

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CHAPTER 61
WATER QUALITY STANDARDS

[Prior to 7/1/83, DEQ Ch 16]

[Prior to 12/3/86, Water, Air and Waste Management[900]]

WATER QUALITY STANDARDS

567—61.1 Rescinded, effective August 31, 1977.

567—61.2(455B) General considerations.

61.2(1) Policy statement. It shall be the policy of the commission to protect and enhance the quality of all the waters of the state. In the furtherance of this policy it will attempt to prevent and abate the pollution of all waters to the fullest extent possible consistent with statutory and technological limitations. This policy shall apply to all point and nonpoint sources of pollution.

These water quality standards establish selected criteria for certain present and future designated uses of the surface waters of the state. The standards establish the areas where these uses are to be protected and provide minimum criteria for waterways having nondesignated uses as well. Many surface waters are designated for more than one use. In these cases the more stringent criteria shall govern for each parameter.

Certain of the criteria are in narrative form without numeric limitations. In applying such narrative standards, decisions will be based on the U.S. Environmental Protection Agency's methodology described in "Guidelines for Deriving Numerical National Water Quality Criteria for the Protection of Aquatic Organisms and Their Uses," (1985) and on the rationale contained in "Quality Criteria for Water," published by the U.S. Environmental Protection Agency (1977), as updated by supplemental Section 304 (of the Act) Ambient Water Quality Criteria documents. To provide human health criteria for parameters not having numerical values listed in 61.3(3) Table 1, the required criteria will be based on the rationale contained in these EPA criteria documents. The human health criterion considered will be the value associated with the consumption of fish flesh and a risk factor of 10^{-5} for carcinogenic parameters. For noncarcinogenic parameters, the recommended EPA criterion will be selected. For Class C water, the EPA criteria for fish and water consumption will be selected using the same considerations for carcinogenic and noncarcinogenic parameters as noted above.

All methods of sample collection, preservation, and analysis used in applying any of the rules in these standards shall be in accord with those prescribed in 567—Chapter 63.

61.2(2) Antidegradation policy. It is the policy of the state of Iowa that:

a. Tier 1 protection. Existing surface water uses and the level of water quality necessary to protect the existing uses will be maintained and protected.

b. Tier 2 protection. Where the quality of the waters exceeds levels necessary to support propagation of fish, shellfish, and wildlife and recreation in and on the water, that quality shall be maintained and protected unless the department finds, after full satisfaction of the intergovernmental coordination and public participation provisions, that allowing lower water quality is necessary to accommodate important economic or social development in the area in which the waters are located. In allowing such degradation or lower water quality, the department shall ensure water quality adequate to protect existing uses fully. Further, the department shall ensure the highest statutory and regulatory requirements for all new and existing point sources and all cost-effective and reasonable best management practices for nonpoint source control before allowing any lowering of water quality.

c. Tier 2½ protection—outstanding Iowa waters. Where high quality waters constitute an outstanding state resource, such as waters of exceptional recreational or ecological significance, that water quality shall be maintained and protected.

d. Tier 3 protection—outstanding national resource waters. Where high quality waters constitute an outstanding national resource, such as waters of national and state parks and wildlife refuges and waters of exceptional recreational or ecological significance, that water quality shall be maintained and protected. Any proposed activity that would result in a permanent new or expanded source of pollutants in an outstanding national resource water is prohibited.

e. The four levels of protection provided by the antidegradation policy in paragraphs “a” through “d” of this subrule shall be implemented according to procedures hereby incorporated by reference and known as the “Iowa Antidegradation Implementation Procedure,” effective February 17, 2010. This document may be obtained on the department’s Web site at <http://www.iowadnr.com/water/standards/index.html>.

f. All unapproved facility plans for new or expanded construction permits, except for construction permits issued for nondischarging facilities, shall undergo an antidegradation review if degradation is likely in the receiving water or downstream waters following February 17, 2010.

g. This policy shall be applied in conjunction with water quality certification review pursuant to Section 401 of the Act. In the event that activities are specifically exempted from flood plain development permits or any other permits issued by this department in 567—Chapters 70, 71, and 72, the activity will be considered consistent with this policy. Other activities not otherwise exempted will be subject to 567—Chapters 70, 71, and 72 and this policy. United States Army Corps of Engineers (Corps) nationwide permits 3, 4, 5, 6, 7, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 25, 27, 29, 30, 31, 32, 33, 34, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, and 50 as well as Corps regional permits 7, 33, and 34 as promulgated October 29, 2008, are certified pursuant to Section 401 of the Clean Water Act subject to the following Corps regional conditions and the state water quality conditions:

(1) Side slopes of a newly constructed channel will be no steeper than 2:1 and planted to permanent, perennial, native vegetation if not armored.

(2) Nationwide permits with mitigation may require recording of the nationwide permit and pertinent drawings with the registrar of deeds or other appropriate official charged with the responsibility for maintaining records of title to, or interest in, real property and may also require the permittee to provide proof of that recording to the Corps.

(3) Mitigation shall be scheduled prior to, or concurrent with, the discharge of dredged or fill material into waters of the United States.

(4) For discharges of dredged or fill material resulting in the permanent loss of more than 1/10 acre of waters of the United States (including jurisdictional wetlands), a compensatory mitigation plan to offset those losses will be required. In addition, a preconstruction notice to the Corps of Engineers in accordance with general condition 27 will be required.

(5) For newly constructed channels through areas that are unvegetated, native grass filter strips, or a riparian buffer with native trees or shrubs a minimum of 35 feet wide from the top of the bank must be planted along both sides of the new channel. A survival rate of 80 percent of desirable species shall be achieved within three years of establishment of the buffer strip.

(6) For single-family residences authorized under nationwide permit 29, the permanent loss of waters of the United States (including jurisdictional wetlands) must not exceed 1/4 acre.

(7) For nationwide permit 46, the discharge of dredged or fill material into ditches that would sever the jurisdiction of an upstream water of the United States from a downstream water of the United States is not allowed.

(8) For projects that impact fens, bogs, seeps, or sedge meadows, an individual Section 401 Water Quality Certification will be required (Iowa Section 401 Water Quality Certification condition).

(9) For nationwide permits when the Corps’ district engineer has issued a waiver to allow the permittee to exceed the limits of the nationwide permit, an individual Section 401 Water Quality Certification will be required (Iowa Section 401 Water Quality Certification condition). Written verification by the Corps or 401 certification by the state is required for activities covered by these permits as required by the nationwide permit or the Corps, and the activities are allowed subject to the terms and conditions of the nationwide and regional permits. The department will maintain and periodically update a guidance document listing special waters of concern. This document will be provided to the Corps for use in determining whether preconstruction notices should be provided to the department and other interested parties prior to taking action on applications for projects that would normally be covered by a nationwide or regional permit and not require preconstruction notice under nationwide permit conditions.

61.2(3) *Minimum treatment required.* All wastes discharged to the waters of the state must be of such quality that the discharge will not cause the narrative or numeric criteria limitations to be exceeded. Where the receiving waters provide sufficient assimilative capacity that the water quality standards are not the limiting factor, all point source wastes shall receive treatment in compliance with minimum effluent standards as adopted in rules by the department.

There are numerous parameters of water quality associated with nonpoint source runoff which are of significance to the designated water uses specified in the general and specific designations in 61.3(455B), but which are not delineated. It shall be the intent of these standards that the limits on such nonpoint source related parameters when adopted shall be those that can be achieved by best management practices as defined in the course of the continuing planning process from time to time. Existing water quality and nonpoint source runoff control technology will be evaluated in the course of the Iowa continuing planning process, and best management practices and limitations on specific water quality parameters will be reviewed and revised from time to time to ensure that the designated water uses and water quality enhancement goals are met.

61.2(4) *Regulatory mixing zones.* Mixing zones are recognized as being necessary for the initial assimilation of point source discharges which have received the required degree of treatment or control. Mixing zones shall not be used for, or considered as, a substitute for minimum treatment technology required by subrule 61.2(3). The objective of establishing mixing zones is to provide a means of control over the placement and emission of point source discharges so as to minimize environmental impacts. Waters within a mixing zone shall meet the general water quality criteria of subrule 61.3(2). Waters at and beyond mixing zone boundaries shall meet all applicable standards and the chronic and human health criteria of subrule 61.3(3), Tables 1 and 3, for that particular water body or segment. A zone of initial dilution may be established within the mixing zone beyond which the applicable standards and the acute criteria of subrule 61.3(3) will be met. For waters designated under subrule 61.3(5), any parameter not included in Tables 1, 2 and 3 of subrule 61.3(3), the chronic and human health criteria, and the acute criterion calculated following subrule 61.2(1), will be met at the mixing zone and zone of initial dilution boundaries, respectively.

a. Due to extreme variations in wastewater and receiving water characteristics, spatial dimensions of mixing zones shall be defined on a site-specific basis. These rules are not intended to define each individual mixing zone, but will set maximum limits which will satisfy most biological, chemical, physical and radiological considerations in defining a particular mixing zone. Additional details are noted in the “Supporting Document for Iowa Water Quality Management Plans,” Chapter IV, July 1976, as revised on November 11, 2009, for considering unusual site-specific features such as side channels and sand bars which may influence a mixing zone. Applications for operation permits under 567—subrule 64.3(1) may be required to provide specific information related to the mixing zone characteristics below their outfall so that mixing zone boundaries can be determined.

b. For parameters included in Table 1 only (which does not include ammonia nitrogen), the dimensions of the mixing zone and the zone of initial dilution will be calculated using a mathematical model presented in the “Supporting Document for Iowa Water Quality Management Plans,” Chapter IV, July 1976, as revised on November 11, 2009, or from instream studies of the mixing characteristics during low flow. In addition, the most restrictive of the following factors will be met:

- (1) The stream flow in the mixing zone may not exceed the most restrictive of the following:
 1. Twenty-five percent of the design low stream flows noted in subrule 61.2(5) for interior streams and rivers, and the Big Sioux and Des Moines Rivers.
 2. Ten percent of the design low stream flows noted in subrule 61.2(5) for the Mississippi and Missouri Rivers.
 3. The stream flow contained in the mixing zone at the most restrictive of the applicable mixing zone length criteria, noted below.
- (2) The length of the mixing zone below the point of discharge shall be set by the most restrictive of the following:
 1. The distance to the juncture of two perennial streams.
 2. The distance to a public water supply intake.

3. The distance to the upstream limits of an established recreational area, such as public beaches, and state, county and local parks.

4. The distance to the middle of a crossover point in a stream where the main current flows from one bank across to the opposite bank.

5. The distance to another mixing zone.

6. Not to exceed a distance of 2000 feet.

7. The location where the mixing zone contained the percentages of stream flow noted in 61.2(4) "b"(1).

(3) The width of the mixing zone is calculated as the portion of the stream containing the allowed mixing zone stream flow. The mixing zone width will be measured perpendicular to the basic direction of stream flow at the downstream boundary of the mixing zone. This measurement will only consider the distance of continuous water surface.

(4) The width and length of the zone of initial dilution may not exceed 10 percent of the width and length of the mixing zone.

c. The stream flow used in determining wasteload allocations to ensure compliance with the maximum contaminant level (MCL), chronic and human health criteria of Table 1 will be that value contained at the boundary of the allowed mixing zone. This stream flow may not exceed the following percentages of the design low stream flow as measured at the point of discharge:

(1) Twenty-five percent for interior streams and rivers, and the Big Sioux and Des Moines Rivers.

(2) Ten percent for the Mississippi and Missouri Rivers.

The stream flow in the zone of initial dilution used in determining effluent limits to ensure compliance with the acute criteria of Table 1 may not exceed 10 percent of the calculated flow associated with the mixing zone.

d. For toxic parameters noted in Table 1, the following exceptions apply to the mixing zone requirements:

(1) No mixing zone or zone of initial dilution will be allowed for waters designated as lakes or wetlands.

(2) No zone of initial dilution will be allowed in waters designated as cold water.

(3) The use of a diffuser device to promote rapid mixing of an effluent in a receiving stream will be considered on a case-by-case basis with its usage as a means for dischargers to comply with an acute numerical criterion.

(4) A discharger to interior streams and rivers, the Big Sioux and Des Moines Rivers, and the Mississippi or Missouri Rivers may provide to the department, for consideration, instream data which technically supports the allowance of an increased percentage of the stream flow contained in the mixing zone due to rapid and complete mixing. Any allowed increase in mixing zone flow would still be governed by the mixing zone length restrictions. The submission of data should follow the guidance provided in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

e. For ammonia criteria noted in Table 3, the dimensions of the mixing zone and the zone of initial dilution will be calculated using a mathematical model presented in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009, or from instream studies of the mixing characteristics during low flow. In addition, the most restrictive of the following factors will be met:

(1) The stream flow in the mixing zone may not exceed the most restrictive of the following:

1. One hundred percent of the design low stream flows noted in subrule 61.2(5) for locations where the dilution ratio is less than or equal to 2:1.

2. Fifty percent of the design low stream flows noted in subrule 61.2(5) for locations where the dilution ratio is greater than 2:1, but less than or equal to 5:1.

3. Twenty-five percent of the design low stream flows noted in subrule 61.2(5) for locations where the dilution ratio is greater than 5:1.

4. The stream flow contained in the mixing zone at the most restrictive of the applicable mixing zone length criteria, noted below.

(2) The length of the mixing zone below the point of discharge shall be set by the most restrictive of the following:

1. The distance to the juncture of two perennial streams.
2. The distance to a public water supply intake.
3. The distance to the upstream limits of an established recreational area, such as public beaches, and state, county, and local parks.
4. The distance to the middle of a crossover point in a stream where the main current flows from one bank across to the opposite bank.
5. The distance to another mixing zone.
6. Not to exceed a distance of 2000 feet.
7. The location where the mixing zone contained the percentages of stream flow noted in 61.2(4) "e"(1).

(3) The width of the mixing zone is calculated as the portion of the stream containing the allowed mixing zone stream flow. The mixing zone width will be measured perpendicular to the basic direction of stream flow at the downstream boundary of the mixing zone. This measurement will only consider the distance of continuous water surface.

(4) The width and length of the zone of initial dilution may not exceed 10 percent of the width and length of the mixing zone.

f. For ammonia criteria noted in Table 3, the stream flow used in determining wasteload allocations to ensure compliance with the chronic criteria of Table 3 will be that value contained at the boundary of the allowed mixing zone. This stream flow may not exceed the percentages of the design low stream flow noted in 61.2(4) "e"(1) as measured at the point of discharge.

The pH and temperature values at the boundary of the mixing zone used to select the chronic ammonia criteria of Table 3 will be from one of the following sources. The source of the pH and temperature data will follow the sequence listed below, if applicable data exists from the source.

(1) Specific pH and temperature data provided by the applicant gathered at their mixing zone boundary. Procedures for obtaining this data are noted in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

(2) Regional background pH and temperature data provided by the applicant gathered along the receiving stream and representative of the background conditions at the outfall. Procedures for obtaining this data are noted in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

(3) The statewide average background values presented in Table IV-2 of the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

The stream flow in the zone of initial dilution used in determining effluent limits to ensure compliance with the acute criteria of Table 3 may not exceed 5 percent of the calculated flow associated with the mixing zone for facilities with a dilution ratio of less than or equal to 2:1, and not exceed 10 percent of the calculated flow associated with the mixing zone for facilities with a dilution ratio of greater than 2:1. The pH and temperature values at the boundary of the zone of initial dilution used to select the acute ammonia criteria of Table 3 will be from one of the following sources and follow the sequence listed below, if applicable data exists from the source.

1. Specific effluent pH and temperature data if the dilution ratio is less than or equal to 2:1.
2. If the dilution ratio is greater than 2:1, the logarithmic average pH of the effluent and the regional or statewide pH provided in 61.2(4) "f" will be used. In addition, the flow proportioned average temperature of the effluent and the regional or statewide temperature provided in 61.2(4) "f" will be used. The procedures for calculating these data are noted in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

g. For ammonia criteria noted in Table 3, the following exceptions apply to the mixing zone requirements.

(1) No mixing zone or zone of initial dilution will be allowed for waters designated as lakes or wetlands.

(2) No zone of initial dilution will be allowed in waters designated as cold water.

(3) The use of a diffuser device to promote rapid mixing of an effluent in a receiving stream will be considered on a case-by-case basis with its usage as a means for dischargers to comply with an acute numerical criterion.

(4) A discharger to interior streams and rivers, the Big Sioux and Des Moines Rivers, and the Mississippi and Missouri Rivers may provide to the department, for consideration, instream data which technically supports the allowance of an increased percentage of the stream flow contained in the mixing zone due to rapid and complete mixing. Any allowed increase in mixing zone flow would still be governed by the mixing zone length restrictions. The submission of data should follow the guidance provided in the "Supporting Document for Iowa Water Quality Management Plans," Chapter IV, July 1976, as revised on November 11, 2009.

h. Temperature changes within mixing zones established for heat dissipation will not exceed the temperature criteria in 61.3(3) "b"(5).

i. The appropriateness of establishing a mixing zone where a substance discharged is bioaccumulative, persistent, carcinogenic, mutagenic, or teratogenic will be carefully evaluated. In such cases, effects such as potential groundwater contamination, sediment deposition, fish attraction, bioaccumulation in aquatic life, bioconcentration in the food chain, and known or predicted safe exposure levels shall be considered.

61.2(5) Implementation strategy. Numerical criteria specified in these water quality standards shall be met when the flow of the receiving stream equals or exceeds the design low flows noted below.

Type of Numerical Criteria	Design Low Flow Regime
Aquatic Life Protection (TOXICS)	
Acute	1Q ₁₀
Chronic	7Q ₁₀
Aquatic Life Protection (AMMONIA - N)	
Acute	1Q ₁₀
Chronic	30Q ₁₀
Human Health Protection & MCL	
Noncarcinogenic	30Q ₅
Carcinogenic	Harmonic mean

a. The allowable 3°C temperature increase criterion for warm water interior streams, 61.3(3) "b"(5) "1," is based in part on the need to protect fish from cold shock due to rapid cessation of heat source and resultant return of the receiving stream temperature to natural background temperature. On low flow streams, in winter, during certain conditions of relatively cold background stream temperature and relatively warm ambient air and groundwater temperature, certain wastewater treatment plants with relatively constant flow and constant temperature discharges will cause temperature increases in the receiving stream greater than allowed in 61.3(3) "b"(5) "1."

b. During the period November 1 to March 31, for the purpose of applying the 3°C temperature increase criterion, the minimum protected receiving stream flow rate below such discharges may be increased to not more than three times the rate of flow of the discharge, where there is reasonable assurance that the discharge is of such constant temperature and flow rate and continuous duration as to not constitute a threat of heat cessation and not cause the receiving stream temperature to vary more than 3°C per day.

c. Site-specific water quality criteria may be allowed in lieu of the specific numerical criteria listed in Tables 1 and 3 of this chapter if adequate documentation is provided to show that the proposed criteria will protect all existing or potential uses of the surface water. Site-specific water quality criteria may be appropriate where:

- (1) The types of organisms differ significantly from those used in setting the statewide criteria; or
- (2) The chemical characteristics of the surface water such as pH, temperature, and hardness differ significantly from the characteristics used in setting the statewide criteria.

Development of site-specific criteria shall include an evaluation of the chemical and biological characteristics of the water resource and an evaluation of the impact of the discharge. All evaluations for site-specific criteria modification must be coordinated through the department, and be conducted using scientifically accepted procedures approved by the department. Any site-specific criterion developed under the provisions of this subrule is subject to the review and approval of the U.S. Environmental Protection Agency. All criteria approved under the provisions of this subrule will be published periodically by the department. Guidelines for establishing site-specific water quality criteria can be found in "Water Quality Standards Handbook," published by the U.S. Environmental Protection Agency, December 1983.

d. A wastewater treatment facility may submit to the department technically valid instream data which provides additional information to be used in the calculations of their wasteload allocations and effluent limitations. This information would be in association with the low flow characteristics, width, length and time of travel associated with the mixing zone or decay rates of various effluent parameters. The wasteload allocation will be calculated considering the applicable data and consistent with the provisions and restrictions in the rules.

e. The department may perform use assessment and related use attainability analyses on water bodies where uses may not be known or adequately documented. The preparation of use attainability analysis documents will consider available U.S. Environmental Protection Agency guidance or other applicable guidance. Credible data and documentation will be used to assist in the preparation of use assessments and use attainability analysis reports.

[ARC 8214B, IAB 10/7/09, effective 11/11/09; ARC 8466B, IAB 1/13/10, effective 2/17/10]

567—61.3(455B) Surface water quality criteria.

61.3(1) *Surface water classification.* All waters of the state are classified for protection of beneficial uses. These classified waters include general use segments and designated use segments.

a. General use segments. These are intermittent watercourses and those watercourses which typically flow only for short periods of time following precipitation and whose channels are normally above the water table. These waters do not support a viable aquatic community during low flow and do not maintain pooled conditions during periods of no flow.

The general use segments are to be protected for livestock and wildlife watering, aquatic life, noncontact recreation, crop irrigation, and industrial, agricultural, domestic and other incidental water withdrawal uses.

b. Designated use segments. These are water bodies which maintain flow throughout the year or contain sufficient pooled areas during intermittent flow periods to maintain a viable aquatic community.

All perennial rivers and streams as identified by the U.S. Geological Survey 1:100,000 DLG Hydrography Data Map (published July 1993) or intermittent streams with perennial pools in Iowa not specifically listed in the surface water classification of 61.3(5) are designated as Class B(WW-1) waters.

All perennial rivers and streams as identified by the U.S. Geological Survey 1:100,000 DLG Hydrography Data Map (published July 1993) or intermittent streams with perennial pools in Iowa are designated as Class A1 waters.

Designated uses of segments may change based on a use attainability analysis consistent with 61.2(5) "e." Designated use changes will be specifically listed in the surface water classification of 61.3(5).

Designated use waters are to be protected for all uses of general use segments in addition to the specific uses assigned. Designated use segments include:

(1) Primary contact recreational use (Class "A1"). Waters in which recreational or other uses may result in prolonged and direct contact with the water, involving considerable risk of ingesting water in quantities sufficient to pose a health hazard. Such activities would include, but not be limited to, swimming, diving, water skiing, and water contact recreational canoeing.

(2) Secondary contact recreational use (Class "A2"). Waters in which recreational or other uses may result in contact with the water that is either incidental or accidental. During the recreational use, the probability of ingesting appreciable quantities of water is minimal. Class A2 uses include fishing,

commercial and recreational boating, any limited contact incidental to shoreline activities and activities in which users do not swim or float in the water body while on a boating activity.

(3) Children's recreational use (Class "A3"). Waters in which recreational uses by children are common. Class A3 waters are water bodies having definite banks and bed with visible evidence of the flow or occurrence of water. This type of use would primarily occur in urban or residential areas.

(4) Cold water aquatic life—Type 1 (Class "B(CW1)"). Waters in which the temperature and flow are suitable for the maintenance of a variety of cold water species, including reproducing and nonreproducing populations of trout (*Salmonidae* family) and associated aquatic communities.

(5) Cold water aquatic life—Type 2 (Class "B(CW2)"). Waters that include small, channeled streams, headwaters, and spring runs that possess natural cold water attributes of temperature and flow. These waters usually do not support consistent populations of trout (*Salmonidae* family), but may support associated vertebrate and invertebrate organisms.

(6) Warm water—Type 1 (Class "B(WW-1)"). Waters in which temperature, flow and other habitat characteristics are suitable to maintain warm water game fish populations along with a resident aquatic community that includes a variety of native nongame fish and invertebrate species. These waters generally include border rivers, large interior rivers, and the lower segments of medium-size tributary streams.

(7) Warm water—Type 2 (Class "B(WW-2)"). Waters in which flow or other physical characteristics are capable of supporting a resident aquatic community that includes a variety of native nongame fish and invertebrate species. The flow and other physical characteristics limit the maintenance of warm water game fish populations. These waters generally consist of small perennially flowing streams.

(8) Warm water—Type 3 (Class "B(WW-3)"). Waters in which flow persists during periods when antecedent soil moisture and groundwater discharge levels are adequate; however, aquatic habitat typically consists of nonflowing pools during dry periods of the year. These waters generally include small streams of marginally perennial aquatic habitat status. Such waters support a limited variety of native fish and invertebrate species that are adapted to survive in relatively harsh aquatic conditions.

(9) Lakes and wetlands (Class "B(LW)"). These are artificial and natural impoundments with hydraulic retention times and other physical and chemical characteristics suitable to maintain a balanced community normally associated with lake-like conditions.

(10) Human health (Class "HH"). Waters in which fish are routinely harvested for human consumption or waters both designated as a drinking water supply and in which fish are routinely harvested for human consumption.

(11) Drinking water supply (Class "C"). Waters which are used as a raw water source of potable water supply.

61.3(2) General water quality criteria. The following criteria are applicable to all surface waters including general use and designated use waters, at all places and at all times for the uses described in 61.3(1) "a."

a. Such waters shall be free from substances attributable to point source wastewater discharges that will settle to form sludge deposits.

b. Such waters shall be free from floating debris, oil, grease, scum and other floating materials attributable to wastewater discharges or agricultural practices in amounts sufficient to create a nuisance.

c. Such waters shall be free from materials attributable to wastewater discharges or agricultural practices producing objectionable color, odor or other aesthetically objectionable conditions.

d. Such waters shall be free from substances attributable to wastewater discharges or agricultural practices in concentrations or combinations which are acutely toxic to human, animal, or plant life.

e. Such waters shall be free from substances, attributable to wastewater discharges or agricultural practices, in quantities which would produce undesirable or nuisance aquatic life.

f. The turbidity of the receiving water shall not be increased by more than 25 Nephelometric turbidity units by any point source discharge.

g. Cations and anions guideline values to protect livestock watering may be found in the “Supporting Document for Iowa Water Quality Management Plans,” Chapter IV, July 1976, as revised on November 11, 2009.

h. The *Escherichia coli* (*E. coli*) content of water which enters a sinkhole or losing stream segment, regardless of the water body’s designated use, shall not exceed a Geometric Mean value of 126 organisms/100 ml or a sample maximum value of 235 organisms/100 ml. No new wastewater discharges will be allowed on watercourses which directly or indirectly enter sinkholes or losing stream segments.

61.3(3) Specific water quality criteria.

a. *Class “A” waters.* Waters which are designated as Class “A1,” “A2,” or “A3” in subrule 61.3(5) are to be protected for primary contact, secondary contact, and children’s recreational uses. The general criteria of subrule 61.3(2) and the following specific criteria apply to all Class “A” waters.

(1) The *Escherichia coli* (*E. coli*) content shall not exceed the levels noted in the Bacteria Criteria Table when the Class “A1,” “A2,” or “A3” uses can reasonably be expected to occur.

Bacteria Criteria Table (organisms/100 ml of water)

Use or Category	Geometric Mean	Sample Maximum
Class A1		
3/15 – 11/15	126	235
11/16 – 3/14	Does not apply	Does not apply
Class A2 (Only)		
3/15 – 11/15	630	2880
11/16 – 3/14	Does not apply	Does not apply
[Class A2 and B(CW)] or OIW or ONRW		
Year-Round	630	2880
Class A3		
3/15 – 11/15	126	235
11/16 – 3/14	Does not apply	Does not apply
Class A1 - Primary Contact Recreational Use Class A2 - Secondary Contact Recreational Use Class A3 - Children’s Recreational Use		

When a water body is designated for more than one of the recreational uses, the most stringent criteria for the appropriate season shall apply.

(2) The pH shall not be less than 6.5 nor greater than 9.0. The maximum change permitted as a result of a waste discharge shall not exceed 0.5 pH units.

b. *Class “B” waters.* All waters which are designated as Class B(CW1), B(CW2), B(WW-1), B(WW-2), B(WW-3) or B(LW) are to be protected for wildlife, fish, aquatic, and semiaquatic life. The following criteria shall apply to all Class “B” waters designated in subrule 61.3(5).

(1) Dissolved oxygen. Dissolved oxygen shall not be less than the values shown in Table 2 of this subrule.

(2) pH. The pH shall not be less than 6.5 nor greater than 9.0. The maximum change permitted as a result of a waste discharge shall not exceed 0.5 pH units.

(3) General chemical constituents. The specific numerical criteria shown in Tables 1, 2, and 3 of this subrule apply to all waters designated in subrule 61.3(5). The sole determinant of compliance with these criteria will be established by the department on a case-by-case basis. Effluent monitoring or instream monitoring, or both, will be the required approach to determine compliance.

1. The acute criteria represent the level of protection necessary to prevent acute toxicity to aquatic life. Instream concentrations above the acute criteria will be allowed only within the boundaries of the zone of initial dilution.

2. The chronic criteria represent the level of protection necessary to prevent chronic toxicity to aquatic life. Excursions above the chronic criteria will be allowed only inside of mixing zones or only for short-term periods outside of mixing zones; however, these excursions cannot exceed the acute criteria shown in Tables 1 and 3. The chronic criteria will be met as short-term average conditions at all times the flow equals or exceeds either the design flows noted in subrule 61.2(5) or any site-specific low flow established under the provisions of subrule 61.2(5).

3. Rescinded IAB 2/15/06, effective 3/22/06.

(4) Rescinded IAB 2/15/06, effective 3/22/06.

(5) Temperature.

1. No heat shall be added to interior streams or the Big Sioux River that would cause an increase of more than 3°C. The rate of temperature change shall not exceed 1°C per hour. In no case shall heat be added in excess of that amount that would raise the stream temperature above 32°C.

2. No heat shall be added to streams designated as cold water fisheries that would cause an increase of more than 2°C. The rate of temperature change shall not exceed 1°C per hour. In no case shall heat be added in excess of that amount that would raise the stream temperature above 20°C.

3. No heat shall be added to lakes and reservoirs that would cause an increase of more than 2°C. The rate of temperature change shall not exceed 1°C per hour. In no case shall heat be added in excess of that amount that would raise the temperature of the lake or reservoirs above 32°C.

4. No heat shall be added to the Missouri River that would cause an increase of more than 3°C. The rate of temperature change shall not exceed 1°C per hour. In no case shall heat be added that would raise the stream temperature above 32°C.

5. No heat shall be added to the Mississippi River that would cause an increase of more than 3°C. The rate of temperature change shall not exceed 1°C per hour. In addition, the water temperature at representative locations in the Mississippi River shall not exceed the maximum limits in the table below during more than 1 percent of the hours in the 12-month period ending with any month. Moreover, at no time shall the water temperature at such locations exceed the maximum limits in the table below by more than 2°C.

Zone II—Iowa-Minnesota state line to the northern Illinois border (Mile Point 1534.6).

Zone III—Northern Illinois border (Mile Point 1534.6) to Iowa-Missouri state line.

Month	Zone II	Zone III
January	4°C	7°C
February	4°C	7°C
March	12°C	14°C
April	18°C	20°C
May	24°C	26°C
June	29°C	29°C
July	29°C	30°C
August	29°C	30°C
September	28°C	29°C
October	23°C	24°C
November	14°C	18°C
December	9°C	11°C

(6) Early life stage for each use designation. The following seasons will be used in applying the early life stage present chronic criteria noted in Table 3b, “Chronic Criterion for Ammonia in Iowa Streams - Early Life Stages Present.”

1. For all Class B(CW1) waters, the early life stage will be year-round.

2. For all Class B(CW2) waters, the early life stage will begin on April 1 and last through September 30.

3. For all Class B(WW-1) waters, the early life stage will begin in March and last through September, except as follows:

- For the following, the early life stage will begin in February and last through September:

—The entire length of the Mississippi and Missouri Rivers,

—The lower reach of the Des Moines River south of the Ottumwa dam, and

—The lower reach of the Iowa River below the Cedar River.

- For the following, the early life stage will begin in April and last through September:

—All Class B(WW-1) waters in the Southern Iowa River Basin,

—All of the Class B(WW-1) reach of the Skunk River, the North Skunk River and the South Skunk River south of Indian Creek (Jasper County), and the Class B(WW-1) tributaries to these reaches, and the entire Class B(WW-1) reach of the English River.

4. For all Class B(WW-2) and Class B(WW-3) waters, the early life stage will begin in April and last through September.

5. For all Class B(LW) lake and wetland waters, the early life stage will begin in March and last through September except for the Class B(LW) waters in the southern two tiers of Iowa counties which will have the early life stage of April through September.

c. Class "C" waters. Waters which are designated as Class "C" are to be protected as a raw water source of potable water supply. The following criteria shall apply to all Class "C" waters designated in subrule 61.3(5).

- (1) Radioactive substances.

1. The combined radium-226 and radium-228 shall not exceed 5 picocuries per liter at the point of withdrawal.

2. Gross alpha particle activity (including radium-226 but excluding radon and uranium) shall not exceed 15 picocuries per liter at the point of withdrawal.

3. The average annual concentration at the point of withdrawal of beta particle and photon radioactivity from man-made radionuclides other than tritium and strontium-90 shall not produce an annual dose equivalent to the total body or any internal organ greater than 4 millirem/year.

4. The average annual concentration of tritium shall not exceed 20,000 picocuries per liter at the point of withdrawal; the average annual concentration of strontium-90 shall not exceed 8 picocuries per liter at the point of withdrawal.

- (2) All substances toxic or detrimental to humans or detrimental to treatment process shall be limited to nontoxic or nondetrimental concentrations in the surface water.

- (3) The pH shall not be less than 6.5 nor greater than 9.0.

d. Class "HH" waters. Waters which are designated as Class HH shall contain no substances in concentrations which will make fish or shellfish inedible due to undesirable tastes or cause a hazard to humans after consumption.

- (1) The human health criteria represent the level of protection necessary, in the case of noncarcinogens, to prevent adverse health effects in humans and, in the case of carcinogens, to prevent a level of incremental cancer risk not exceeding 1 in 100,000. Instream concentrations in excess of the human health criteria will be allowed only within the boundaries of the mixing zone.

- (2) Reserved.

TABLE 1. Criteria for Chemical Constituents

(all values as micrograms per liter as total recoverable unless noted otherwise)

Human health criteria for carcinogenic parameters noted below were based on the prevention of an incremental cancer risk of 1 in 100,000. For parameters not having a noted human health criterion, the U.S. Environmental Protection Agency has not developed final national human health guideline values. For noncarcinogenic parameters, the recommended EPA criterion was selected. For Class C waters, the EPA criteria for fish and water consumption were selected using the same considerations for carcinogenic and noncarcinogenic parameters as noted above. For Class C waters for which no EPA human health criteria were available, the EPA MCL value was selected.

Parameter		Use Designations							
		B(CW1)	B(CW2)	B(WW-1)	B(WW-2)	B(WW-3)	B(LW)	C	HH
Alachlor	MCL	—	—	—	—	—	—	2	—
Aldrin	Acute	—	—	3	3	3	—	—	—
	Human Health — Fish	—	—	—	—	—	—	—	.00050 ^(e)
	Human Health + — F & W	—	—	—	—	—	—	—	.00049 ^(f)
Aluminum	Chronic	87	—	87	87	87	748	—	—
	Acute	1106	—	750	750	750	983	—	—
Antimony	Human Health — Fish	—	—	—	—	—	—	—	640 ^(e)
	Human Health + — F & W	—	—	—	—	—	—	—	5.6 ^(f)
Arsenic (III)	Chronic	200	—	150	150	150	200	—	—
	Acute	360	—	340	340	340	360	—	—
	Human Health — Fish	—	—	—	—	—	—	—	50 ^{(e)(g)}
	Human Health — F & W	—	—	—	—	—	—	—	.18 ^{(f)(g)}
Asbestos	Human Health — F & W	—	—	—	—	—	—	—	7 ^{(a)(f)}
Atrazine	MCL	—	—	—	—	—	—	3	—
Barium	Human Health + — F & W	—	—	—	—	—	—	—	1000 ^(f)
Benzene	Human Health — F & W	—	—	—	—	—	—	—	22 ^(f)
	Human Health — Fish	—	—	—	—	—	—	—	510 ^(e)
Benzo(a)Pyrene	Human Health — F & W	—	—	—	—	—	—	—	.038 ^(f)
	Human Health — Fish	—	—	—	—	—	—	—	.18 ^(e)
Beryllium	MCL	—	—	—	—	—	—	4	—
Bromoform	Human Health — F & W	—	—	—	—	—	—	—	43 ^(f)
	Human Health — Fish	—	—	—	—	—	—	—	1400 ^(e)
Cadmium	Chronic	1	—	.45 ^(h)	.45 ^(h)	.45 ^(h)	1	—	—
	Acute	4	—	4.32 ^(h)	4.32 ^(h)	4.32 ^(h)	4	—	—
	Human Health + — Fish	—	—	—	—	—	—	—	168 ^(e)
	MCL	—	—	—	—	—	—	5	—
Carbofuran	MCL	—	—	—	—	—	—	40	—
Carbon Tetrachloride	Human Health — F & W	—	—	—	—	—	—	—	2.3 ^(f)
	Human Health — Fish	—	—	—	—	—	—	—	16 ^(e)
Chlordane	Chronic	.004	—	.0043	.0043	.0043	.004	—	—
	Acute	2.5	—	2.4	2.4	2.4	2.5	—	—
	Human Health — Fish	—	—	—	—	—	—	—	.0081 ^(e)
	Human Health — F & W	—	—	—	—	—	—	—	.008 ^(f)

Parameter		Use Designations							
		B(CW1)	B(CW2)	B(WW-1)	B(WW-2)	B(WW-3)	B(LW)	C	HH
Chloride	Chronic	389(m)*	389(m)*	389(m)*	389(m)*	389(m)*	389(m)*	—	—
	Acute	629(m)*	629(m)*	629(m)*	629(m)*	629(m)*	629(m)*	—	—
	MCL	—	—	—	—	—	—	250*	—
Chlorobenzene	Human Health + — Fish	—	—	—	—	—	—	—	1.6*(e)
	Human Health + — F & W	—	—	—	—	—	—	—	130 ^(f)
	MCL	—	—	—	—	—	—	100	—
Chlorodibromomethane	Human Health — F & W	—	—	—	—	—	—	—	4.0 ^(f)
	Human Health — Fish	—	—	—	—	—	—	—	130 ^(e)
Chloroform	Human Health — F & W	—	—	—	—	—	—	—	57 ^(f)
	Human Health — Fish	—	—	—	—	—	—	—	4700 ^(e)
Chloropyrifos	Chronic	.041	—	.041	.041	.041	.041	—	—
	Acute	.083	—	.083	.083	.083	.083	—	—
Chromium (VI)	Chronic	40	—	11	11	11	10	—	—
	Acute	60	—	16	16	16	15	—	—
	Human Health + — Fish	—	—	—	—	—	—	—	3365 ^(e)
	MCL	—	—	—	—	—	—	100	—
Copper	Chronic	20	—	16.9 ^(f)	16.9 ^(f)	16.9 ^(f)	10	—	—
	Acute	30	—	26.9 ^(f)	26.9 ^(f)	26.9 ^(f)	20	—	—
	Human Health + — Fish	—	—	—	—	—	—	—	1000 ^(e)
	Human Health + — F & W	—	—	—	—	—	—	—	1300 ^(f)
Cyanide	Chronic	5	—	5.2	5.2	5.2	10	—	—
	Acute	20	—	22	22	22	45	—	—
	Human Health + — F & W	—	—	—	—	—	—	—	140 ^(f)
	Human Health — Fish	—	—	—	—	—	—	—	140 ^(e)
Dalapon	MCL	—	—	—	—	—	—	200	—
Dibromochloropropane	MCL	—	—	—	—	—	—	.2	—
4,4-DDT ++	Chronic	.001	—	.001	.001	.001	.001	—	—
	Acute	.9	—	1.1	1.1	1.1	.55	—	—
	Human Health — Fish	—	—	—	—	—	—	—	.0022 ^(e)
	Human Health — F & W	—	—	—	—	—	—	—	.0022 ^(f)
o-Dichlorobenzene	MCL	—	—	—	—	—	—	600	—
para-Dichlorobenzene	Human Health + — F & W	—	—	—	—	—	—	—	63 ^(f)
	Human Health + — Fish	—	—	—	—	—	—	—	190 ^(e)
3,3-Dichlorobenzidine	Human Health — Fish	—	—	—	—	—	—	—	.28 ^(e)
	Human Health — F & W	—	—	—	—	—	—	—	.21 ^(f)

Parameter		Use Designations							
		B(CW1)	B(CW2)	B(WW-1)	B(WW-2)	B(WW-3)	B(LW)	C	HH
Oxamyl (Vydate)	MCL	—	—	—	—	—	—	200	—
Parathion	Chronic	.013	—	.013	.013	.013	.013	—	—
	Acute	.065	—	.065	.065	.065	.065	—	—
Pentachlorophenol (PCP)	Chronic	(d)	—	(d)	(d)	(d)	(d)	—	—
	Acute	(d)	—	(d)	(d)	(d)	(d)	—	—
	Human Health — Fish	—	—	—	—	—	—	—	30 ^(e)
	Human Health — F & W	—	—	—	—	—	—	—	2.7 ^(f)
Phenols	Chronic	50	—	50	50	50	50	—	—
	Acute	1000	—	2500	2500	2500	1000	—	—
	Human Health + — Fish	—	—	—	—	—	—	—	1700 ^{*(e)}
	Human Health + — F & W	—	—	—	—	—	—	—	21 ^{*(f)}
Picloram	MCL	—	—	—	—	—	—	500	—
Polychlorinated Biphenyls (PCBs)	Chronic	.014	—	.014	.014	.014	.014	—	—
	Acute	2	—	2	2	2	2	—	—
	Human Health — Fish	—	—	—	—	—	—	—	.00064 ^(e)
	Human Health — F & W	—	—	—	—	—	—	—	.00064 ^(f)
Polynuclear Aromatic Hydrocarbons (PAHs)**	Chronic	.03	—	.03	3	3	.03	—	—
	Acute	30	—	30	30	30	30	—	—
	Human Health — Fish	—	—	—	—	—	—	—	.18 ^(e)
	Human Health — F & W	—	—	—	—	—	—	—	.038 ^(f)
Selenium	Chronic	10	—	5	5	5	70	—	—
	Acute	15	—	19.3	19.3	19.3	100	—	—
	Human Health + — F & W	—	—	—	—	—	—	—	170 ^(f)
	Human Health + — Fish	—	—	—	—	—	—	—	4200 ^(e)
Silver	Chronic	N/A	—	N/A	N/A	N/A	N/A	—	—
	Acute	30	—	3.8	3.8	3.8	4	—	—
	MCL	—	—	—	—	—	—	50	—
2,4,5-TP (Silvex)	MCL	—	—	—	—	—	—	10	—
Simazine	MCL	—	—	—	—	—	—	4	—
Styrene	MCL	—	—	—	—	—	—	100	—
Tetrachlorethylene	Human Health — F & W	—	—	—	—	—	—	—	6.9 ^(f)
	Human Health — Fish	—	—	—	—	—	—	—	33 ^(e)
Thallium	Human Health + — F & W	—	—	—	—	—	—	—	.24 ^(f)
	Human Health + — Fish	—	—	—	—	—	—	—	.47 ^(e)

Parameter		Use Designations							
		B(CW1)	B(CW2)	B(WW-1)	B(WW-2)	B(WW-3)	B(LW)	C	HH
Toluene	Chronic	50	—	50	150	150	50	—	—
	Acute	2500	—	2500	7500	7500	2500	—	—
	Human Health + — Fish	—	—	—	—	—	—	—	15*(e)
	Human Health + — F & W	—	—	—	—	—	—	—	1300(f)
Total Residual Chlorine (TRC)	Chronic	10	—	11	11	11	10	—	—
	Acute	35	—	19	19	19	20	—	—
Toxaphene	Chronic	.037	—	.002	.002	.002	.037	—	—
	Acute	.73	—	.73	.73	.73	.73	—	—
	Human Health — Fish	—	—	—	—	—	—	—	.0028(e)
	Human Health — F & W	—	—	—	—	—	—	—	.0028(f)
1,2,4-Trichlorobenzene	MCL	—	—	—	—	—	—	70	—
1,1,1-Trichloroethane	MCL	—	—	—	—	—	—	200	—
	Human Health + — Fish	—	—	—	—	—	—	—	173*(e)
1,1,2-Trichloroethane	Human Health — F & W	—	—	—	—	—	—	—	6(f)
Trichloroethylene (TCE)	Chronic	80	—	80	80	80	80	—	—
	Acute	4000	—	4000	4000	4000	4000	—	—
	Human Health — Fish	—	—	—	—	—	—	—	300(e)
	Human Health — F & W	—	—	—	—	—	—	—	25(f)
Trihalomethanes (total)(c)	MCL	—	—	—	—	—	—	80	—
Vinyl Chloride	Human Health — F & W	—	—	—	—	—	—	—	.25(f)
	Human Health — Fish	—	—	—	—	—	—	—	24(e)
Xylenes (Total)	MCL	—	—	—	—	—	—	10*	—
Zinc	Chronic	200	—	215(f)	215(f)	215(f)	100	—	—
	Acute	220	—	215(f)	215(f)	215(f)	110	—	—
	Human Health + — Fish	—	—	—	—	—	—	—	26*(e)
	Human Health + — F & W	—	—	—	—	—	—	—	7.4*(f)

* units expressed as milligrams/liter

** to include the sum of known and suspected carcinogenic PAHs (includes benzo(a)anthracene, benzo(b)fluoranthene, benzo(k)fluoranthene, chrysene, dibenzo(a,h)anthracene, and indeno(1,2,3-cd)pyrene)

† expressed as nanograms/liter

+ represents the noncarcinogenic human health parameters

++ The concentrations of 4,4-DDT or its metabolites; 4,4-DDE and 4,4-DDD, individually shall not exceed the human health criteria.

(a) units expressed as million fibers/liter (longer than 10 micrometers)

(b) includes alpha-endosulfan, beta-endosulfan, and endosulfan sulfate in combination or as individually measured

(c) The sum of the four trihalomethanes (bromoform [tribromomethane], chlorodibromomethane, chloroform [trichloromethane], and dichlorobromomethane) may not exceed the MCL.

(d) Class B numerical criteria for pentachlorophenol are a function of pH using the equation: Criterion ($\mu\text{g/l}$) = $e^{[1.005(\text{pH}) - x]}$, where $e = 2.71828$ and x varies according to the following table:

	B(CW1)	B(CW2)	B(WW-1)	B(WW-2)	B(WW-3)	B(LW)
Acute	3.869	—	4.869	4.869	4.869	4.869
Chronic	4.134	—	5.134	5.134	5.134	5.134

- (e) This Class HH criterion would be applicable to any Class B(LW), B(CW1), B(WW-1), B(WW-2), or B(WW-3) water body that is also designated Class HH.
- (f) This Class HH criterion would be applicable to any Class C water body that is also designated Class HH.
- (g) inorganic form only
- (h) Class B(WW-1), B(WW-2), and B(WW-3) criteria listed in main table are based on a hardness of 200 mg/l (as CaCO₃ (mg/l)). Numerical criteria (µg/l) for cadmium are a function of hardness (as CaCO₃ (mg/l)) using the equation for each use according to the following table:

	B(WW-1)	B(WW-2)	B(WW-3)
Acute	$e^{[1.0166\text{Ln}(\text{Hardness}) - 3.924]}$	$e^{[1.0166\text{Ln}(\text{Hardness}) - 3.924]}$	$e^{[1.0166\text{Ln}(\text{Hardness}) - 3.924]}$
Chronic	$e^{[0.7409\text{Ln}(\text{Hardness}) - 4.719]}$	$e^{[0.7409\text{Ln}(\text{Hardness}) - 4.719]}$	$e^{[0.7409\text{Ln}(\text{Hardness}) - 4.719]}$

- (i) Class B(WW-1), B(WW-2), and B(WW-3) criteria listed in main table are based on a hardness of 200 mg/l (as CaCO₃ (mg/l)). Numerical criteria (µg/l) for copper are a function of hardness (CaCO₃ (mg/l)) using the equation for each use according to the following table:

	B(WW-1)	B(WW-2)	B(WW-3)
Acute	$e^{[0.9422\text{Ln}(\text{Hardness}) - 1.700]}$	$e^{[0.9422\text{Ln}(\text{Hardness}) - 1.700]}$	$e^{[0.9422\text{Ln}(\text{Hardness}) - 1.700]}$
Chronic	$e^{[0.8545\text{Ln}(\text{Hardness}) - 1.702]}$	$e^{[0.8545\text{Ln}(\text{Hardness}) - 1.702]}$	$e^{[0.8545\text{Ln}(\text{Hardness}) - 1.702]}$

- (j) Class B(WW-1), B(WW-2), and B(WW-3) criteria listed in main table are based on a hardness of 200 mg/l (as CaCO₃ (mg/l)). Numerical criteria (µg/l) for lead are a function of hardness (CaCO₃ (mg/l)) using the equation for each use according to the following table:

	B(WW-1)	B(WW-2)	B(WW-3)
Acute	$e^{[1.2731\text{Ln}(\text{Hardness}) - 1.46]}$	$e^{[1.2731\text{Ln}(\text{Hardness}) - 1.46]}$	$e^{[1.2731\text{Ln}(\text{Hardness}) - 1.46]}$
Chronic	$e^{[1.2731\text{Ln}(\text{Hardness}) - 4.705]}$	$e^{[1.2731\text{Ln}(\text{Hardness}) - 4.705]}$	$e^{[1.2731\text{Ln}(\text{Hardness}) - 4.705]}$

- (k) Class B(WW-1), B(WW-2), and B(WW-3) criteria listed in main table are based on a hardness of 200 mg/l (as CaCO₃ (mg/l)). Numerical criteria (µg/l) for nickel are a function of hardness (CaCO₃ (mg/l)) using the equation for each use according to the following table:

	B(WW-1)	B(WW-2)	B(WW-3)
Acute	$e^{[0.846\text{Ln}(\text{Hardness}) + 2.255]}$	$e^{[0.846\text{Ln}(\text{Hardness}) + 2.255]}$	$e^{[0.846\text{Ln}(\text{Hardness}) + 2.255]}$
Chronic	$e^{[0.846\text{Ln}(\text{Hardness}) + 0.0584]}$	$e^{[0.846\text{Ln}(\text{Hardness}) + 0.0584]}$	$e^{[0.846\text{Ln}(\text{Hardness}) + 0.0584]}$

- (l) Class B(WW-1), B(WW-2), and B(WW-3) criteria listed in main table are based on a hardness of 200 mg/l (as CaCO₃ (mg/l)). Numerical criteria (µg/l) for zinc are a function of hardness (CaCO₃ (mg/l)) using the equation for each use according to the following table:

	B(WW-1)	B(WW-2)	B(WW-3)
Acute	$e^{[0.8473\text{Ln}(\text{Hardness}) + 0.884]}$	$e^{[0.8473\text{Ln}(\text{Hardness}) + 0.884]}$	$e^{[0.8473\text{Ln}(\text{Hardness}) + 0.884]}$
Chronic	$e^{[0.8473\text{Ln}(\text{Hardness}) + 0.884]}$	$e^{[0.8473\text{Ln}(\text{Hardness}) + 0.884]}$	$e^{[0.8473\text{Ln}(\text{Hardness}) + 0.884]}$

- (m) Acute and chronic criteria listed in main table are based on a hardness of 200 mg/l (as CaCO₃ (mg/l)) and a sulfate concentration of 63 mg/l. Numerical criteria (µg/l) for chloride are a function of hardness (CaCO₃ (mg/l)) and sulfate (mg/l) using the equation for each use according to the following table:

	B(CW1), B(CW2), B(WW-1), B(WW-2), B(WW-3), B(LW)
Acute	$287.8(\text{Hardness})^{0.205797}(\text{Sulfate})^{-0.07452}$
Chronic	$177.87(\text{Hardness})^{0.205797}(\text{Sulfate})^{-0.07452}$

TABLE 2. Criteria for Dissolved Oxygen*(all values expressed in milligrams per liter)*

	B(CW1)	B(CW2)	B(WW-1)	B(WW-2)	B(WW-3)	B(LW)
Minimum value for at least 16 hours of every 24-hour period	7.0	7.0	5.0	5.0	5.0	5.0*
Minimum value at any time during every 24-hour period	5.0	5.0	5.0	4.0	4.0	5.0*

**applies only to the upper layer of stratification in lakes*

TABLE 3a. Acute Criterion for Ammonia in Iowa Streams

Acute Criterion, mg/l as N (or Criterion Maximum Concentration, CMC)		
pH	Class B(WW-1), B(WW-2), B(WW-3) & B(LW)	Class B(CW1) & B(CW2)
6.5	48.8	32.6
6.6	46.8	31.3
6.7	44.6	29.8
6.8	42.0	28.0
6.9	39.1	26.1
7.0	36.1	24.1
7.1	32.8	21.9
7.2	29.5	19.7
7.3	26.2	17.5
7.4	23.0	15.3
7.5	19.9	13.3
7.6	17.0	11.4
7.7	14.4	9.64
7.8	12.1	8.11
7.9	10.1	6.77
8.0	8.40	5.62
8.1	6.95	4.64
8.2	5.72	3.83
8.3	4.71	3.15
8.4	3.88	2.59
8.5	3.20	2.14
8.6	2.65	1.77
8.7	2.20	1.47
8.8	1.84	1.23
8.9	1.56	1.04
9.0	1.32	0.885

TABLE 3b. Chronic Criterion for Ammonia in Iowa Streams - Early Life Stages Present

Chronic Criterion - Early Life Stages Present, mg/l as N (or Criterion Continuous Concentration, CCC)										
pH	Temperature, °C									
	0	14	16	18	20	22	24	26	28	30
6.5	6.67	6.67	6.06	5.33	4.68	4.12	3.62	3.18	2.80	2.46
6.6	6.57	6.57	5.97	5.25	4.61	4.05	3.56	3.13	2.75	2.42
6.7	6.44	6.44	5.86	5.15	4.52	3.98	3.50	3.07	2.70	2.37
6.8	6.29	6.29	5.72	5.03	4.42	3.89	3.42	3.00	2.64	2.32
6.9	6.12	6.12	5.56	4.89	4.30	3.78	3.32	2.92	2.57	2.25
7.0	5.91	5.91	5.37	4.72	4.15	3.65	3.21	2.82	2.48	2.18
7.1	5.67	5.67	5.15	4.53	3.98	3.50	3.08	2.70	2.38	2.09
7.2	5.39	5.39	4.90	4.31	3.78	3.33	2.92	2.57	2.26	1.99
7.3	5.08	5.08	4.61	4.06	3.57	3.13	2.76	2.42	2.13	1.87
7.4	4.73	4.73	4.30	3.78	3.32	2.92	2.57	2.26	1.98	1.74
7.5	4.36	4.36	3.97	3.49	3.06	2.69	2.37	2.08	1.83	1.61

Chronic Criterion - Early Life Stages Present, mg/l as N (or Criterion Continuous Concentration, CCC)										
pH	Temperature, °C									
	0	14	16	18	20	22	24	26	28	30
7.6	3.98	3.98	3.61	3.18	2.79	2.45	2.16	1.90	1.67	1.47
7.7	3.58	3.58	3.25	2.86	2.51	2.21	1.94	1.71	1.50	1.32
7.8	3.18	3.18	2.89	2.54	2.23	1.96	1.73	1.52	1.33	1.17
7.9	2.8	2.8	2.54	2.24	1.96	1.73	1.52	1.33	1.17	1.03
8.0	2.43	2.43	2.21	1.94	1.71	1.50	1.32	1.16	1.02	0.897
8.1	2.10	2.10	1.91	1.68	1.47	1.29	1.14	1.00	0.879	0.773
8.2	1.79	1.79	1.63	1.43	1.26	1.11	0.973	0.855	0.752	0.661
8.3	1.52	1.52	1.39	1.22	1.07	0.941	0.827	0.727	0.639	0.562
8.4	1.29	1.29	1.17	1.03	0.906	0.796	0.700	0.615	0.541	0.475
8.5	1.09	1.09	0.990	0.870	0.765	0.672	0.591	0.520	0.457	0.401
8.6	0.920	0.920	0.836	0.735	0.646	0.568	0.499	0.439	0.386	0.339
8.7	0.778	0.778	0.707	0.622	0.547	0.480	0.422	0.371	0.326	0.287
8.8	0.661	0.661	0.601	0.528	0.464	0.408	0.359	0.315	0.277	0.244
8.9	0.565	0.565	0.513	0.451	0.397	0.349	0.306	0.269	0.237	0.208
9.0	0.486	0.486	0.442	0.389	0.342	0.300	0.264	0.232	0.204	0.179

TABLE 3c. Chronic Criterion for Ammonia in Iowa Streams - Early Life Stages Absent

Chronic Criterion - Early Life Stages Absent, mg/l as N (or Criterion Continuous Concentration, CCC)										
pH	Temperature, °C									
	0-7	8	9	10	11	12	13	14	15*	16*
6.5	10.8	10.1	9.51	8.92	8.36	7.84	7.35	6.89	6.46	6.06
6.6	10.7	9.99	9.37	8.79	8.24	7.72	7.24	6.79	6.36	5.97
6.7	10.5	9.81	9.20	8.62	8.08	7.58	7.11	6.66	6.25	5.86
6.8	10.2	9.58	8.98	8.42	7.90	7.40	6.94	6.51	6.10	5.72
6.9	9.93	9.31	8.73	8.19	7.68	7.20	6.75	6.33	5.93	5.56
7.0	9.60	9.00	8.43	7.91	7.41	6.95	6.52	6.11	5.73	5.37
7.1	9.20	8.63	8.09	7.58	7.11	6.67	6.25	5.86	5.49	5.15
7.2	8.75	8.20	7.69	7.21	6.76	6.34	5.94	5.57	5.22	4.90
7.3	8.24	7.73	7.25	6.79	6.37	5.97	5.60	5.25	4.92	4.61
7.4	7.69	7.21	6.76	6.33	5.94	5.57	5.22	4.89	4.59	4.30
7.5	7.09	6.64	6.23	5.84	5.48	5.13	4.81	4.51	4.23	3.97
7.6	6.46	6.05	5.67	5.32	4.99	4.68	4.38	4.11	3.85	3.61
7.7	5.81	5.45	5.11	4.79	4.49	4.21	3.95	3.70	3.47	3.25
7.8	5.17	4.84	4.54	4.26	3.99	3.74	3.51	3.29	3.09	2.89
7.9	4.54	4.26	3.99	3.74	3.51	3.29	3.09	2.89	2.71	2.54
8.0	3.95	3.70	3.47	3.26	3.05	2.86	2.68	2.52	2.36	2.21
8.1	3.41	3.19	2.99	2.81	2.63	2.47	2.31	2.17	2.03	1.91
8.2	2.91	2.73	2.56	2.40	2.25	2.11	1.98	1.85	1.74	1.63
8.3	2.47	2.32	2.18	2.04	1.91	1.79	1.68	1.58	1.48	1.39
8.4	2.09	1.96	1.84	1.73	1.62	1.52	1.42	1.33	1.25	1.17

Chronic Criterion - Early Life Stages Absent, mg/l as N (or Criterion Continuous Concentration, CCC)										
pH	Temperature, °C									
	0-7	8	9	10	11	12	13	14	15*	16*
8.5	1.77	1.66	1.55	1.46	1.37	1.28	1.20	1.13	1.06	0.99
8.6	1.49	1.40	1.31	1.23	1.15	1.08	1.01	0.951	0.892	0.836
8.7	1.26	1.18	1.11	1.04	0.976	0.915	0.858	0.805	0.754	0.707
8.8	1.07	1.01	0.944	0.885	0.829	0.778	0.729	0.684	0.641	0.601
8.9	0.917	0.860	0.806	0.756	0.709	0.664	0.623	0.584	0.548	0.513
9.0	0.790	0.740	0.694	0.651	0.610	0.572	0.536	0.503	0.471	0.442

*At 15°C and above, the criterion for fish early life stage (ELS) absent is the same as the criterion for fish ELS present.

TABLE 4. Aquatic Life Criteria for Sulfate for Class B Waters

(all values expressed in milligrams per liter)

Hardness mg/l as CaCO ₃	Chloride		
	Cl ⁻ < 5 mg/l	5 ≤ Cl ⁻ < 25	25 ≤ Cl ⁻ ≤ 500
H < 100 mg/l	500	500	500
100 ≤ H ≤ 500	500	$[-57.478 + 5.79(\text{hardness}) + 54.163(\text{chloride})] \times 0.65$	$[1276.7 + 5.508(\text{hardness}) - 1.457(\text{chloride})] \times 0.65$
H > 500	500	2,000	2,000

61.3(4) *Class "C" waters.* Rescinded IAB 4/18/90, effective 5/23/90.

61.3(5) *Surface water classification.* The department hereby incorporates by reference "Surface Water Classification," effective February 17, 2010. This document may be obtained on the department's Web site at <http://www.iowadnr.com/water/standards/index.html>.

61.3(6) *Cold water use designation assessment protocol.* The department hereby incorporates by reference "Cold Water Use Designation Assessment Protocol," effective December 15, 2004. This document may be obtained on the department's Web site at <http://www.iowadnr.com/water/standards/index.html>.

61.3(7) *Warm water stream use assessment and attainability analysis protocol.* The department hereby incorporates by reference "Warm Water Stream Use Assessment and Attainability Analysis Protocol," effective March 22, 2006. This document may be obtained on the departments Web site at <http://www.iowadnr.com/water/standards/index.html>.

61.3(8) *Recreational use assessment and attainability analysis protocol.* The department hereby incorporates by reference "Recreational Use Assessment and Attainability Analysis Protocol," effective March 19, 2008. This document may be obtained on the department's Web site.

This rule is intended to implement Iowa Code chapter 455B, division I, and division III, part 1. [ARC 8039B, IAB 8/12/09, effective 9/16/09; ARC 8214B, IAB 10/7/09, effective 11/11/09; ARC 8226B, IAB 10/7/09, effective 11/11/09; ARC 8466B, IAB 1/13/10, effective 2/17/10]

567—61.4 to 61.9 Reserved.

VOLUNTEER MONITORING DATA REQUIREMENTS

567—61.10(455B) Purpose. The department uses water quality monitoring data for a number of purposes, including determining compliance with effluent limits for operation permits issued under 567—Chapter 64. The department also uses water quality monitoring data to determine the relative health of a water body by comparing monitoring data to the appropriate water quality standards established in 567—Chapter 61, a process known as water body assessments. Water body assessments

are performed to prepare the biennial water quality report required under Section 305(b) of the Act and the list of impaired waters under Section 303(d) of the Act.

Iowa Code sections 455B.193 to 455B.195 require that credible data, as defined in Iowa Code section 455B.171, be used for the purpose of preparing Section 303(d) lists and other water quality program functions. Data provided by a volunteer are not considered credible data unless provided by a qualified volunteer. The purpose of this chapter is to establish minimum requirements for data produced by volunteers to meet the credible data and qualified volunteer requirements.

567—61.11(455B) Monitoring plan required. Volunteer water quality monitoring data submitted to the department must have been produced in accordance with a department-approved volunteer water quality monitoring plan before the data may be used for any of the purposes listed in Iowa Code section 455B.194. Approval of a plan will establish qualified volunteer status for the personnel identified in the plan for those monitoring activities covered under the plan.

61.11(1) *Submittal of the plan.* Prior to initiation of volunteer water quality monitoring activities intended to produce credible data, a water quality monitoring plan must be submitted to the department for review and approval. The plan must be submitted to the Volunteer Monitoring Coordinator, Department of Natural Resources, Wallace State Office Building, Des Moines, Iowa 50319, a minimum of 90 days before planned initiation of volunteer monitoring activities. A letter transmitting the plan must specifically request formal review and approval of the plan and identify a contact person. Volunteer monitors are encouraged to communicate with the department and to attend volunteer monitoring training sessions prior to formal submittal of a plan.

61.11(2) *Content of the plan.* A volunteer monitoring plan must contain, at a minimum, the following to be considered an acceptable volunteer monitoring plan:

- a. A statement of the intent of the monitoring effort.
- b. The name(s) of the person or persons that will be involved in data collection or analysis, the specific responsibilities of each person or group of people, and the general qualifications of the volunteers to carry out those responsibilities. For groups, such as educational institutions, it will be acceptable to identify the persons involved by general description (e.g., tenth grade biology class) with the exception of persons in responsible charge.
- c. The name(s) of the person or persons that will oversee the monitoring plan, ensure that quality assurance and control objectives are being met, and certify the data. The person or persons in responsible charge must have training commensurate with the level of expertise to ensure that credible data is being generated.
- d. The duration of the volunteer monitoring effort. In general, the department will not approve plans of greater than three years' duration unless a longer duration is justified.
- e. Location and frequency of sample collection.
- f. Methods of data collection and analysis.
- g. Record keeping and data reporting procedures.

61.11(3) *Department review of the plan.* The department will review monitoring plans and normally approve or disapprove the plan within 90 days of receipt. The department will work with the contact person identified in the plan to make any necessary changes prior to taking formal action. The department will use guidelines contained in the publications EPA Requirements for Quality Assurance Project Plans (EPA QA/R-5, 2001) and Volunteer Monitor's Guide to Quality Assurance Project Plans (1966, EPA 841-B-96-003) or equivalent updates to determine if the plans provide adequate quality assurance and quality control measures. Approval or disapproval of the plan will be in the form of a letter and approval may include conditions or limitations.

61.11(4) *Changes in monitoring plans.* The department must approve any changes to an approved monitoring plan. Data collected under a modified plan will not be considered credible data until such time as the department has approved the modifications. Modifications to an approved plan should be submitted at the earliest possible time to avoid interruptions in data collection and to ensure continuity of data.

61.11(5) Appeal of disapproval. If a monitoring plan submitted for approval is disapproved, the decision may be appealed by filing an appeal with the director within 30 days of disapproval. The form of the notice of appeal and appeal procedures are governed by 567—Chapter 7.

567—61.12(455B) Use of volunteer monitoring data. Data produced under an approved water quality monitoring plan will be considered credible data for the purposes listed in Iowa Code section 455B.194 if the following conditions are met.

61.12(1) Data submittal. A qualified volunteer monitor or qualified volunteer monitoring group must specifically request that data produced under an approved volunteer monitoring plan be considered credible data. A letter identifying the specific data must be submitted along with a certification from the volunteer or the person in responsible charge for volunteer groups that the data, to the best of the volunteer's or responsible person's knowledge, was produced in accordance with the approved volunteer monitoring plan. The department shall provide a standard format on the IOWATER Web site for submittal of qualified volunteer data and related information. The department encourages volunteers to enter monitoring data on the IOWATER volunteer monitoring database maintained by the department, but doing so does not constitute submittal to or acceptance of the data by the department for uses requiring credible data. Volunteer data shall be labeled as such in any departmental reports, Web sites, or databases.

61.12(2) Department review of submitted data. The department must review and approve the submitted data. The person submitting the data will be informed of the department's decision either to accept or reject the data. The department will attempt to resolve any apparent inconsistencies or questionable values in the submitted data prior to making a final decision.

567—61.13(455B) Department audits of volunteer monitoring activities. The department shall conduct field audits of a statistically valid and representative sample of volunteer data collection and analysis procedures to ensure compliance with an approved plan and may conduct confirmatory monitoring tests. Volunteers shall be informed of any audit results and be provided with an opportunity to address any concerns to the extent possible. The department reserves the right to rescind approval of an approved plan if it finds substantial problems that cannot be addressed in a timely manner to ensure the quality of the data being produced.

These rules are intended to implement Iowa Code chapter 455B, division III, part 1.

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[◇] Two or more ARCs

CHAPTER 133
RULES FOR DETERMINING
CLEANUP ACTIONS AND RESPONSIBLE PARTIES

567—133.1(455B,455E) Scope.

133.1(1) These rules establish the procedures and criteria the department will use to determine the parties responsible and cleanup actions necessary to meet the goals of the state pertaining to the protection of the groundwater. These rules pertain to the cleanup of groundwater itself and soils and surface water where groundwater may be impacted. They may also be used as guidelines in other environmental protection activities authorized by Iowa Code chapter 455B. Where specific federal or state programs or funds exist to address situations that are also governed by these rules, the rules and standards of the specific programs or funds will be integrated and utilized to achieve an equitable, expeditious and environmentally sound resolution of the particular contamination situation. These rules apply specifically to point source contamination only.

133.1(2) These rules apply specifically to cleanup actions required to abate, prevent or remediate a hazardous condition, the presence of a hazardous substance or waste, the release of a regulated substance, or the discharge of a pollutant as those terms are defined in Iowa Code chapter 455B.

133.1(3) These rules shall not limit the department's authority to require remedial or preventative action, or to take remedial or preventative action, as necessary to protect the public health, the environment, or the quality of life. The department will make its evaluation on a case-by-case basis, considering site characteristics, and where more than one contaminant is present or there is no established action level, will consider the toxicity, mobility and persistence of contaminants involved. The evaluation may include the potential synergistic, antagonistic, or cumulative effects of the contaminants involved in a particular case.

133.1(4) Persons subject to these rules retain all applicable appeal rights provided in Iowa Code chapter 455B.

133.1(5) This chapter is applicable to releases of petroleum from underground storage tanks subject to regulation under Iowa Code chapter 455B, Division IV, Part 8, to the extent they are not inconsistent with the corrective action rules in 567—135.6(455B) to 567—135.17(455B). This subrule is not intended to limit the authority of the department to establish liability against responsible parties other than owners and operators as defined in Iowa Code sections 455B.471(5) and 455B.471(6).

567—133.2(455B,455E) Definitions.

"Action level" means, for any contaminant, the HAL, if one exists; if there is no HAL, then the NRL, if one exists; if there is no HAL or NRL, then the MCL. If there is no HAL, NRL, or MCL, an action level may be established by the department based on current technical literature and recommended guidelines of EPA and recognized experts, on a case-by-case basis.

"Active cleanup" means removal, treatment, or isolation of a contaminant from groundwater or associated environment through the directed efforts of humans.

"AFS" means the Special Publication 30, "Investigation and Monetary Values of Fish and Freshwater Mussel Kills," published by the American Fisheries Society.

"Aggravated risk" means a contamination situation which presents a potentially catastrophic or an immediate and substantial risk of harm to human life or health or to the environment. Examples include exposure of humans, animals or the food chain to acutely toxic substances, contamination of a drinking water supply, threat of fire or explosion, or similar situations.

"Air or air resources" means those naturally occurring constituents of the atmosphere, including those gases essential for human, plant, and animal life.

"Background" means groundwater quality unaffected by human activities, and generally shall be determined by historical data of the geological services bureau or other government agencies for the type of aquifer or location involved in a given case. If available data is not adequate, background may be established by groundwater samples upgradient of a source or potential source of a substance which is detected in or has a reasonable probability of entering the groundwater.

“Best available technology” means those processes which most effectively remove, treat, or isolate contaminants from groundwater or associated environment, as determined through professional judgment considering actual equipment or techniques currently in use, published technical articles and research results, engineering reference materials, consultation with known experts in the field, and guidelines or rules of other regulatory agencies.

“Best management practices” means maintenance procedures, schedules of activities, prohibition of practices, and other management practices, or a combination thereof, which, after problem assessment and evaluation of alternatives is determined to be the most effective means of preventing or abating contamination at a location.

“Biological resources” means fish, wildlife and other biota belonging to, managed by, held in trust by, appertaining to, or otherwise controlled by the state of Iowa, the United States, or local government. Fish and wildlife include freshwater aquatic and terrestrial species; game, nongame, and commercial species; and threatened and endangered species. Other biota encompass shellfish, terrestrial and aquatic plants, and other living organisms not otherwise listed in this definition.

“Contaminant” means any chemical, ion, radionuclide, synthetic organic compound, microorganism, waste or other substance which does not occur naturally in groundwater or which occurs naturally at a lower concentration, and includes all hazardous substances as defined in 42 U.S.C. 9601, and any element, compound, mixture, solution or substance designated pursuant to 40 CFR 302.4 as of September 13, 1988.

“Damages” means the costs of restoration, rehabilitation, and replacement of resources, or acquisition of equivalent resources, as determined in accordance with this chapter; the reasonable and necessary costs of the assessment, to include the cost of performing the assessment and administrative costs and expenses necessary for, and incidental to, the assessment; lost services to the public; and, in the event the damages claim is not resolved within six months after the incident leading to the damages, interest at the current rate published in the Iowa Administrative Bulletin by the department of revenue pursuant to Iowa Code section 421.7. The interest amount shall be computed from the date the amount of the claim is confirmed by a final ruling of the commission in a contested case decision.

“Drinking water supply” means any raw or finished water source that is or may be used by a public water system, as defined in Iowa Code section 455B.171, or as drinking water by one or more individuals.

“Geologic resources” means those elements of Earth’s crust such as soils, sediments, rocks, and minerals, including petroleum and natural gas, that are not included in the definitions of groundwater and surface water resources.

“Groundwater” means any water of the state as defined in Iowa Code section 455B.171 which occurs beneath the surface of the earth in a saturated geologic formation of rock or soil.

“Groundwater resources” means water in a saturated zone or stratum beneath the surface of land or water and the rocks or sediments through which groundwater moves. It includes groundwater resources that meet the definition of drinking water supplies.

“HAL” means a lifetime health advisory level for a contaminant, established by the United States Environmental Protection Agency (EPA). Health advisories represent the concentration of a single contaminant, based on current toxicological information, in drinking water which is not expected to cause adverse health effects over lifetime exposure.

“Hazardous substance” means a hazardous substance as defined in Iowa Code section 455B.381.

“MCL” means the enforceable maximum contaminant level established by the EPA pursuant to the Safe Drinking Water Act.

“Natural resources” or *“resources”* means land, fish, wildlife, biota, air, water, groundwater, drinking water supplies, and other such resources belonging to, managed by, held in trust by, appertaining to, or otherwise controlled by the United States, the state of Iowa, or local government. These natural resources have been categorized into the following five groups: surface water resources, groundwater resources, air resources, geologic resources, and biological resources.

“NRL” means the negligible risk level for carcinogens established by the EPA, which is an estimate of one additional cancer case per million people exposed over a lifetime to the contaminant (1×10^{-6}).

“*Passive cleanup*” means the removal or treatment of a contaminant in groundwater, or associated environment, through management practices or the construction of barriers, trenches and other similar facilities for prevention of contamination, as well as the use of natural processes such as groundwater recharge, natural decay and chemical or biological decomposition.

“*Point source*” means any building, structure, installation, equipment, pipe or pipeline (including any pipe into a sewer or publicly owned treatment works), well, pit, pond, lagoon, impoundment, ditch, landfill, storage container, motor vehicle, rolling stock, or aircraft, or any site or area where a contaminant has been deposited, stored, disposed of, or placed, or otherwise come to be located.

“*Preventative*” or “*prevention*” refers, in the context of these rules, to actions or efforts to minimize or stop further contamination in a situation where contamination already exists or is imminent.

“*Remedial action plan*” means a written report which includes all relevant information, findings, and conclusions from a site assessment, including all analytical results and identification of contaminant migration pathways; identification and evaluation of cleanup alternatives, including both active and passive measures using best available technology and best management practices; a recommended cleanup action or combination of action, including identification of expected cleanup levels consistent with the cleanup goal of 133.4(3)“*b*”; a monitoring network and schedule to document cleanup levels; and a proposed schedule of implementation.

“*Responsible person*” means any person who is legally liable for the contamination in question or who is legally responsible for abating contamination under any applicable law, including Iowa Code chapters 455B and 455E, and the common law. This may include the person causing, allowing or otherwise participating in the activities or events which cause the contamination, persons who have failed to conduct their activities so as to prevent the release of contaminants into groundwater, property owners who are obligated to abate a condition, or persons responsible for or successor to such persons.

“*Significant risk*” means:

1. The presence in groundwater of a contaminant in excess of an action level;
2. The presence of a contaminant in the soils, surface water, or other environment in proximity to groundwater which may reasonably be expected to contaminate the groundwater to an action level; or
3. The presence of a contaminant or contaminants in the groundwater, or in the soils, surface water or other environment in proximity of groundwater which may be expected to contaminate groundwater in quantities, concentrations, or combinations which may significantly adversely impact the public health, safety, environment, or quality of life. This criterion would normally be applied where there is no established action level or where combinations of more than one contaminant are present.

“*Site assessment plan*” means a written proposal for study of a contamination situation to determine the types, amounts, and sources of contaminants present, hydrogeological characteristics of the site, and the vertical and horizontal extent of contamination, with a goal of developing an adequate remedial action plan. The proposal must include: recommendations for collection of relevant historical data such as site management practices, inventory records, literature searches, photographs and personal interviews; a methodology for obtaining groundwater flow information including well placements, construction and elevation, bore logs, static groundwater table measurements, groundwater elevations, groundwater gradients (isopleth), and information on soil transmissivity, porosity and permeability; and a methodology for identifying contaminant plumes, including additional monitoring wells to identify the horizontal and vertical extent of contamination, a site plot showing the estimated configuration of contamination, and a sampling schedule and list of constituents to be analyzed. The plan development may require preliminary field investigations.

“*Surface water resources*” means the waters of the state, including the sediments suspended in water or lying on the bank, bed, or shoreline. This term does not include groundwater or water or sediments in ponds, lakes, or reservoirs designed for waste treatment under applicable laws regulating waste treatment. [ARC 8470B, IAB 1/13/10, effective 2/17/10]

567—133.3(455B,455E) Documentation of contamination and source.

133.3(1) *Sampling and analytical procedures.* Unless rules for specific programs under USEPA or department authority provide otherwise, or unless other methods are approved by the department for a

specific situation, samples taken and analyses made to document contamination or cleanup levels under this chapter shall be conducted in accordance with the following:

a. Samples. “A Compendium of Superfund Field Operations Methods,” USEPA, Office of Emergency and Remedial Response, Washington, D.C. 20460 (EPA/540/P-87/001, OSWER Directive 93.55.0-14, December 1987).

b. Analyses. “Test Methods for Evaluation of Solid Waste, Physical-Chemical Methods (SW-846),” USEPA, Third Edition, November 1986, as revised through December 1988. Until the department adopts rules regarding certification of laboratories, analyses shall be conducted at a laboratory that certifies to the department that the appropriate analytical procedure is utilized, or a laboratory which has been approved under EPA’s Contract Laboratory Program. Upon adoption of rules by the department regarding certification of laboratories, all analyses shall be made at a certified laboratory. The parties, both the department and person responsible for investigating, shall have the opportunity to split samples for independent analysis, and where appropriate a sample portion shall be retained for a reasonable period of time for possible reanalysis.

133.3(2) Department determination of contamination. When the department receives or obtains evidence of groundwater contamination or the release or presence of contaminants in the environment associated with groundwater, where contamination of the groundwater may reasonably be expected, the department shall make reasonable efforts to document the source of contamination, and shall require responsible persons to take appropriate preventative, investigatory and remedial actions. Evidence of contamination may include but is not limited to the following:

- a.* Water samples indicating the presence of a contaminant at levels above background.
- b.* Soil or surface water samples indicating the presence of a contaminant at levels above background, where release to the groundwater is likely.
- c.* Known releases of contaminants into the environment in quantities and locations that could reasonably be expected to cause groundwater contamination.
- d.* Other events that the department determines could potentially cause groundwater contamination.

The amount and type of evidence necessary to document contamination or potential contamination will vary with the circumstances of each case, including the amount and type of contaminant involved, site topography and geologic conditions, and potential adverse effects. Normally, a reasonable number of water and soil samples will be taken or analyses obtained by the department. However, where a significant quantity of contaminants is known to have been released into the environment, for example from a spill, which could reach groundwater, the department is not required to collect samples.

133.3(3) Department determination of source. The department shall determine whether the contamination is or likely was caused by a particular source or sources, for example a known spill of contaminants or current or past facilities or activities in the vicinity which involved products or substances which could be a likely source. If no such person or event can be identified, the department shall make reasonable efforts to determine whether there is a relatively restricted area of more concentrated contaminants in the vicinity which is or is likely to be a source of the contamination. This subrule does not require the department to identify a specific person or persons responsible for the contamination, but to determine whether the contamination has or has likely come from a relatively defined source.

133.3(4) Determination of responsible persons. Where a source or likely source of contamination is identified, the person or persons responsible for that source or sources shall conduct necessary preventative, investigatory and remedial actions.

a. Identification. The persons responsible or potentially responsible initially shall be identified by the department through such measures as on-site observations; interviews with witnesses and local officials; review of public records, including department files; and interviews with or information obtained from potentially responsible persons. Where there may be more than one source, or the source is otherwise not conclusively identified, persons who handle or have handled materials or wastes in the vicinity of the contamination, which could be the source, shall investigate and provide information satisfactory to the department to confirm or disaffirm that their activities are a source of

the contamination. Investigation by the responsible or potentially responsible person may include inspection of inventory or other records, and soil and groundwater monitoring to better define the source. Such monitoring shall conform to the requirements of 133.4(3)“a,” provided that a full-scale assessment may not be required for this purpose.

b. Notification. The department shall notify in writing the persons determined responsible under the above procedures, and include a brief statement of the facts upon which the department concluded that they are responsible, and the actions required; provided that where immediate action is necessary, verbal notification may be given, followed up with written notification. The persons notified may provide information disputing or supplementing the information relied on by the department, which shall be considered by the department.

c. Responsible persons may be jointly and severally liable, and the department is not required to name all potentially responsible parties in directing responsive actions to contamination.

567—133.4(455B,455E) Response to contamination.

133.4(1) *Prevention of further contamination.* In all cases where an active source of contamination is identified, such as leaking tanks or current practices, which may be readily corrected, the source shall be removed, repaired or otherwise contained, or the contaminating practices ceased, immediately upon discovery of the source. In addition, readily accessible contaminants, for example concentrated contaminants spilled on the ground or accessible through a recovery well or system, shall be promptly removed to avoid or minimize further contamination in the groundwater.

133.4(2) *Aggravated risk.* Where the contamination presents an aggravated risk, the preventative, investigatory and remedial measures provided in subrules 133.4(1) and 133.4(3) shall be expedited to remove such risk. In addition, the following actions shall be taken by the responsible parties, if necessary, to protect the public health or environment:

- a.* Providing alternate water supplies.
- b.* Installing security fencing or other measures to limit access.
- c.* Extraordinary measures to control the source of release.
- d.* Removal of hazardous substances to an approved site for storage, treatment or disposal.
- e.* Placing physical barriers to deter the spread of the release.
- f.* Recommending to appropriate authorities the evacuation of threatened individuals.
- g.* Using other materials to restrain the spread of the contaminant or to mitigate its effects.
- h.* Executing damage control or salvage operations.

133.4(3) *Significant risk.* In cases of significant risk, the following investigatory and remedial measures shall be implemented:

a. Investigation. The responsible party shall determine the extent and levels of contamination through a site assessment conducted under the supervision of a registered professional engineer, an expert in the field of hydrogeology, or other qualified person. A site assessment plan shall be submitted to the department within 45 days of notice by the department, unless a shorter time is required or a longer time is authorized by the department. The plan shall be approved by the department prior to initiation of the assessment, unless otherwise approved by the department. The site assessment shall be conducted within a reasonable time and a remedial action plan shall be submitted to the department, within the time directed or approved by the department. The department may require further investigation by the responsible person in order to adequately assess the extent of contamination, and may require the remedial action plan to be supplemented if necessary.

b. Required cleanup actions.

(1) Groundwater. The goal of groundwater cleanup is use of best available technology and best management practices as long as it is reasonable and practical to remove all contaminants, and in any event until water contamination remains below the action level for any contaminant, and the department determines that the contamination is not likely to increase and no longer presents a significant risk. Where site conditions and available technology are such that attainment of these goals would be impractical, the department may establish an alternative cleanup level or levels, including such other conditions as will adequately protect the public health, safety, environment, and quality of life.

(2) Other. Where significant amounts of contaminants are documented as being present in the soils or other environment, such that groundwater contamination is occurring or is likely, active cleanup of the contaminated soils or other environment shall be implemented to the extent reasonable and necessary to prevent or minimize release to the groundwater; passive cleanup may be allowed in extraordinary circumstances.

133.4(4) Other. Where significant risk is not currently present, the responsible person may be required to monitor the groundwater and implement reasonable management or other preventative measures to minimize further contamination.

567—133.5(455B,455E) Report to commission. Department actions taken pursuant to this chapter shall be reported to the commission.

567—133.6(455B) Compensation for damages to natural resources.

133.6(1) Applicability. This rule applies to persons who, by release of a hazardous substance to the environment, cause injury to, destruction of, or loss of natural resources held in trust by the state for the public. In most cases this would involve the destruction of aquatic life or other wildlife under the ownership of the state, as provided in Iowa Code section 481A.2. This rule relates to the compensation to the state and public for the natural resource damages and is in addition to any other legal recourse for the event or action that caused the destruction or damage.

133.6(2) Liability to the state. Persons who cause injury to, destruction of, or loss of natural resources of the state are liable to the state as provided by Iowa Code section 455B.392(1)(c). This rule establishes the methodologies and criteria for evaluating the extent and value of the damage and establishes the methods of compensation. If the person and the department cannot agree to the proper resolution of a particular case, the issues of liability, damage and compensation will be established through contested case proceedings, as provided by 567—Chapter 7.

133.6(3) Assessment. When natural resources are destroyed or damaged by an identifiable source, the degree and value of the losses shall be assessed by collecting, compiling, and analyzing relevant information, statistics, or data through prescribed methodologies to determine damages, as set forth in this rule.

a. General. Except as specified otherwise in this rule, the definitions, methodologies, and criteria in 43 CFR 11 may be used to assess natural resource damages.

b. Fish loss. Assessment of damages for fish kills shall be in accordance with the following:

(1) Normally investigators will follow the methods prescribed by AFS to determine numbers of fish killed, by species and size.

(2) During periods of ice cover, where local conditions prevent using these methods, or in other appropriate circumstances, for example when the resources are known to have been diminished by prior incidents, investigators will utilize the best information available to determine numbers of fish killed by species and size. Information may include existing or prior data on population levels in the affected water body or nearby water bodies with similar characteristics, including any historical fish kill data.

(3) The monetary valuation of fish shall be the replacement values as published in AFS for all fish lost except the following: channel catfish, flathead catfish, blue catfish, northern pike, muskellunge, northern pike/muskellunge hybrid, rainbow trout, brown trout, brook trout, white bass, yellow bass, white bass/striped bass hybrid, largemouth bass, smallmouth bass, spotted bass, crappie, rock bass, bluegill, redear sunfish, warmouth, pumpkinseed, freshwater drum, yellow perch, walleye, sauger, and walleye/sauger hybrid. The value of these fish shall be \$15 each, unless AFS establishes a higher value. Notwithstanding the above, the value of each fish classified by the department as an endangered or threatened species shall be \$1,000.

(4) The value of lost services to the public shall be the number of fishing trips lost over the period of the resource loss, as determined through local creel survey information or through interpolation from the most recent statewide creel survey. Each trip shall be valued at \$30.

(5) The cost of the investigation shall include salaries plus overhead for the time of staff, including support staff, involved in investigating the fish kill and performing the assessment; meals and lodging for

staff while they are in the field conducting the assessment; mileage, valued at the current rate established pursuant to Iowa Code section 18.117; costs borne by the department associated with containment or cleanup operations; and any other costs directly associated with the investigation and assessment.

133.6(4) Compensation. The department will extend to the responsible person the opportunity to reach voluntary agreement as to the amount of damages and the compensation method. If the person disputes liability or the damage amount, the department will make a demand for payment and the person may appeal and demand contested case procedures under 567—Chapter 7. The method of compensation shall be solely in the discretion of the department.

a. Direct monetary payment. Compensation will normally be by direct monetary payment to the department. The money received will be used to replace, restore or rehabilitate the lost or damaged resources. Resource enhancement projects, support of educational programs relating to resource protection or enhancement, or resource acquisition of equal or greater value also may be funded. If practical, such alternatives should provide similar services to the public and should be in the vicinity of the loss.

b. Indirect monetary payment. In appropriate cases, an equal or greater amount of compensation may be made by monetary payment to another government agency or private nonprofit group in the natural resource field for the same purposes as provided in paragraph “a.”

c. Direct funding of projects. With the approval and oversight of the department, the person may be allowed to contract directly for the same purposes as provided in paragraph “a.”

This rule is intended to implement Iowa Code section 455B.392.

[ARC 8470B, IAB 1/13/10, effective 2/17/10]

This chapter is intended to implement Iowa Code section 455E.5(5) and Iowa Code chapter 455B, Division III, Part 1 and Division IV, Part 4.

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CHAPTER 135
TECHNICAL STANDARDS AND CORRECTIVE ACTION REQUIREMENTS FOR
OWNERS AND OPERATORS OF UNDERGROUND STORAGE TANKS

[Prior to 12/3/86, Water, Air and Waste Management[900]]

567—135.1(455B) Authority, purpose and applicability.

135.1(1) Authority. Iowa Code chapter 455B, division IV, part 8, authorizes the department to regulate underground tanks used for storage of regulated substances, and to adopt rules relating to detection, prevention and correction of releases of regulated substances from such tanks, maintenance of financial responsibility by owners or operators of such tanks, new tank performance standards, notice and reporting requirements, and designation of regulated substances.

135.1(2) Purpose. The purpose of these rules is to protect the public health and safety and the natural resources of Iowa by timely and appropriate detection, prevention and correction of releases of regulated substances from underground storage tanks (UST).

135.1(3) Applicability.

a. The requirements of this chapter apply to all owners and operators of a UST system as defined in 135.2(455B) except as otherwise provided in paragraphs “*b*,” “*c*,” and “*d*” of this subrule. Any UST system listed in paragraph “*c*” of this subrule must meet the requirements of 135.1(4).

b. The following UST systems are excluded from the requirements of this chapter:

(1) Any UST system holding hazardous wastes listed or identified under Subtitle C of the Solid Waste Disposal Act, or a mixture of such hazardous waste and other regulated substances.

(2) Any wastewater treatment tank system that is part of a wastewater treatment facility regulated under Section 402 or 307(b) of the federal Clean Water Act.

(3) Equipment or machinery that contains regulated substances for operational purposes such as hydraulic lift tanks and electrical equipment tanks.

(4) Any UST system whose capacity is 110 gallons or less.

(5) Any UST system that contains a de minimus concentration of regulated substances.

(6) Any emergency spill or overflow containment UST system that is expeditiously emptied after use.

c. Deferrals. Rules 135.3(455B), 135.4(455B), 135.5(455B), 135.6(455B) and 135.9(455B) do not apply to any of the following types of UST systems:

(1) Wastewater treatment tank systems;

(2) Any UST systems containing radioactive material that are regulated under the federal Atomic Energy Act of 1954 (42 U.S.C. 2011 and following);

(3) Any UST system that is part of an emergency generator system at nuclear power generation facilities regulated by the Nuclear Regulatory Commission under 10 CFR 50 Appendix A;

(4) Airport hydrant fuel distribution systems; and

(5) UST systems with field-constructed tanks.

d. Deferrals. Rule 135.5(455B) does not apply to any UST system that stores fuel solely for use by emergency power generators. All new and replacement UST systems for emergency power generators must meet the secondary containment requirements in subrule 135.3(9) and the leak detection and delivery prohibition requirements in subrule 135.3(8).

e. Nonpetroleum underground storage tank systems. Rules 135.8(455B) to 135.12(455B) do not apply to any nonpetroleum underground storage tank system except as otherwise provided for by the department.

135.1(4) Interim prohibition for deferred UST systems.

a. No person may install a UST system listed in 135.1(3) “*c*” for the purpose of storing regulated substances unless the UST system (whether of single- or double-wall construction):

(1) Will prevent releases due to corrosion or structural failure for the operational life of the UST system;

(2) Is cathodically protected against corrosion, constructed of noncorrodible material, steel clad with a noncorrodible material, or designed in a manner to prevent the release or threatened release of any stored substance; and

(3) Is constructed or lined with material that is compatible with the stored substance.

b. Notwithstanding paragraph “*a*” of this subrule, a UST system without corrosion protection may be installed at a site that is determined by a corrosion expert not to be corrosive enough to cause it to have a release due to corrosion during its operating life. Owners and operators must maintain records that demonstrate compliance with the requirements of this paragraph for the remaining life of the tank.

NOTE: The National Association of Corrosion Engineers Standard RP-02-85, “Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems,” may be used as guidance for complying with 135.1(4) “*b.*”

567—135.2(455B) Definitions.

“*Aboveground release*” means any release to the surface of the land or to surface water. This includes, but is not limited to, releases from the aboveground portion of a UST system and aboveground releases associated with overfills and transfer operations as the regulated substance moves to or from a UST system.

“*Active remediation*” means corrective action undertaken to reduce contaminant concentrations by other than passive remediation or monitoring.

“*Ancillary equipment*” means any devices including, but not limited to, such devices as piping, fittings, flanges, valves, and pumps used to distribute, meter, or control the flow of regulated substances to and from a UST.

“*Appurtenances*” means devices such as piping, fittings, flanges, valves, dispensers and pumps used to distribute, meter, or control the flow of regulated substances to or from an underground storage tank.

“*ASTM*” means the American Society of Testing and Materials.

“*Bedrock*” means the rock, usually solid, underlying soil or any other unconsolidated surficial cover.

“*Below-ground release*” means any release to the subsurface of the land and to groundwater. This includes, but is not limited to, releases from the below-ground portions of an underground storage tank system and below-ground releases associated with overfills and transfer operations as the regulated substance moves to or from an underground storage tank.

“*Beneath the surface of the ground*” means beneath the ground surface or otherwise covered with earthen materials.

“*Best available technology*” means those practices which most appropriately remove, treat, or isolate contaminants from groundwater, soil or associated environment, as determined through professional judgment considering actual equipment or techniques currently in use, published technical articles, site hydrogeology and research results, engineering and groundwater professional reference materials, consultation with experts in the field, capital and operating costs, and guidelines or rules of other regulatory agencies.

“*Best management practices*” means maintenance procedures, schedule of activities, prohibition of practices, and other management practices, or a combination thereof, which, after problem assessment, is determined to be the most effective means of monitoring and preventing additional contamination of the groundwater and soil.

“*Carcinogenic risk*” means the incremental risk of a person developing cancer over a lifetime as a result of exposure to a chemical, expressed as a probability such as one in a million (10^{-6}). For carcinogenic chemicals of concern, probability is derived from application of certain designated exposure assumptions and a slope factor.

“*Cathodic protection*” is a technique to prevent corrosion of a metal surface by making that surface the cathode of an electrochemical cell. For example, a tank system can be cathodically protected through the application of either galvanic anodes or impressed current.

“*Cathodic protection tester*” means a person who can demonstrate an understanding of the principles and measurements of all common types of cathodic protection systems as applied to buried or submerged metal piping and tank systems. At a minimum, such persons must have education and experience in soil

resistivity, stray current, structure-to-soil potential, and component electrical isolation measurements of buried metal piping and tank systems.

“*CERCLA*” means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

“*Certified groundwater professional*” means a person certified pursuant to 1995 Iowa Code section 455G.18 and 567—Chapter 134.

“*Change-in-service*” means changing the use of a tank system from a regulated to a nonregulated use.

“*Chemicals of concern*” means the compounds derived from petroleum-regulated substances which are subject to evaluation for purposes of applying risk-based corrective action decision making. These compounds are benzene, ethylbenzene, toluene, and xylenes (BTEX) and naphthalene, benzo(a)pyrene, benz(a)anthracene, and chrysene. (NOTE: Measurement of these last four constituents may be done by a conversion method from total extractable hydrocarbons, see subrule 135.8(3).)

“*Class A operator*” means a person responsible for managing resources and personnel to achieve and maintain compliance with regulatory requirements under this chapter. This includes ensuring appropriate individuals are trained in the proper operation and maintenance of the underground storage tank system, the maintenance of all required records, the procedures for response to emergencies caused by releases or spills, and assuring financial responsibility and documentation to the department or its representatives as required.

“*Class B operator*” means a person who implements applicable underground storage tank regulatory requirements and standards. This includes implementing the day-to-day aspects of operating, maintaining, and record keeping for underground storage tanks at one or more facilities. A Class B operator typically monitors, maintains and ensures that release detection methods, record-keeping, and reporting requirements are met; release prevention equipment, record-keeping, and reporting requirements are met; all relevant equipment complies with performance standards; and appropriate individuals are trained to properly respond to emergencies caused by releases and spills.

“*Class C operator*” means an on-site employee who typically controls or monitors the dispensing or sale of regulated substances and who is the first line of response to events indicating emergency conditions.

“*Compatible*” means the ability of two or more substances to maintain their respective physical and chemical properties upon contact with one another for the design life of the tank system under conditions likely to be encountered in the UST.

“*Conduit*” means underground structures which act as pathways and receptors for chemicals of concern, including but not limited to gravity drain lines and sanitary or storm sewers.

“*Connected piping*” means all underground piping including valves, elbows, joints, flanges, and flexible connectors attached to a tank system through which regulated substances flow. For the purpose of determining how much piping is connected to any individual UST system, the piping that joins two UST systems should be allocated equally between them.

“*Consumptive use*” with respect to heating oil means consumed on the premises.

“*Corrective action*” means an action taken to reduce, minimize, eliminate, clean up, control or monitor a release to protect the public health and safety or the environment. Corrective action includes, but is not limited to, excavation of an underground storage tank for the purpose of repairing a leak or removal of a tank, removal of contaminated soil, disposal or processing of contaminated soil, cleansing of groundwaters or surface waters, natural biodegradation, institutional controls, technological controls and site management practices. Corrective action does not include replacement of an underground storage tank. Corrective action specifically excludes third-party liability.

“*Corrective action meeting process*” means a series of meetings organized by department staff with owners or operators and other interested parties such as certified groundwater professionals, funding source representatives, and affected property owners. The purpose of the meeting process is to develop and agree on a corrective action plan and the terms for implementation of the plan.

“*Corrective action plan*” means a plan which specifies the corrective action to be undertaken by the owner or operator in order to comply with requirements in this chapter and which is incorporated

into a memorandum of agreement or other written agreement between the department and the owner or operator. The plan may include but is not limited to provisions for additional site assessment, site monitoring, Tier 2 revisions, Tier 3 assessment, excavation, and other soil and groundwater remedial action.

“Corrosion expert” means a person who, by reason of thorough knowledge of the physical sciences and the principles of engineering and mathematics acquired by a professional education and related practical experience, is qualified to engage in the practice of corrosion control on buried or submerged metal piping systems and metal tanks. Such a person must be accredited or certified as being qualified by the National Association of Corrosion Engineers or be a registered professional engineer who has certification or licensing that includes education and experience in corrosion control of buried or submerged metal piping systems and metal tanks.

“Department” means Iowa department of natural resources.

“Dielectric material” means a material that does not conduct direct electrical current. Dielectric coatings are used to electrically isolate UST systems from the surrounding soils. Dielectric bushings are used to electrically isolate portions of the UST systems (e.g., tank from piping).

“Dispenser” means equipment that is used to transfer a regulated substance from underground piping through a rigid or flexible hose or piping located aboveground to a point of use outside the underground storage tank system, such as a motor vehicle.

“Drinking water well” means any groundwater well used as a source for drinking water by humans and groundwater wells used primarily for the final production of food or medicine for human consumption in facilities routinely characterized with the Standard Industrial Codes (SIC) group 283 for drugs and 20 for foods.

“Electrical equipment” means underground equipment that contains dielectric fluid that is necessary for the operation of equipment such as transformers and buried electrical cable.

“Enclosed space” means space which can act as a receptor or pathway capable of creating a risk of explosion or inhalation hazard to humans and includes “explosive receptors” and “confined spaces.” Explosive receptors means those receptors designated in these rules which are evaluated for explosive risk. Confined spaces means those receptors designated in these rules for evaluation of vapor inhalation risks.

“Excavation zone” means the volume containing the tank system and backfill material bounded by the ground surface, walls, and floor of the pit and trenches into which the UST system is placed at the time of installation.

“Existing tank system” means a tank system used to contain an accumulation of regulated substances or for which installation has commenced on or before January 14, 1987. Installation is considered to have commenced if:

The owner or operator has obtained all federal, state, and local approvals or permits necessary to begin physical construction of the site or installation of the tank system; and if,

1. Either a continuous on-site physical construction or installation program has begun; or,
2. The owner or operator has entered into contractual obligations, which cannot be canceled or modified without substantial loss, for physical construction at the site or installation of the tank system to be completed within a reasonable time.

“Farm tank” is a tank located on a tract of land devoted to the production of crops or raising animals, including fish, and associated residences and improvements. A farm tank must be located on the farm property. “Farm” includes fish hatcheries, rangeland and nurseries with growing operations.

“Flow-through process tank” is a tank that forms an integral part of a production process through which there is a steady, variable, recurring, or intermittent flow of materials during the operation of the process. Flow-through process tanks do not include tanks used for the storage of materials prior to their introduction into the production process or for the storage of finished products or by-products from the production process.

“Free product” refers to a regulated substance that is present as a nonaqueous phase liquid (e.g., liquid not dissolved in water).

“*Gathering lines*” means any pipeline, equipment, facility, or building used in the transportation of oil or gas during oil or gas production or gathering operations.

“*Groundwater ingestion pathway*” means a pathway through groundwater by which chemicals of concern may result in exposure to a human receptor as specified in rules applicable to Tier 1, Tier 2 and Tier 3.

“*Groundwater plume*” means the extent of groundwater impacted by the release of chemicals of concern.

“*Groundwater to plastic water line pathway*” means a pathway through groundwater which leads to a plastic water line.

“*Groundwater vapor to enclosed space pathway*” means a pathway through groundwater by which vapors from chemicals of concern may lead to a receptor creating an inhalation or explosive risk hazard.

“*Hazardous substance UST system*” means an underground storage tank system that contains a hazardous substance defined in Section 101(14) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (but not including any substance regulated as a hazardous waste under subtitle C) or any mixture of such substances and petroleum, and which is not a petroleum UST system.

“*Hazard quotient*” means the ratio of the level of exposure of a chemical of concern over a specified time period to a reference dose for that chemical of concern derived for a similar exposure period. Unless otherwise specified, the hazard quotient designated in these rules is one.

“*Heating oil*” means petroleum that is No. 1, No. 2, No. 4-light, No. 4-heavy, No. 5-light, No. 5-heavy, and No. 6 technical grades of fuel oil; other residual fuel oils (including Navy Special Fuel Oil and Bunker C); and other fuels when used as substitutes for one of these fuel oils. Heating oil is typically used in the operation of heating equipment, boilers, or furnaces.

“*Highly permeable soils*” means for the purpose of UST closures: fractured bedrock, any soils with a hydraulic conductivity rate greater than 0.3 meters per day, or any soil material classified by the Unified Soil Classification System as published by the United States Department of the Interior or ASTM designation as (1) GW - well graded gravel, gravel-sand mixtures, little or no fines, (2) GP - poorly graded gravel, gravel-sand mixtures, little or no fines, (3) SW - well graded sands, gravelly sands, little or no fines, or (4) SP - poorly graded sands, gravelly sands, little or no fines.

“*Hydraulic conductivity*” means the rate of water movement through the soil measured in meters per day (m/d) as determined by the following methods. For a saturated soil, the Bouwer-Rice method or its equivalent shall be used. For unsaturated soil, use a Guelph permeameter or an equivalent in situ constant-head permeameter in a boring finished above the water table. If an in situ method cannot be used for unsaturated soil because of depth, or if the soil is homogeneous and lacks flow-conducting channels, fractures, cavities, etc., laboratory measurement of hydraulic conductivity is acceptable.

If laboratory methods are used, collect undisturbed soil samples using a thin-walled tube sampler in accordance with American Society of Testing and Materials (ASTM) Standard D1587. Samples shall be clearly marked, preserved and transported to the laboratory. The laboratory shall measure hydraulic conductivity using a constant-head permeameter in accordance with ASTM Standard D2434 or a falling-head permeameter in accordance with accepted methodology.

“*Hydraulic lift tank*” means a tank holding hydraulic fluid for a closed-loop mechanical system that uses compressed air or hydraulic fluid to operate lifts, elevators, and other similar devices.

“*Institutional controls*” means the restriction on use or access (for example, fences, deed restrictions, restrictive zoning) to a site or facility to eliminate or minimize potential exposure to a chemical(s) of concern. Institutional controls include any of the following:

1. A law of the United States or the state;
2. A regulation issued pursuant to federal or state laws;
3. An ordinance or regulation of a political subdivision in which real estate subject to the institutional control is located;
4. A restriction on the use of or activities occurring at real estate which are embodied in a covenant running with the land which:

- Contains a legal description of the real estate in a manner which satisfies Iowa Code section 558.1 et seq.;
- Is properly executed, in a manner which satisfies Iowa Code section 558.1 et seq.;
- Is recorded in the appropriate office of the county in which the real estate is located;
- Adequately and accurately describes the institutional control; and
- Is in the form of a covenant as set out in Appendix C or in such a manner reasonably acceptable to the department.

5. Any other institutional control the owner or operator can reasonably demonstrate to the department which will reduce the risk from a release throughout the period necessary to ensure that no applicable target risk is likely to be exceeded.

“Liquid trap” means sumps, well cellars, and other traps used in association with oil and gas production, gathering, and extraction operations (including gas production plants), for the purpose of collecting oil, water, and other liquids. These liquid traps may temporarily collect liquids for subsequent disposition or reinjection into a production or pipeline stream, or may collect and separate liquids from a gas stream.

“Maintenance” means the normal operational upkeep to prevent an underground storage tank system from releasing product.

“MCLs” means the drinking water primary maximum contaminant levels set out in 567—41.3(455B).

“Memorandum of agreement” means a written agreement between the department and the owner or operator which specifies the corrective action that will be undertaken by the owner or operator in order to comply with requirements in this chapter and the terms for implementation of the plan. The plan may include but is not limited to provisions for additional site assessment, site monitoring, Tier 2 revisions, Tier 3 assessment, excavation, and other soil and groundwater remedial action.

“Motor fuel” means petroleum or a petroleum-based substance that is motor gasoline, aviation gasoline, No. 1 or No. 2 diesel fuel, or any grade of gasohol, and is typically used in the operation of a motor engine.

“New tank system” means a tank system that will be used to contain an accumulation of regulated substances and for which installation has commenced after January 14, 1987. (See also “Existing Tank System.”)

“Noncarcinogenic risk” means the potential for adverse systemic or toxic effects caused by exposure to noncarcinogenic chemicals of concern, expressed as the hazard quotient.

“Noncommercial purposes” with respect to motor fuel means not for resale.

“Non-drinking water well” means any groundwater well (except an extraction well used as part of a remediation system) not defined as a drinking water well including a groundwater well which is not properly plugged in accordance with department rules in 567—Chapters 39 and 49.

“Nonresidential area” means land which is not currently used as a residential area and which is zoned for nonresidential uses.

“On the premises where stored” with respect to heating oil means UST systems located on the same property where the stored heating oil is used.

“Operational life” refers to the period beginning when installation of the tank system has commenced until the time the tank system is properly closed under rule 135.15(455B).

“Operator” means any person in control of, or having responsibility for, the daily operation of the UST system.

“Overfill release” is a release that occurs when a tank is filled beyond its capacity, resulting in a discharge of the regulated substance to the environment.

“Owner” means:

1. In the case of a UST system in use on July 1, 1985, or brought into use after that date, any person who owns a UST system used for storage, use, or dispensing of regulated substances; and
2. In the case of any UST system in use before July 1, 1985, but no longer in use on that date, any person who owned such UST immediately before the discontinuation of its use.

“*Owner*” does not include a person, who, without participating in the management or operation of the underground storage tank or the tank site, holds indicia of ownership primarily to protect that person’s security interest in the underground storage tank or the tank site property, prior to obtaining ownership or control through debt enforcement, debt settlement, or otherwise.

“*Pathway*” means a transport mechanism by which chemicals of concern may reach a receptor(s) or the location(s) of a potential receptor.

“*Permanent closure*” means removing all regulated substances from the tank system, assessing the site for contamination, and permanently removing tank and piping from the ground or filling the tank in place with a solid inert material and plugging all piping. Permanent closure also includes partial closure of a tank system such as removal or replacement of tanks or piping only.

“*Person*” means an individual, trust, firm, joint stock company, federal agency, corporation, state, municipality, commission, political subdivision of a state, or any interstate body. “*Person*” also includes a consortium, a joint venture, a commercial entity, and the United States government.

“*Person who conveys or deposits a regulated substance*” means a person who sells or supplies the owner or operator with the regulated substance and the person who transports or actually deposits the regulated substance in the underground tank.

“*Petroleum UST system*” means an underground storage tank system that contains petroleum or a mixture of petroleum with de minimus quantities of other regulated substances. Such systems include those containing motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils.

“*Pipe*” or “*piping*” means a hollow cylinder or tubular conduit that is constructed of nonearthen materials and that routinely contains and conveys regulated substances from the underground tank(s) to the dispenser(s) or other end-use equipment. Such piping includes any elbows, couplings, unions, valves, or other in-line fixtures that contain and convey regulated substances from the underground tank(s) to the dispenser(s). This definition does not include vent, vapor recovery, or fill lines.

“*Pipeline facilities (including gathering lines)*” are new and existing pipe rights-of-way and any associated equipment, facilities, or buildings.

“*Point of compliance*” means the location(s) at the source(s) of contamination or at the location(s) between the source(s) and the point(s) of exposure where concentrations of chemicals of concern must meet applicable risk-based screening levels at Tier 1 or other target level(s) at Tier 2 or Tier 3.

“*Point of exposure*” means the location(s) at which an actual or potential receptor may be exposed to chemicals of concern via a pathway.

“*Potential receptor*” means a receptor not in existence at the time a Tier 1, Tier 2 or Tier 3 site assessment is prepared, but which could reasonably be expected to exist within 20 years of the preparation of the Tier 1, Tier 2 or Tier 3 site assessment or as otherwise specified in these rules.

“*Preferential pathway*” means conditions which act as a pathway permitting contamination to migrate through soils and to groundwater at a faster rate than would be expected through naturally occurring undisturbed soils or unfractured bedrock including but not limited to wells, cisterns, tile lines, drainage systems, utility lines and envelopes, and conduits.

“*Protected groundwater source*” means a saturated bed, formation, or group of formations which has a hydraulic conductivity of at least 0.44 meters per day (m/d) and a total dissolved solids of less than 2,500 milligrams per liter (mg/l) or a bedrock aquifer with total dissolved solids of less than 2,500 milligrams per liter (mg/l) if bedrock is encountered before groundwater.

“*Public water supply well*” means a well connected to a system for the provision to the public of piped water for human consumption, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

“*Receptor*” means enclosed spaces, conduits, protected groundwater sources, drinking and non-drinking water wells, surface water bodies, and public water systems which when impacted by chemicals of concern may result in exposure to humans and aquatic life, explosive conditions or other adverse effects on health, safety and the environment as specified in these rules.

“*Reference dose*” means a designated toxicity value established in these rules for evaluating potential noncarcinogenic effects in humans resulting from exposure to a chemical(s) of concern. Reference doses are designated in Appendix A.

“*Regulated substance*” means an element, compound, mixture, solution or substance which, when released into the environment, may present substantial danger to the public health or welfare or the environment. Regulated substance includes:

1. Substances designated in Table 302.4 of 40 CFR Part 302 (September 13, 1988),
2. Substances which exhibit the characteristics identified in 40 CFR 261.20 through 261.24 (May 10, 1984) and which are not excluded from regulation as a hazardous waste under 40 CFR 261.4(b) (May 10, 1984),
3. Any substance defined in Section 101(14) of the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA) of 1980 (but not including any substance regulated as a hazardous waste under subtitle C), and
4. Petroleum, including crude oil or any fraction thereof that is liquid at standard conditions of temperature and pressure (60 degrees Fahrenheit and 14.7 pounds per square inch absolute). The term “regulated substance” includes but is not limited to petroleum and petroleum-based substances comprised of a complex blend of hydrocarbons derived from crude oil through processes of separation, conversion, upgrading, and finishing, such as motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils.

“*Release*” means any spilling, leaking, emitting, discharging, escaping, leaching or disposing of a regulated substance, including petroleum, from a UST into groundwater, surface water or subsurface soils.

“*Release detection*” means determining whether a release of a regulated substance has occurred from the UST system into the environment or into the interstitial space between the UST system and its secondary barrier or secondary containment around it.

“*Repair*” means to restore a tank or UST system component that has caused a release of product from the UST system.

“*Replace*” or “*replacement*” means the installation of a new underground tank system or component, including dispensers, in substantially the same location as an existing tank system or component in lieu of that tank system or component.

“*Residential area*” means land used as a permanent residence or domicile, such as a house, apartment, nursing home, school, child care facility or prison, land zoned for such uses, or land where no zoning is in place.

“*Residential tank*” is a tank located on property used primarily for dwelling purposes.

“*Risk-based screening level (RBSL)*” means the risk-based concentration level for chemicals of concern developed for a Tier 1 analysis to be met at the point(s) of compliance and incorporated in the Tier 1 Look-up Table in Appendix A.

“*SARA*” means the federal Superfund Amendments and Reauthorization Act of 1986.

“*Secondary containment tank*” or “*secondary containment piping*” means a tank or piping which is designed with an inner primary shell and a liquid-tight outer secondary shell or jacket which extends around the entire inner shell, and which is designed to contain any leak through the primary shell from any part of the tank or piping that routinely contains product, and which also allows for monitoring of the interstitial space between the shells and the detection of any leak.

“*Septic tank*” is a watertight covered receptacle designed to receive or process, through liquid separation or biological digestion, the sewage discharged from a building sewer. The effluent from such receptacle is distributed for disposal through the soil and settled solids and scum from the tank are pumped out periodically and hauled to a treatment facility.

“*Site assessment investigation*” means an investigation conducted by a registered groundwater professional to determine relevant site historical data, the types, amounts, and sources of petroleum contaminants present, hydrogeological characteristics of the site, full vertical and horizontal extent of the contamination in soils and groundwater, direction and rate of flow of the contamination, ranges of concentration of the contaminants by analysis of soils and groundwater, the vertical and horizontal

extent of the contamination exceeding department standards, and the actual or potential threat to public health and safety and the environment.

“Site cleanup report” means the report required to be submitted by these rules and in accordance with department guidance which may include the results of Tier 2 or Tier 3 assessment and analysis.

“Site-specific target level (SSTL)” means the risk-based target level(s) for chemicals of concern developed as the result of a Tier 2 or Tier 3 assessment which must be achieved at applicable point(s) of compliance at the source to meet the target level(s) at the point(s) of exposure.

“Soil leaching to groundwater pathway” means a pathway through soil by which chemicals of concern may leach to groundwater and through a groundwater transport pathway impact an actual or potential receptor.

“Soil plume” means the vertical and horizontal extent of soil impacted by the release of chemicals of concern.

“Soil to plastic water line pathway” means a pathway which leads from soil to a plastic water line.

“Soil vapor to enclosed space pathway” means a pathway through soil by which vapors from chemicals of concern may lead to a receptor creating an inhalation or explosive risk hazard.

“Storm water or wastewater collection system” means piping, pumps, conduits, and any other equipment necessary to collect and transport the flow of surface water run-off resulting from precipitation, or domestic, commercial, or industrial wastewater to and from retention areas or any areas where treatment is designated to occur. The collection of storm water and wastewater does not include treatment except where incidental to conveyance.

“Surface impoundment” is a natural topographic depression, constructed excavation, or diked area formed primarily of earthen materials (although it may be lined with manufactured materials) that is not an injection well.

“Surface water body” means general use segments as provided in 567—paragraph 61.3(1)“a” and designated use segments of water bodies as provided in 567—paragraph 61.3(1)“b” and 567—subrule 61.3(5).

“Surface water criteria” means, for chemicals of concern, the Criteria for Chemical Constituents in Table 1 of rule 567—61.3(455B), except that “1,000 ug/L” will be substituted for the chronic levels for toluene for Class B designated use segments.

“Surface water pathway” means a pathway which leads to a surface water body.

“Tank” is a stationary device designed to contain an accumulation of regulated substances and constructed of nonearthen materials (e.g., concrete, steel, plastic) that provide structural support.

“Target level” means the allowable concentrations of chemicals of concern established to achieve an applicable target risk which must be met at the point(s) of compliance as specified in these rules.

“Target risk” refers to an applicable carcinogenic and noncarcinogenic risk factor designated in these rules and used in determining target levels (for carcinogenic risk assessment, target risk is a separate factor, different from exposure factors, both of which are used in determining target levels).

“Technological controls” means a physical action which does not involve source removal or reduction, but severs or reduces exposure to a receptor, such as caps, containment, carbon filters, point of use water treatment, etc.

“Tier 1 level” means the groundwater and soil levels in the Tier 1 Look-up Table set out in rule 135.9(455B) and Appendix A.

“Tier 1 site assessment” means the evaluation of limited site-specific data compared to the Tier 1 levels established in these rules for the purpose of determining which pathways do not require assessment and evaluation at Tier 2 and which sites warrant a no further action required classification without further assessment and evaluation.

“Tier 2 site assessment” means the process of assessing risk to actual and potential receptors by using site-specific field data and designated Tier 2 exposure and fate and transport models to determine the applicable target level(s).

“Tier 3 site assessment” means a site-specific risk assessment utilizing more sophisticated data or analytic techniques than a Tier 2 site assessment.

“*Under-dispenser containment (UDC)*” means containment underneath a dispenser that will prevent leaks from the dispenser from reaching soil or groundwater. Such containment must:

- Be intact and liquid-tight on its sides and bottom and at any penetrations;
- Be compatible with the substance conveyed by the piping; and
- Allow for visual inspection and monitoring and access to the components in the containment system.

“*Underground area*” means an underground room, such as a basement, cellar, shaft or vault, providing enough space for physical inspection of the exterior of the tank situated on or above the surface of the floor.

“*Underground release*” means any below-ground release.

“*Underground storage tank*” or “*UST*” means any one or combination of tanks (including underground pipes connected thereto) that is used to contain an accumulation of regulated substances, and the volume of which (including the volume of underground pipes connected thereto) is 10 percent or more beneath the surface of the ground. This term does not include any:

a. Farm or residential tank of 1100 gallons or less capacity used for storing motor fuel for noncommercial purposes. Iowa Code section 455B.471 requires those tanks existing prior to July 1, 1987, to be registered. Tanks installed on or after July 1, 1987, must comply with all 567—Chapter 135 rules;

b. Tank used for storing heating oil for consumptive use on the premises where stored;

c. Septic tank;

d. Pipeline facility (including gathering lines) regulated under:

(1) The Natural Gas Pipeline Safety Act of 1968 (49 U.S.C. App. 1671, et seq.), or

(2) The Hazardous Liquid Pipeline Safety Act of 1979 (49 U.S.C. App. 2001, et seq.), or

(3) Which is an intrastate pipeline facility regulated under state laws comparable to the provisions of the law referred to in “d”(1) or “d”(2) of this definition;

e. Surface impoundment, pit, pond, or lagoon;

f. Storm-water or wastewater collection system;

g. Flow-through process tank;

h. Liquid trap or associated gathering lines directly related to oil or gas production and gathering operations; or

i. Storage tank situated in an underground area (such as a basement, cellar, mineworking, drift, shaft, or tunnel) if the storage tank is situated upon or above the surface of the floor.

The term “underground storage tank” or “UST” does not include any pipes connected to any tank which is described in paragraphs “a” through “j” of this definition.

“*Underground utility vault*” means any constructed space accessible for inspection and maintenance associated with subsurface utilities.

“*Unreasonable risk to public health and safety or the environment*” means the Tier 1 levels for a Tier 1 site assessment, the applicable target level for a Tier 2 site assessment, and the applicable target level for a Tier 3 site assessment.

“*Upgrade*” means the addition or retrofit of some systems such as cathodic protection, lining, or spill and overfill controls to improve the ability of an underground storage tank system to prevent the release of product.

“*UST system*” or “*tank system*” means an underground storage tank, connected underground piping, underground ancillary equipment, and containment system, if any.

“*Utility envelope*” means the backfill and trench used for any subsurface utility line, drainage system and tile line.

“*Wastewater treatment tank*” means a tank that is designed to receive and treat an influent wastewater through physical, chemical, or biological methods.

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567—135.3(455B) UST systems—design, construction, installation and notification.

135.3(1) Performance standards for new UST systems. In order to prevent releases due to structural failure, corrosion, or spills and overfills for as long as the UST system is used to store regulated substances, all owners and operators of new UST systems must meet the following requirements.

a. Tanks. Each tank must be properly designed and constructed, and any portion underground that routinely contains product must be protected from corrosion, in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory as specified below:

- (1) The tank is constructed of fiberglass-reinforced plastic; or

NOTE: The following industry codes may be used to comply with 135.3(1)“a”(1): Underwriters Laboratories Standard 1316, “Standard for Glass-Fiber-Reinforced Plastic Underground Storage Tanks for Petroleum Products”; Underwriters Laboratories of Canada CAN4-S615-M83, “Standard for Reinforced Plastic Underground Tanks for Petroleum Products”; or American Society of Testing and Materials Standard D4021-86, “Standard Specification for Glass-Fiber-Reinforced Polyester Underground Petroleum Storage Tanks.”

- (2) The tank is constructed of steel and cathodically protected in the following manner:

1. The tank is coated with a suitable dielectric material;
2. Field-installed cathodic protection systems are designed by a corrosion expert;
3. Impressed current systems are designed to allow determination of current operating status as required in 135.4(2)“c”; and
4. Cathodic protection systems are operated and maintained in accordance with 135.4(2) or according to guidelines established by the department; or

NOTE: The following codes and standards may be used to comply with 135.3(1)“a”(2): Steel Tank Institute “Specification for STI-P3 System of External Corrosion Protection of Underground Steel Storage Tanks”; Underwriters Laboratories Standard 1746, “Corrosion Protection Systems for Underground Storage Tanks”; Underwriters Laboratories of Canada CAN4-S603-M85, “Standard for Steel Underground Tanks for Flammable and Combustible Liquids,” and CAN4-GO3.1-M85, “Standard for Galvanic Corrosion Protection Systems for Underground Tanks for Flammable and Combustible Liquids,” and CAN4-S631-M84, “Isolating Bushings for Steel Underground Tanks Protected with Coatings and Galvanic Systems”; or National Association of Corrosion Engineers Standard RP-02-85, “Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems,” and Underwriters Laboratories Standard 58, “Standard for Steel Underground Tanks for Flammable and Combustible Liquids.”

- (3) The tank is constructed of a steel-fiberglass-reinforced plastic composite; or

NOTE: The following industry codes may be used to comply with 135.3(1)“a”(3): Underwriters Laboratories Standard 1746, “Corrosion Protection Systems for Underground Storage Tanks,” or the Association for Composite Tanks ACT-100, “Specification for the Fabrication of FRP Clad Underground Storage Tanks.”

(4) The tank is constructed of metal without additional corrosion protection measures provided that:

1. The tank is installed at a site that is determined by a corrosion expert not to be corrosive enough to cause it to have a release due to corrosion during its operating life; and
2. Owners and operators maintain records that demonstrate compliance with the requirements of 135.3(1)“a”(4)“1” for the remaining life of the tank; or

(5) The tank construction and corrosion protection are determined by the department to be designed to prevent the release or threatened release of any stored regulated substance in a manner that is no less protective of human health and the environment than 135.3(1)“a”(1) to (4).

b. Piping. The piping that routinely contains regulated substances and is in contact with the ground must be properly designed, constructed, and protected from corrosion in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory as specified below:

- (1) The piping is constructed of fiberglass-reinforced plastic; or

NOTE: The following codes and standards may be used to comply with 135.3(1) "b"(1): Underwriters Laboratories Subject 971, "UL Listed Non-Metal Pipe"; Underwriters Laboratories Standard 567, "Pipe Connectors for Flammable and Combustible and LP Gas"; Underwriters Laboratories of Canada Guide ULC-107, "Glass Fiber Reinforced Plastic Pipe and Fittings for Flammable Liquids"; and Underwriters Laboratories of Canada Standard CAN 4-S633-M81, "Flexible Underground Hose Connectors."

(2) The piping is constructed of steel and cathodically protected in the following manner:

1. The piping is coated with a suitable dielectric material;
2. Field-installed cathodic protection systems are designed by a corrosion expert;
3. Impressed current systems are designed to allow determination of current operating status as required in 135.4(2) "c"; and
4. Cathodic protection systems are operated and maintained in accordance with 135.4(2) or guidelines established by the department; or

NOTE: The following codes and standards may be used to comply with 135.3(1) "b"(2): National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code"; American Petroleum Institute Publication 1615, "Installation of Underground Petroleum Storage Systems"; American Petroleum Institute Publication 1632, "Cathodic Protection of Underground Petroleum Storage Tanks and Piping Systems"; and National Association of Corrosion Engineers Standard RP-01-69, "Control of External Corrosion on Submerged Metallic Piping Systems."

(3) The piping is constructed of metal without additional corrosion protection measures provided that:

1. The piping is installed at a site that is determined by a corrosion expert to not be corrosive enough to cause it to have a release due to corrosion during its operating life; and
2. Owners and operators maintain records that demonstrate compliance with the requirements of 135.3(1) "b"(3) "1" for the remaining life of the piping; or

NOTE: National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code"; and National Association of Corrosion Engineers Standard RP-01-69, "Control of External Corrosion on Submerged Metallic Piping Systems," may be used to comply with 135.3(1) "b"(3).

(4) The piping construction and corrosion protection are determined by the department to be designed to prevent the release or threatened release of any stored regulated substance in a manner that is no less protective of human health and the environment than the requirements in 135.3(1) "b"(1) to (3).

c. Spill and overflow prevention equipment.

(1) Except as provided in subparagraph (2), to prevent spilling and overflowing associated with product transfer to the UST system, owners and operators must use the following spill and overflow prevention equipment:

1. Spill prevention equipment that will prevent release of product to the environment when the transfer hose is detached from the fill pipe (for example, a spill catchment basin); and
2. Overflow prevention equipment that will:
 - Automatically shut off flow into the tank when the tank is no more than 95 percent full; or
 - Alert the transfer operator when the tank is no more than 90 percent full by restricting the flow into the tank or triggering a high-level alarm; or

Restrict flow 30 minutes prior to overflowing, alert the operator with a high-level alarm one minute before overflowing, or automatically shut off the flow into the tank so that none of the fittings located on top of the tank are exposed to product due to overflowing.

(2) Owners and operators are not required to use the spill and overflow prevention equipment specified in subparagraph (1) if:

1. Alternative equipment is used that is determined by the department to be no less protective of human health and the environment than the equipment specified in subparagraph (1) "1" or "2" of this paragraph; or
2. The UST system is filled by transfers of no more than 25 gallons at one time.

d. Installation. All tanks and piping must be properly installed in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory and in accordance with the manufacturer's instructions.

NOTE: Tank and piping system installation practices and procedures described in the following codes may be used to comply with the requirements of 135.3(1)“d”: American Petroleum Institute Publication 1615, “Installation of Underground Petroleum Storage System”; Petroleum Equipment Institute Publication RP100, “Recommended Practices for Installation of Underground Liquid Storage Systems”; or American National Standards Institute Standard 831.3, “Petroleum Refinery Piping,” and American National Standards Institute Standard 831.4, “Liquid Petroleum Transportation Piping System.”

e. Certification of installation. All owners and operators must ensure that one or more of the following methods of certification, testing, or inspection is used to demonstrate compliance with paragraph “d” of this subrule by providing a certification of compliance on the UST notification form in accordance with 135.3(3).

- (1) The installer has been certified by the tank and piping manufacturers; or
- (2) The installer has been certified or licensed by the department as provided in 567—Chapter 134, Part C; or
- (3) The installation has been inspected and certified by a registered professional engineer with education and experience in UST system installation; or
- (4) The installation has been inspected and approved by an inspector certified or licensed by the Iowa comprehensive petroleum underground storage tank fund board; or
- (5) All work listed in the manufacturer’s installation checklists has been completed; or
- (6) The owner and operator have complied with another method for ensuring compliance with paragraph “d” that is determined by the department to be no less protective of human health and the environment.

135.3(2) Upgrading of existing UST systems.

a. Alternatives allowed. Not later than December 22, 1998, all existing UST systems must comply with one of the following requirements:

- (1) New UST system performance standards under 135.3(1);
- (2) The upgrading requirements in paragraphs “b” through “d” below; or
- (3) Closure requirements under rule 135.15(455B), including applicable requirements for corrective action under rules 135.7(455B) to 135.12(455B).

Replacement or upgrade of a tank system on a petroleum contaminated site classified as a high or low risk in accordance with subrule 135.12(455B) shall be a double wall tank or a tank equipped with a secondary containment system with monitoring of the space between the primary and secondary containment structures in accordance with 135.5(4)“g” or other approved tank system or methodology approved by the Iowa comprehensive petroleum underground storage tank fund board.

b. Tank upgrading requirements. Steel tanks must be upgraded to meet one of the following requirements in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory:

- (1) *Interior lining.* A tank may be upgraded by internal lining if:
 1. The lining is installed in accordance with the requirements of 135.4(4), and
 2. Within ten years after lining, and every five years thereafter, the lined tank is internally inspected and found to be structurally sound with the lining still performing in accordance with original design specifications.

(2) *Cathodic protection.* A tank may be upgraded by cathodic protection if the cathodic protection system meets the requirements of 135.3(1)“a”(2)“2,”“3,” and “4” and the integrity of the tank is ensured using one of the following methods:

1. The tank is internally inspected and assessed to ensure that the tank is structurally sound and free of corrosion holes prior to installing the cathodic protection system; or
2. The tank has been installed for less than ten years and is monitored monthly for releases in accordance with 135.5(4)“d” through “h”; or
3. The tank has been installed for less than ten years and is assessed for corrosion holes by conducting two tightness tests that meet the requirements of 135.5(4)“c.” The first tightness test must be conducted prior to installing the cathodic protection system. The second tightness test must be

conducted between three and six months following the first operation of the cathodic protection system;
or

4. The tank is assessed for corrosion holes by a method that is determined by the department to prevent releases in a manner that is no less protective of human health and the environment than 135.3(2) “b”(2)“1” to “3.”

(3) *Internal lining combined with cathodic protection.* A tank may be upgraded by both internal lining and cathodic protection if:

1. The lining is installed in accordance with the requirements of 135.4(4); and
2. The cathodic protection system meets the requirements of 135.3(1) “a”(2)“2,” “3,” and “4.”

NOTE: The following codes and standards may be used to comply with subrule 135.3(2): American Petroleum Institute Publication 1631, “Recommended Practice for the Interior Lining of Existing Steel Underground Storage Tanks”; National Leak Prevention Association Standard 631, “Spill Prevention, Minimum 10-Year Life Extension of Existing Steel Underground Tanks by Lining Without the Addition of Cathodic Protection”; National Association of Corrosion Engineers Standard RP-02-85, “Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems”; and American Petroleum Institute Publication 1632, “Cathodic Protection of Underground Petroleum Storage Tanks and Piping Systems.”

c. Piping upgrading requirements. Metal piping that routinely contains regulated substances and is in contact with the ground must be cathodically protected in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory and must meet the requirements of 135.3(1) “b”(2)“2,” “3,” and “4.”

NOTE: The codes and standards listed in the note following 135.3(1) “b”(2) may be used to comply with this requirement.

d. Spill and overflow prevention equipment. To prevent spilling and overflowing associated with product transfer to the UST system, all existing UST systems must comply with new UST system spill and overflow prevention equipment requirements specified in 135.3(1) “c.”

135.3(3) Notification requirements.

a. Except as provided in 135.3(3) “b,” the owner of an underground storage tank existing on or before July 1, 1985, shall complete and submit to the department a copy of the notification form provided by the department by May 1, 1986.

b. The owner of an underground storage tank taken out of operation between January 1, 1974, and July 1, 1985, shall complete and submit to the department a copy of the notification form provided by the department by May 8, 1986, unless the owner knows the tank has been removed from the ground. For purposes of this subrule, “owner” means the person who owned the tank immediately before the discontinuation of the tank’s use.

c. An owner or operator who brings into use an underground storage tank after July 1, 1985, shall complete and submit to the department a copy of the notification form provided by the department within 30 days of installing the tank in the ground. The owner or operator shall not allow the deposit of any regulated substance into the tank without prior approval of the department or until the tank has been issued a tank registration tag and is covered by an approved financial responsibility mechanism in accordance with 567—Chapter 136.

d. All owners and operators of new UST systems must certify in the notification form compliance with the following requirements:

- (1) Installation of tanks and piping under 135.3(1) “e”;
- (2) Cathodic protection of steel tanks and piping under 135.3(1) “a” and “b”;
- (3) Financial responsibility under 567—Chapter 136, Iowa Administrative Code;
- (4) Release detection under 135.5(2) and 135.5(3).

e. All owners and operators of new UST systems must ensure that the installer certifies in the notification form that the methods used to install the tanks and piping comply with the requirements in 135.3(1) “d.”

f. Exemption from reporting requirement. Paragraphs “a” to “c” do not apply to an underground storage tank for which notice was given pursuant to Section 103, Subsection c, of the Comprehensive Environmental Response, Compensation and Liabilities Act of 1980. (42 U.S.C. Subsection 9603(c))

g. Reporting fee. The notice by the owner to the department under paragraphs “a” to “c” shall be accompanied by a fee of \$10 for each tank included in the notice.

h. Notification requirement for installing a tank. A person installing an underground storage tank and the owner or operator of the underground storage tank must notify the department of their intent to install the tank 30 days prior to installation. Notification shall be on a form provided by the department.

i. Notification requirements for a person who sells, installs, modifies or repairs a tank. A person who sells, installs, modifies, or repairs a tank used or intended to be used in Iowa shall notify, in writing, the purchaser and the owner or operator of the tank of the obligations specified in paragraphs 135.3(3) “c” and “j” and the financial assurance requirements in 567—Chapter 136. The notification must include the prohibition on depositing a regulated substance into tanks which have not been registered and issued tags by the department. A standard notification form supplied by the department may be used to satisfy this requirement.

j. It is unlawful for a person to deposit or accept a regulated substance in an underground storage tank that has not been registered and issued permanent or annual tank management tags in accordance with rule 567—135.3(455B). It is unlawful for a person to deposit or accept a regulated substance into an underground storage tank if the person has received notice from the department that the underground storage tank is subject to a delivery prohibition or if there is a “red tag” attached to the UST fill pipe or fill pipe cap as provided in subrule 135.3(8).

(1) The department may provide written authorization to receive a regulated substance when there is a delay in receiving tank tags or at new tank installations to allow for testing the tank system.

(2) The department may provide known depositors of regulated substances lists of underground storage tank sites that have been issued tank tags, those that have not been issued tank tags, and those subject to a delivery prohibition pursuant to subrule 135.3(8). These lists do not remove the requirement for depositors to verify that current tank tags are affixed to the fill pipe prior to delivering product. Regulated substances cannot be delivered to underground storage tanks without current tank tags or those displaying a delivery prohibition “red tag” as provided in subrule 135.3(8).

(3) A person shall not deposit a regulated substance in an underground storage tank after receiving written or oral notice from the department that the tank is not covered by an approved form of financial responsibility in accordance with 567—Chapter 136.

k. If an owner or operator fails to register an underground storage tank within 30 days after installation or obtain annual renewal tags by April 1, the owner or operator shall pay an additional \$250 upon registration of the tank or application for tank tag renewal. The imposition of this fee does not preclude the department from assessing an additional administrative penalty in accordance with Iowa Code section 455B.476.

135.3(4) *Farm and residential tanks.*

a. The owner or operator of a farm or residential tank of 1100 gallons or less capacity used for storing motor fuel for noncommercial purposes is subject to the requirements of this subrule.

b. Farm and residential tanks, installed before July 1, 1987, shall be reported on a notification form by July 1, 1989, but owners or operators are not required to pay a registration fee.

c. Farm and residential tanks that were installed on or after July 1, 1987, shall be in compliance with all the underground storage tank regulations.

135.3(5) *Registration tags and annual management fee.*

a. Tanks of 1100 gallons or less capacity that have registered with the department will be issued a permanent registration tag.

b. The owner or operator of tanks over 1100-gallon capacity must submit a tank management fee of \$65 per tank by January 15 of each year. The owner or operator must also submit written proof that the tanks are covered by an approved form of financial responsibility in accordance with 567—Chapter 136. Upon proper payment of the fee and acceptable proof of financial responsibility, a one-year registration

tag will then be issued for the period from April 1 to March 31. The department shall refund a tank management fee if the tank is permanently closed prior to the effective date of April 1 for that year.

c. The owner or operator shall affix the tag to the fill pipe of the underground storage tank where it will be readily visible.

d. A person who conveys or deposits a regulated substance shall inspect the underground storage tank to determine the existence or absence of a current registration tag, a current annual tank management fee tag, or a delivery prohibition “red tag” as provided in subrule 135.3(8). If the tag is not affixed to the fill pipe or fill pipe cap or if a delivery prohibition “red tag” is displayed, the person shall not deposit the substance in the tank.

e. The owner or operator must return the tank tags upon request of the department for failure to meet the requirements of rules 135.3(455B) to 135.5(455B) or the financial responsibility rules in 567—Chapter 136 after permanent tank closure or when tanks are temporarily closed for over 12 months, or when the tank system is suspected to be leaking and the responsible party fails to respond as required in subrule 135.8(1). The department will not return the tags until the tank system is in full compliance with the technical requirements of this chapter and financial responsibility requirements of 567—Chapter 136.

135.3(6) *Petroleum underground storage tank registration amnesty program.*

a. A petroleum underground storage tank required to be registered under 135.3(3) and 135.3(4), which has not been registered prior to July 1, 1988, may be registered under the following conditions:

(1) The tank registration fee under 135.3(3) “g” shall accompany the registration.

(2) The storage tank management fee under 135.3(5) shall be paid for past years in which the tank should have been registered.

b. If a tank is registered under this subrule on or prior to October 1, 1989, penalties under Iowa Code section 455B.477 shall be waived.

135.3(7) *Exemption certificates from the environmental charge on petroleum diminution.*

a. An owner or operator of a petroleum underground storage tank that is exempt, deferred, or excluded from regulation under Iowa Code sections 455G.1 to 455G.17, can apply for an exemption certificate from the department to exempt a tank from the environmental charge on petroleum diminution. Exempted tanks include those listed in 135.1(3) “b” and “c” and those excluded in the definition of “underground storage tank” in 135.2(455B). Application for the exemption certificate shall be made on the form provided by the department.

b. An exemption certificate is not required for those classes of tanks that the Iowa comprehensive petroleum underground storage tank fund board has waived from the exemption certificate requirement.

c. The department shall revoke and require the return of the exemption certificate if the petroleum underground storage tank becomes subject to Iowa Code sections 455G.1 to 455G.17.

135.3(8) *Delivery prohibition process.*

a. *Identifying sites subject to delivery response prohibition action.*

(1) Annual registration tag and tank management fee process. Owners and operators shall certify to the following on a form prepared by the department when applying for annual tank tags pursuant to subrule 135.3(5):

1. Installation and performance of an approved UST and piping release detection method as provided in rule 135.5(455B), including an annual line tightness test and a line leak detector test if applicable.

2. Installation of an approved overfill and spill protection system as provided in paragraph 135.3(1) “c.”

3. Installation of an approved corrosion protection system as provided in paragraphs 135.3(1) “a” and “b.”

4. If the UST system has been out of operation for more than three months, that the UST system has been temporarily closed in accordance with rule 135.15(455B) and a certification of temporary closure has been submitted to the department.

5. If the UST system has been removed or filled in place within the last 12 months, the date of removal or filling in place and whether a closure report has been submitted as provided in rule 135.15(455B).

(2) Sites with provisional status. If the UST system has been classified as operating under provisional status as provided in paragraph 135.3(8)“c,” owners and operators when applying for annual tank tags pursuant to subrule 135.3(5) must certify on a form prepared by the department that the owners and operators are in compliance with an approved provisional status remedial plan as provided in paragraph 135.3(8)“c.”

(3) Compliance inspections. The department may initiate a delivery prohibition response action based on: (1) a finding resulting from a third-party compliance inspection conducted pursuant to rule 135.20(455B); (2) a department investigation and inspection conducted pursuant to Iowa Code section 455B.475; or (3) review of a UST system check or other documentation submitted in response to a suspected release under rule 135.6(455B) or in response to a confirmed release under rule 135.7(455B).

b. Delivery prohibition eligibility criteria. A delivery prohibition response action may be initiated upon a finding that the UST system is out of compliance with department rules and meets the eligibility criteria as specified below. Reinstatement criteria define the standards and process for owners and operators to document that they have taken corrective action sufficient to authorize resumption of fuel to the USTs. Prior to initiation of the delivery prohibition, owners and operators are afforded a minimum level of procedural due process such as prior notice and the opportunity to present facts to dispute the finding. Where notice and the opportunity to take corrective action prior to initiation of a delivery prohibition response action are required, notice by the department or by a certified compliance inspector as provided in rule 135.20(455B) shall be sufficient.

If the department finds that any one of the following criteria has been satisfied, the department may initiate a delivery prohibition response action following the notice procedures outlined in paragraph “e” of this subrule. After initiation of the delivery prohibition response action, the department will offer the owner or operator an opportunity to establish reinstatement criteria by written documentation and, if requested, an in-person meeting.

(1) An approved release detection method for USTs or UST piping is not installed, such as automatic tank gauging, groundwater monitoring wells and line leak detectors, and there is no record that an approved method such as inventory control, statistical inventory reconciliation, or interstitial space monitoring has been employed during the previous three months. If the owner or operator claims to have documentation that an approved release detection method has been conducted, the owner or operator will be given two business days to produce the documentation.

REINSTATEMENT CRITERIA: The owner or operator must submit results of a passing UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4)“c” and 135.5(5)“b.” The owner or operator must also document installation and operation of an approved release detection system. This may include proof that a contract has been signed with a qualified statistical inventory reconciliation provider or that a qualified inventory control method has been implemented and training has been provided to onsite supervisory personnel.

(2) No documentation of a required annual line tightness test or line leak detector test has been provided, and the owner or operator has failed to conduct the required testing within 14 days of written notice by the department or a certified compliance inspector as provided in rule 135.20(455B).

REINSTATEMENT CRITERIA: The owner or operator must provide documentation of a passing line precision tightness test at the 0.1 gallon-per-hour leak rate in paragraph 135.5(5)“b” and a line leak detector test as provided in paragraph 135.5(5)“a.”

(3) Overfill and spill protection is not installed.

REINSTATEMENT CRITERION: The owner or operator must provide documentation that overfill and spill protection equipment has been installed.

(4) A corrosion protection system is not installed or there is no record that an impressed current corrosion protection system has been in operation for the prior six months.

REINSTATEMENT CRITERIA: A manned entry tank integrity inspection must be completed prior to installation of a corrosion protection system, and the owner or operator must submit results of a passing

UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4) “c” and 135.5(5) “b.” A corrosion protection analysis must be completed and approved by the department.

(5) The owner or operator has failed to provide proof of financial responsibility in accordance with 567—Chapter 136.

REINSTATEMENT CRITERION: The owner or operator must submit acceptable proof of financial responsibility in accordance with 567—Chapter 136.

(6) A qualified UST system release detection method is installed and is being used but the documentation or the absence of documentation is sufficient to question the reliability of the release detection over the past 12-month period. The owner or operator shall be notified of the deficiencies, shall be given at least two business days to produce documentation of compliance and, if necessary, shall be required to conduct a leak detection system analysis and a system tightness test within 14 days. If the owner or operator fails to produce documentation of compliance or to conduct the system analysis and the UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4) “c” and 135.5(5) “b,” the department may initiate a delivery prohibition response action. Notice by the department or a compliance inspector as provided in rule 135.20(455B) shall be sufficient to initiate a delivery prohibition response action.

REINSTATEMENT CRITERIA: The owner or operator must submit documentation that the leak detection method analysis sufficiently documents compliance and explains the reasons for the accuracy and reliability concerns. If necessary, the owner or operator must submit passing results of a UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4) “c” and 135.5(5) “b.”

(7) The owner or operator has failed to document completion of a three-year corrosion protection test or to repair defective corrosion protection equipment within 30 days after notice of the violation by the department or a certified compliance inspector as provided in rule 135.20(455B).

REINSTATEMENT CRITERION: The owner or operator must submit documentation of a three-year corrosion protection test as provided in rule 135.3(455B).

(8) The owner or operator has failed to complete a compliance inspection required by rule 135.20(455B) within 60 days after written notice of the violation by the department.

REINSTATEMENT CRITERION: The owner or operator must submit a compliance inspection report as provided in rule 135.20(455B).

(9) The owner or operator has failed to take necessary abatement action in response to a confirmed release as provided in subrules 135.7(2) and 135.7(3).

REINSTATEMENT CRITERION: The owner or operator must document compliance with the abatement provisions in subrules 135.7(2) and 135.7(3).

(10) The owner or operator has failed to undertake and document release investigation and confirmation steps within seven days in response to a suspected release as provided in paragraph 135.6(3) “a.”

REINSTATEMENT CRITERION: The owner or operator must document release confirmation and system check as provided in paragraph 135.6(3) “a.”

c. Provisional status. The department may classify a UST system as operating under a provisional status when the department documents a pattern of UST operation and maintenance violations under rules 135.3(455B) through 135.5(455B) and suspected release and confirmed release response actions under rules 135.6(455B) and 135.7(455B). The department shall provide the owner or operator with a notice specifying the basis for the proposed classification and a proposed remedial action plan. The objective of the remedial action plan is to provide the owner and operator an opportunity to undertake certain remedial actions sufficient to establish a reasonable likelihood that future regulatory compliance will be achieved.

The remedial action plan may include but is not limited to provisions for owner/operator training, development of a facility-specific compliance manual, more frequent third-party compliance inspections than otherwise required under rule 135.20(455B), monthly reporting, and retention of a third-party compliance manager/consultant. If the owner or operator and the department cannot reach agreement on a remedial action plan, the department may initiate enforcement action by issuance of an administrative

order pursuant to 567—Chapter 10. This provision does not grant the owner or operator an entitlement to this procedure, and the department reserves all discretion to undertake an enforcement action and assess penalties as provided in Iowa Code sections 455B.476 and 455B.477.

d. Administrative orders. The department may impose a delivery prohibition as a remedy for violations of the operation and maintenance provisions in rules 135.3(455B) through 135.5(455B) and the suspected and confirmed release response actions in rules 135.6(455B) and 135.7(455B). This remedy may be in addition to the assessment of penalties as provided in Iowa Code section 455B.476 and other appropriate injunctive relief necessary to correct violations.

e. Due process prior to initiation of a delivery prohibition response action.

(1) Prior to imposing a delivery prohibition response action under paragraph 135.3(8) “b” above, the department will provide notice to the owner or operator or, if notice to the owner or operator cannot be confirmed, to a person in charge at the UST facility of the basis for the finding and the intent to initiate a delivery prohibition response action. Notice may be by verbal contact, by facsimile, or by regular or certified mail to the UST facility address or the owner’s or operator’s last-known address. The owner and operator will be given a minimum of one business day to provide documentation that the finding is inaccurate or that reinstatement criteria in subparagraphs 135.3(8) “b”(1) through (5) have been satisfied. Additional days and the opportunity for a telephone or in-person conference may be provided the owner and operator to contest the factual basis for a finding under subparagraphs 135.3(8) “b”(6) through (10). Additional procedural due process may be afforded the owner and operator on a case-by-case basis sufficient to satisfy Constitutional due process standards.

If insufficient information is submitted to change the finding, the department will notify the owner or operator and a person in charge at the UST facility of the final decision to impose the delivery prohibition response action.

(2) Provisional status. Upon a finding that an owner or operator under provisional status has failed to comply with the terms of a remedial action plan as provided above, the department may initiate a delivery prohibition response action by giving actual notice to the owner or operator of the basis for the finding of noncompliance and the department’s intent to initiate a delivery prohibition response action. The delivery prohibition response action shall not be imposed without providing the owner or operator the opportunity for an evidentiary hearing consistent with the provisions for suspension and revocation of licenses under 567—Chapter 7.

f. Delivery prohibition procedure. Upon oral or written notice that the delivery prohibition response action has been imposed, the owner or operator and any person in charge of the UST facility shall be notified that they are not authorized to receive any further delivery of regulated substances until conditions for reinstatement of eligibility are satisfied. Owners and operators are required to immediately remove and return to the department the current annual tank management fee tags or the tank registration tags if there are no tank management fee tags. Owners and operators are required to provide the department with names and contact information for all persons who convey or deposit regulated substances to the USTs. The department will attempt to notify known persons who convey or deposit regulated substances to the USTs that they are not authorized to deliver to the USTs until further notice by the department as provided in paragraph 135.3(3) “j” and subrule 135.3(5).

If the tank tags are not returned within three business days, the department shall visit the site, remove the tags, and affix a “red tag” to the fill pipes or fill pipe caps of all affected USTs. It is unlawful for any person to deposit or accept a regulated substance into a UST that has a “red tag” affixed to the fill pipe or fill pipe cap. The department may allow the owner and operator to dispense and sell the remainder of existing fuel unless the department determines there is an immediate risk of a release or other risk to human health, safety or the environment. The department shall confirm in writing the basis for the delivery prohibition response action, contacts made prior to the action, and steps the owner or operator must take to reinstate fuel delivery.

135.3(9) Secondary containment requirements for new and replacement UST system installations. All new and replacement underground storage tank systems and appurtenances used for the storage and dispensing of petroleum products installed after November 28, 2007, shall have secondary containment in accordance with this subrule. The secondary containment provision includes

the installation of turbine sumps, transition or intermediate sumps and under-dispenser containment (UDC).

a. The secondary containment may be manufactured as an integral part of the primary containment or constructed as a separate containment system.

b. Installation of any new or replacement turbine pumps involving the direct connection to the tank shall have secondary containment.

c. Any replacement of ten feet or more of piping shall have secondary containment.

d. All piping replacements requiring secondary containment shall be constructed with transition or intermediate containment sumps.

e. The design and construction of all primary and secondary containment shall meet the performance standards in subrule 135.3(1) and paragraphs 135.5(3)“*b*” and 135.5(4)“*g*.” At a minimum, the secondary containment must:

(1) Contain regulated substances released from the tank system until detected and removed;

(2) Prevent the release of regulated substances into the environment at any time during the operational life of the underground storage tank system; and

(3) Be checked for evidence of a release at least every 30 days as provided in paragraph 135.5(2)“*a*.”

f. Secondary containment with interstitial monitoring in accordance with paragraphs 135.5(3)“*b*,”135.5(4)“*g*” and 135.5(5)“*d*” shall become the primary method of leak detection for all new and replacement tanks and piping installed after November 28, 2007.

g. Testing and inspection. Secondary containment systems shall be liquid-tight and must be inspected and tested every two years. The sensing devices must be tested every two years.

(1) Inspections for secondary containment sumps (spill catchment basins, turbine sumps, transition or intermediate sumps, and under-dispenser containment) shall:

1. Consist of a visual inspection by an Iowa-licensed installer or Iowa-certified inspector every two years. Sumps must be intact (no cracks or perforations) and liquid-tight, including sides and bottom.

2. Sumps must be maintained and kept free of debris, liquid and ice at all times.

3. Regulated substances spilled into any spill catchment basin, turbine sump, transition/intermediate sump or under-dispenser containment shall be immediately removed.

(2) Sensing devices used to monitor the interstitial space shall be tested at least every two years for proper function.

h. Under-dispenser containment. When installing a new motor fuel dispenser or replacing a motor fuel dispenser, a UDC shall be installed whenever:

(1) A motor fuel dispenser is installed at a location where there previously was no dispenser (new UST system or new dispenser location at an existing UST system); or

(2) An existing motor fuel dispenser is removed and replaced with another dispenser and the equipment used to connect the dispenser to the underground storage tank system is replaced. This equipment includes flexible connectors or risers or other transitional components that are beneath the dispenser and connect the dispenser to the piping. A UDC is not required when only the emergency shutoff or shear valves or check valves are replaced.

(3) A UDC shall also be installed beneath the motor fuel dispenser whenever ten feet or more of piping is repaired or replaced within ten feet of a motor fuel dispenser.

i. Exceptions from secondary containment standards. A tank owner or operator may request an exception from the secondary containment standard if the location of the UST system is greater than 1,000 feet from a community water system or potable drinking water well. A community water system includes the distribution piping.

(1) “Community water system (CWS)” means a public water system which has at least 15 service connections used by year-round residents or regularly serves at least 25 year-round residents. “Public water supply system” means a system for the provision to the public of water for human consumption through pipes or other constructed conveyances, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year. Such term includes: any collection, treatment, storage, and distribution facilities under control of the operator of

such system and used primarily in connection with such system; and any collection or pretreatment storage facilities not under such control which are used primarily in connection with such system. Such term does not include any “special irrigation district.” A “public water supply system” is either a “community water system” or a “noncommunity water system.”

(2) “Potable drinking water well” means any hole (dug, driven, drilled, or bored) that extends into the earth until it meets groundwater and that supplies water for a noncommunity public water system or supplies water for household use (consisting of drinking, bathing, and cooking or other similar uses). Such wells may provide water to entities such as a single-family residence, a group of residences, businesses, schools, parks, campgrounds, and other permanent or seasonal communities. A “noncommunity water system” is defined in rule 567—40.2(455B) as a public water system that is not a community water system. A “noncommunity water system” is either a “transient noncommunity water system (TNC)” or a “nontransient noncommunity water system (NTNC).”

(3) To determine if a new or replacement underground storage tank, piping, or motor fuel dispenser system is within 1,000 feet of an existing community water system or an existing potable drinking water well, at a minimum the distance must be measured from the closest part of the new or replacement underground storage tank or piping or the motor fuel dispenser system to:

1. The closest part of the nearest existing community water system, including:

- The location of the wellhead(s) for groundwater and the location of the intake point(s) for surface water;

- Water lines, processing tanks, and water storage tanks; and

- Water distribution/service lines under the control of the community water system operator.

2. The wellhead of the nearest existing potable drinking water well.

(4) If a new or replacement underground storage tank, piping, or motor fuel dispenser that is not within 1,000 feet of an existing community water system will be installed, and a community water system that will be within 1,000 feet of the UST system is planned or a permit application has been submitted to the department under 567—Chapter 40, secondary containment and under-dispenser containment are required unless the permit is denied.

(5) If a new or replacement underground storage tank, piping, or motor fuel dispenser that is not within 1,000 feet of an existing potable drinking water well will be installed and the owner will be installing a potable drinking water well at the new facility, or a private water well permit has been submitted pursuant to 567—Chapter 38 and pursuant to applicable county and municipal ordinances for a potable drinking water well that will be within 1,000 feet of the UST system, secondary containment and under-dispenser containment are required unless the permit is denied.

j. Documentation for exception from secondary containment. The following documentation must be provided by the tank owner or operator when requesting an exception from the UST system secondary containment requirement.

(1) A statement from the manager of the local community water system that the community water system is not located or planned within 1,000 feet of the UST system location. This would include rural water systems.

(2) A map showing homes and businesses within 1,000 feet of the UST system location.

(3) Identification of the source of water for the business at the UST system location.

(4) The results of an on-foot search around businesses and homes within a 1,000-foot radius for possible potable drinking water wells. Documentation that there are no pending nonpublic water well permit applications within 1,000 feet of the UST system from any applicable municipal permitting authority, county department of health with department-delegated authority, or the department if there is not delegated permitting authority.

(5) Search results from the Geographic Information System (GIS) well mapping for well locations available from the Iowa Geological Survey.

(6) Documentation that the department’s water supply section has no pending applications for a public water supply construction permit within 1,000 feet of a proposed UST system installation or replacement or motor fuel dispenser installation or replacement.

567—135.4(455B) General operating requirements.**135.4(1) Spill and overfill control.**

a. Owners and operators must ensure that releases due to spilling or overfilling do not occur. The owner and operator must ensure that the volume available in the tank is greater than the volume of product to be transferred to the tank before the transfer is made and that the transfer operation is monitored constantly to prevent overfilling and spilling.

NOTE: The transfer procedures described in National Fire Protection Association Publication 385 may be used to comply with 135.4(1) “*a.*” Further guidance on spill and overfill prevention appears in American Petroleum Institute Publication 1621, “Recommended Practice for Bulk Liquid Stock Control at Retail Outlets,” and National Fire Protection Association Standard 30, “Flammable and Combustible Liquids Code.”

b. The owner and operator must report, investigate, and clean up any spills and overfills in accordance with 135.6(4).

135.4(2) Operation and maintenance of corrosion protection. All owners and operators of steel UST systems with corrosion protection must comply with the following requirements to ensure that releases due to corrosion are prevented for as long as the UST system is used to store regulated substances:

a. All corrosion protection systems must be operated and maintained to continuously provide corrosion protection to the metal components of that portion of the tank and piping that routinely contain regulated substances and are in contact with the ground.

b. All UST systems equipped with cathodic protection systems must be inspected for proper operation by a qualified cathodic protection tester in accordance with the following requirements:

(1) *Frequency.* All cathodic protection systems must be tested within six months of installation and at least every three years thereafter or according to another reasonable time frame established by the department; and

(2) *Inspection criteria.* The criteria that are used to determine that cathodic protection is adequate as required by this subrule must be in accordance with a code of practice developed by a nationally recognized association.

NOTE: National Association of Corrosion Engineers Standard RP-02-85, “Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems,” may be used to comply with 135.4(2) “*b*”(2).

c. UST systems with impressed current cathodic protection systems must also be inspected every 60 days to ensure the equipment is running properly.

d. For UST systems using cathodic protection, records of the operation of the cathodic protection must be maintained (in accordance with 135.4(5)) to demonstrate compliance with the performance standards in this subrule. These records must provide the following:

(1) The results of the last three inspections required in paragraph “*c*”; and

(2) The results of testing from the last two inspections required in paragraph “*b*.”

135.4(3) Compatibility. Owners and operators must use a UST system made of or lined with materials that are compatible with the substance stored in the UST system.

NOTE: Owners and operators storing alcohol blends may use the following codes to comply with the requirements of subrule 135.4(3): American Petroleum Institute Publication 1626, “Storing and Handling Ethanol and Gasoline-Ethanol Blends at Distribution Terminals and Service Stations”; and American Petroleum Institute Publication 1627, “Storage and Handling of Gasoline-Methanol/Cosolvent Blends at Distribution Terminals and Service Stations.”

135.4(4) Repairs allowed. Owners and operators of UST systems must ensure that repairs will prevent releases due to structural failure or corrosion as long as the UST system is used to store regulated substances. The repairs must meet the following requirements:

a. Repairs to UST systems must be properly conducted in accordance with a code of practice developed by a nationally recognized association or an independent testing laboratory.

NOTE: The following codes and standards may be used to comply with 135.4(4) “*a*”: National Fire Protection Association Standard 30, “Flammable and Combustible Liquids Code”; American Petroleum Institute Publication 2200, “Repairing Crude Oil, Liquefied Petroleum Gas, and Product Pipelines”;

American Petroleum Institute Publication 1631, "Recommended Practice for the Interior Lining of Existing Steel Underground Storage Tanks"; and National Leak Prevention Association Standard 631, "Spill Prevention, Minimum 10 Year Life Extension of Existing Steel Underground Tanks by Lining Without the Addition of Cathodic Protection."

b. Repairs to fiberglass-reinforced plastic tanks may be made by the manufacturer's authorized representatives or in accordance with a code of practice developed by a nationally recognized association or an independent testing laboratory.

c. Metal pipe sections and fittings that have released product as a result of corrosion or other damage must be replaced. Fiberglass pipes and fittings may be repaired in accordance with the manufacturer's specifications.

d. Repaired tanks and piping must be tightness tested in accordance with 135.5(4)"*c*" and 135.5(5)"*b*" within 30 days following the date of the completion of the repair except as provided in subparagraphs (1) to (3) below:

(1) The repaired tank is internally inspected in accordance with a code of practice developed by a nationally recognized association or an independent testing laboratory; or

(2) The repaired portion of the UST system is monitored monthly for releases in accordance with a method specified in 135.5(4)"*d*" through "*h*"; or

(3) Another test method is used that is determined by the department to be no less protective of human health and the environment than those listed above.

e. Within six months following the repair of any cathodically protected UST system, the cathodic protection system must be tested in accordance with 135.4(2)"*b*" and "*c*" to ensure that it is operating properly.

f. UST system owners and operators must maintain records of each repair for the remaining operating life of the UST system that demonstrate compliance with the requirements of this subrule.

135.4(5) Reporting and record keeping. Owners and operators of UST systems must cooperate fully with inspections, monitoring and testing conducted by the department, as well as requests for document submission, testing, and monitoring by the owner or operator pursuant to Section 9005 of Subtitle I of the Resource Conservation and Recovery Act, as amended.

a. Reporting. Owners and operators must submit the following information to the department:

(1) Notification for all UST systems (135.3(3)), which includes certification of installation for new UST systems (135.3(1)"*e*");

(2) Reports of all releases including suspected releases (135.6(1)), spills and overfills (135.6(4)), and confirmed releases (135.7(2));

(3) Corrective actions planned or taken including initial abatement measures (135.7(3)), initial site characterization (135.9(455B)), free product removal (135.7(5)), investigation of soil and groundwater cleanup and corrective action plan (135.8(455B) to 135.12(455B)); and

(4) A notification before permanent closure or change-in-service (135.15(2)).

b. Record keeping. Owners and operators must maintain the following information:

(1) A corrosion expert's analysis of site corrosion potential if corrosion protection equipment is not used (135.3(1)"*a*"(4); (135.3(1)"*b*"(3)).

(2) Documentation of operation of corrosion protection equipment (135.4(2));

(3) Documentation of UST system repairs (135.4(4)"*f*");

(4) Recent compliance with release detection requirements (135.5(6)); and

(5) Results of the site investigation conducted at permanent closure (135.15(5)).

c. Availability and maintenance of records. Owners and operators must keep the records required either:

(1) At the UST site and immediately available for inspection by the department; or

(2) At a readily available alternative site and be provided for inspection to the department upon request.

NOTE: In the case of permanent closure records required under 135.15(5), owners and operators are also provided with the additional alternative of mailing closure records to the department if they cannot be kept at the site or an alternative site as indicated above.

135.4(6) *Training required for UST operators.*

a. An owner or operator shall designate Class A, Class B, and Class C operators for each underground storage tank system or facility that has underground storage tanks regulated by the department, except for unstaffed facilities, which may designate only Class A and Class B operators.

b. A facility may not operate after December 31, 2011, unless operators have been designated and trained as required in this rule, or unless otherwise agreed upon by the department based on a finding of good cause for failure to meet this requirement and a plan for designation and training at the earliest practicable date.

c. Trained operators must be readily available to respond to suspected or confirmed releases, equipment shut-offs or failures, and other unusual operating conditions.

d. A Class A or Class B operator should be immediately available for telephone consultation with the Class C operator when a facility is in operation. Class A or Class B operators should be able to be on site at the storage tank facility within four hours.

e. For staffed facilities, a Class C operator must be on site whenever the UST facility is in operation.

f. For unstaffed facilities, a Class B operator must be geographically located such that the person can be on site within two hours of being contacted by the public, the owner or operator of the facility, or the department. Emergency contact information and emergency procedures must be prominently displayed at the site. An unstaffed facility shall have an emergency shutoff device as provided in 135.5(1) and a sign posted in a conspicuous place that includes the name and telephone number of the facility owner, an emergency response telephone number to contact the Class B operator, and information on local emergency responders.

g. Designated operators must successfully complete required training under subrule 135.4(9) no later than December 31, 2011.

h. A person may be designated for more than one class of operator.

i. When a facility is found to be out of compliance, the department may require the owner and operator to retrain the designated UST system Class A, B, or C operator under a plan approved by the department. The retraining must occur within 60 days from departmental notice for Class A and Class B operators and within 15 days for Class C operators.

135.4(7) *UST operator responsibilities.**a. Class A operator.*

(1) Class A operators have the primary responsibility to operate and maintain the underground storage tank system and facility. The Class A operator's responsibilities include managing resources and personnel to achieve and maintain compliance with regulatory requirements under this chapter in the following ways:

1. Class A operators assist the owner by ensuring that underground storage tank systems are properly installed and expeditiously repaired and inspected; financial responsibility is maintained; and records of system installation, modification, inspection and repair are retained and made available to the department and licensed compliance inspectors. The Class A operator shall properly respond to and report emergencies caused by releases or spills from UST systems, ensure that the annual tank management fees are paid, and ensure that Class B and Class C operators are properly trained.

2. Class A operators shall be familiar with training requirements for each class of operator and may provide required training for Class C operators.

3. Class A operators shall provide site drawings that indicate equipment locations for Class B and Class C operators.

(2) Department-licensed installers, installation inspectors, and compliance inspectors may perform Class A operator duties when employed or contracted by the tank owner to perform these functions so long as they are properly trained and designated as Class A operators pursuant to subrules 135.4(9) through 135.4(11). Class A operators who are also licensed compliance inspectors under 567—Chapter 134, Part C, may perform in-house facility inspections of the UST system, but shall not perform department-mandated compliance inspections pursuant to rule 567—135.20(455B). Compliance

inspections of a UST facility required by rule 567—135.20(455B) must be completed by a third-party compliance inspector licensed under 567—Chapter 134, Part B.

(3) When there is a change in ownership or operator status, the new owner or operator is responsible for designating a Class A operator prior to bringing the UST system into operation. The Class A operator is responsible for ensuring that all necessary documentation for change of ownership is completed and submitted to the department and that all compliance requirements of this chapter are satisfied prior to bringing the UST system into operation. The compliance requirements may be provided to the owner or operator using the department's checklist.

If the UST system was temporarily closed, the designated Class A operator must ensure the department's checklist for returning a UST into service is followed, all compliance requirements of this chapter have been met, and the necessary documentation is submitted to the department.

(4) When there is a change in UST ownership, property ownership or operator status, the designated Class A operator for the current owner and operator is responsible for notifying the department when the change is final and, if possible, prior to the new owner or operator taking possession of the site.

b. Class B operator.

(1) A Class B operator implements applicable underground storage tank regulatory requirements and standards in the field or at the tank facility. A Class B operator oversees and implements the day-to-day aspects of operation, maintenance, and record keeping for the underground storage tanks at facilities within four hours of travel time from the Class B operator's principal place of business. A Class B operator's responsibilities include, but are not limited to:

1. Performing mandated system tests at required intervals and making sure spill prevention, overfill control equipment, and corrosion protection equipment are properly functioning.

2. Assisting the owner by ensuring that release detection equipment is operational, release detection monitoring and tests are performed at the proper intervals, and release detection records are retained and made available to the department and compliance inspectors.

3. Making sure record-keeping and reporting requirements are met and that relevant equipment manufacturers' or third-party performance standards are available and followed.

4. Properly responding to, investigating, and reporting emergencies caused by releases or spills from USTs.

5. Performing UST release detection in accordance with rule 567—135.5(455B).

6. Monitoring the status of UST release detection.

7. Meeting spill prevention, overfill prevention, and corrosion protection requirements.

8. Reporting suspected and confirmed releases and taking release prevention and response actions according to the requirements of rule 567—135.6(455B).

9. Training and documenting Class C operators to make sure at least one Class C operator is on site during operating hours. Class B operators shall be familiar with Class C operator responsibilities and may provide required training for Class C operators.

(2) Department-licensed installers, installation inspectors, and compliance inspectors may perform Class B operator duties when employed or contracted by the tank owner to perform these functions so long as they are properly trained and designated as Class B operators under subrules 135.4(9) through 135.4(11). Class B operators who are also licensed compliance inspectors under 567—Chapter 134, Part C, may perform in-house facility inspections of the UST system, but cannot perform department-mandated compliance inspections pursuant to rule 567—135.20(455B). Compliance inspections of a UST facility pursuant to rule 567—135.20(455B) must be completed by a third-party compliance inspector licensed under 567—Chapter 134, Part B.

(3) The owner or operator of a site undergoing a change in ownership shall designate a Class B operator prior to bringing the UST system into operation. The Class B operator must conduct an inspection using the department's inspection checklist and submit the completed checklist along with the change of ownership form prior to operation. If a UST system was temporarily closed, the Class B operator shall ensure that the department's checklist for returning a UST to service is followed and that the necessary documentation is submitted to the department prior to operation of the UST system.

c. Class C operator. A Class C operator is an on-site employee who typically controls or monitors the dispensing or sale of regulated substances and is the first to respond to events indicating emergency conditions. A Class C operator must be present at the facility at all times during normal operating hours. A Class C operator monitors product transfer operations to ensure that spills and overfills do not occur. The Class C operator must know how to properly respond to spills, overfills and alarms when they do occur. In the event of a spill, overfill or alarm, a Class C operator shall notify the Class A and Class B operators, as well as the department and appropriate local emergency authorities as required by rule.

(1) Within six months after October 14, 2009, written basic operating instructions, emergency contact names and telephone numbers, and basic procedures specific to the facility shall be provided to all Class C operators and readily available on site.

(2) There may be more than one Class C operator at a storage tank facility, but not all employees of a facility need be Class C operators.

135.4(8) UST operator training course requirements. Individuals must attend a department-approved training course covering material designated for each operator class. Individuals must attend every session of the training, take the examination, and attend examination review.

a. Class A operators. To be certified as a Class A operator, the applicant must successfully complete a department-approved training course that covers underground storage tank system requirements as outlined in 567—Chapters 134 to 136. The course must also provide a general overview of the department's UST program, purpose, groundwater protection goals, public safety and administrative requirements. The training must include, but is not limited to, the following:

(1) Components and materials of underground storage tank systems.

(2) A general discussion of the content of PEI/RP900-08, Recommended Practices for the Inspection and Maintenance of UST Systems, and PEI/RP500, Recommended Practices for Inspection and Maintenance of Motor Fuel Dispensing Equipment.

(3) Spill and overfill prevention, to include the American Petroleum Institute (API) Publication RP1621, "Recommended Practice for Bulk Liquid Stock Control at Retail Outlets," and National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code."

(4) Ensuring product delivery to the correct tank by using color-symbol codes in the API Standard RP1637, "Using the API Color-Symbol System to Mark Equipment and Vehicles for Product Identification at Service Stations and Distribution Terminals."

(5) Proper fuel ordering and delivery, including procedures in API RP1007, "Loading and Unloading of MC/DOT 406 Cargo Tank Motor Vehicles."

(6) Release detection methods and related reporting requirements.

(7) Corrosion protection and inspection requirements, including the requirement to have a department-licensed cathodic protection tester.

(8) Discussion of the benefits of monthly or frequent inspections and content and use of inspection checklists. Training materials for operators shall include the department's "Iowa UST Operator Inspection Checklist" or a checklist template similar to the department's document.

(9) Requirement and content of third-party compliance inspections.

(10) How to properly respond to an emergency, including hazardous conditions.

(11) Product and equipment compatibility, including the department's ethanol compatibility guidance and certification.

(12) Financial responsibility, including detailed explanation of liability, notice and claim procedures, and the six-month window to check for and report a release prior to insurance termination to maintain coverage for corrective action.

(13) Notification of installation and storage tank registration requirements.

(14) Requirement to use department-licensed companies and individuals for UST installation, testing, lining, and removal.

(15) Temporary and permanent closure procedures and requirements.

(16) NESHAP vapor recovery requirements.

(17) Conditions under which the department may stop fuel delivery and take enforcement action.

(18) Ensuring that annual tank management fees are paid.

(19) Ensuring that suspected and confirmed releases are investigated and reported according to subrule 135.6(1).

b. Class B operators. To be certified as a Class B operator, the individual must successfully complete a department-approved training course that provides in-depth understanding of UST system regulations applicable to this class. Training must also provide a general overview of the department's UST program, purpose, groundwater protection goals, public safety and administrative requirements. Training shall cover the operation and maintenance requirements set forth in this chapter, including, but not limited to, the following:

(1) A general discussion of the content of PEI/RP900-08, Recommended Practices for the Inspection and Maintenance of UST Systems, and PEI/RP500, Recommended Practices for Inspection and Maintenance of Motor Fuel Dispensing Equipment.

(2) Components and materials of underground storage tank systems.

(3) Spill and overfill prevention.

(4) Ensuring product delivery to the correct tank by using color-symbol codes in the API Standard RP1637.

(5) Proper fuel ordering and delivery, including procedures from API RP1007.

(6) Methods of release detection and related reporting requirements.

(7) Corrosion protection and related testing.

(8) Discussion of the benefits of monthly or frequent inspections and content and use of inspection checklists. Training materials for operators shall include the department's "Iowa UST Operator Inspection Checklist" or a checklist template similar to the department's document.

(9) Requirement and content of third-party compliance inspections.

(10) Emergency response, reporting and investigating releases.

(11) Product and equipment compatibility, including the department's ethanol compatibility guidance and certification.

(12) Financial responsibility, including detailed explanation of liability, notice and claim procedures, and the six-month window to check for and report a release prior to insurance termination to maintain coverage for corrective action.

(13) Notification of installation and storage tank registration requirements.

(14) Requirement to use department-licensed companies and individuals for UST installation, testing, lining, and removal.

(15) Reporting and record-keeping requirements.

(16) Overview of Class C operator training requirements.

(17) NESHAP vapor recovery requirements.

(18) Conditions under which the department may stop fuel delivery and take enforcement action.

c. Class C operators. To be certified as a Class C operator, an individual must complete a department-approved training course that covers, at a minimum, a general overview of the department's UST program and purpose; groundwater protection goals; public safety and administrative requirements; and action to be taken in response to an emergency condition due to a spill or release from a UST system. Training must include written procedures for the Class C operator, including notification instructions necessary in the event of emergency conditions. The written instructions and procedures must be readily available on site. A Class A or Class B operator may provide Class C training.

135.4(9) Examination and review requirement. Class A and Class B operators must complete the department-approved training course and take an examination to verify their understanding and knowledge. The examination may include both written and practical (hands-on) testing activities. The trainer must follow up the examination with a review of missed test questions with the class or individual to ensure understanding of problem areas. Upon successful completion of the training course, the applicant will receive a certificate verifying the applicant's status as a Class A, Class B, or Class C operator.

a. Reciprocity. The department may waive the training course for operators upon a showing of successful completion of a training course and examination approved by another state or regulatory

agency that the department determines are substantially equivalent to the UST requirements contained in this chapter.

b. Transferability to another UST site. Class A and Class B operators may transfer to other UST facilities in Iowa provided the operator is properly designated by the facility owner as a Class A or Class B operator according to 567—subrule 134.4(13). Class A and Class B operators transferring from other states shall seek prior approval of training qualifications, unless the department has preapproved the out-of-state program as substantially equivalent to the requirements of this chapter.

135.4(10) Timing of UST operator training.

a. An owner shall ensure that Class A, Class B, and Class C operators are trained as soon as practicable after October 14, 2009, contingent upon availability of approved training providers, but not later than December 31, 2011, except as provided in paragraph 135.4(6) “b.”

b. When a Class A or Class B operator is replaced, a new operator must be trained prior to assuming duties for that class of operator.

c. Class C operators must be trained before assuming the duties of a Class C operator. Within six months after October 14, 2009, written basic operating instructions, emergency contact names and telephone numbers, and basic procedures specific to the facility shall be provided to all Class C operators and readily available on site. A Class C operator may be briefed on these procedures concurrent with annual safety training required under Occupational Safety and Health Administration regulations, 29 CFR, Part 1910.

135.4(11) Documentation of operator training.

a. The owner of an underground storage tank facility shall maintain a list of designated operators. The list shall be made available to the department in accordance with subrule 135.4(5). The list shall represent the current Class A, Class B and Class C operators for the UST facility and must include:

(1) The name of each operator and the operator’s class(es); contact information for Class A and Class B operators; the date each operator successfully completed initial training and refresher training, if any; the name of the company providing the training; and the name of the trainer.

(2) For all classes of operators, the site(s) for which an operator is responsible if more than one site.

b. A copy of the certificates of training for Class A and Class B operators shall be on file and readily available for inspection in accordance with subrule 135.4(5).

c. A copy of the certificates of training for Class B and Class C operators shall be available at each facility for which the operator is responsible.

d. Class A and Class B operator contact information, including names and telephone numbers and any emergency information, shall be conspicuously posted at unstaffed facilities near the dispensers and the station building.

[ARC 8124B, IAB 9/9/09, effective 10/14/09]

567—135.5(455B) Release detection.

135.5(1) General requirements for all UST systems.

a. Owners and operators of new and existing UST systems must provide a method, or combination of methods, of release detection that:

(1) Can detect a release from any portion of the tank and the connected underground piping that routinely contains product;

(2) Is installed, calibrated, operated, and maintained in accordance with the manufacturer’s instructions, including routine maintenance and service checks for operability or running condition; and

(3) Meets the performance requirements in 135.5(4) or 135.5(5), with any performance claims and their manner of determination described in writing by the equipment manufacturer or installer. In addition, methods conducted in accordance with 135.5(4) “b,” “c,” and “d” and 135.5(5) “b” after December 22, 1990, and 135.5(5) “a” after September 22, 1991, except for methods permanently installed prior to those dates, must be capable of detecting the leak rate or quantity specified for that method with a probability of detection of 0.95 and a probability of false alarm of 0.05.

b. When a release detection method operated in accordance with the performance standards in 135.5(4) and 135.5(5) indicates a release may have occurred, owners and operators must notify the department in accordance with rule 135.6(455B).

c. Owners and operators of all UST systems must comply with the release detection requirements of this rule by December 22 of the year listed in the following table:

Year System Was Installed	Scheduled for Phase-in of Release Detection				
	Year When Release Detection is Required (by December 22 of the Year Indicated)				
	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>1992</u>	<u>1993</u>
Before 1965 or Date Unknown	RD	P			
1965-1969		P/RD			
1970-1974		P	RD		
1975-1979		P		RD	
1980-1988		P			RD
New Tanks	Immediately upon installation				

P = Must begin release detection for all pressurized piping in accordance with 135.5(2)“b”(1).
RD = Must begin release detection for tanks and suction piping in accordance with 135.5(2)“a,” 135.5(2)“b”(2), and 135.5(3).

d. Any existing UST system that cannot apply a method of release detection that complies with the requirements of this rule must complete the closure procedures in rule 135.15(455B) by the date on which release detection is required for that UST system under paragraph “c.”

e. UST systems using pressurized piping that operate with no on-site personnel shall comply with the following requirements:

(1) Whenever an in-line leak detector is installed or replaced, it must be capable of shutting down the submersible pump.

(2) Existing sites with an in-line leak detection system in place on February 17, 2010, may continue operation provided that, by January 1, 2013, either of the following UST system modifications is made:

1. An in-line leak detector capable of shutting off the submersible pump is installed; or

2. The UST system is equipped with a device that immediately alerts the Class B operator or designee when a leak is detected. The Class B operator or designee shall be on site within two hours of notification and shut down the submersible pump. The UST system cannot be returned to service until the problem that caused the release response is resolved.

3. A temporary extension of time to meet these upgrade requirements may be granted if it can be shown that there is no reasonable alternative fueling source in the vicinity or fueling is needed to satisfy emergency or public safety considerations. The request for temporary extension must include documentation and a plan for upgrading prior to January 1, 2013.

(3) At sites with secondary containment sumps and continuous automatic sump sensors for leak detection monitoring, the continuous automatic sump sensors must shut off product flow when a leak is detected. If it is determined that a malfunction of the leak detection system is the cause of the shutdown, the UST system must be immediately repaired but may continue to be operated while the repairs are made.

135.5(2) Requirements for petroleum UST systems. Owners and operators of petroleum UST systems must provide release detection for tanks and piping as follows:

a. *Tanks.* Tanks must be monitored at least every 30 days for releases using one of the methods listed in 135.5(4)“d” to “h” except that:

(1) UST systems that meet the performance standards in 135.3(1) or 135.3(2), and the monthly inventory control requirements in 135.5(4)“a” or “b,” may use tank tightness testing (conducted in

accordance with 135.5(4)“c”) at least every five years until December 22, 1998, or until ten years after the tank is installed or upgraded under 135.3(2)“b,” whichever is later;

(2) UST systems that do not meet the performance standards in 135.3(1) or 135.3(2) may use monthly inventory controls (conducted in accordance with 135.5(4)“a” or “b”) and annual tank tightness testing (conducted in accordance with 135.5(4)“c”) until December 22, 1998, when the tank must be upgraded under 135.3(2) or permanently closed under 135.15(2); and

(3) Tanks with capacity of 550 gallons or less may use weekly tank gauging (conducted in accordance with 135.5(4)“b”).

b. Piping. Underground piping that routinely contains regulated substances must be monitored for releases in a manner that meets one of the following requirements:

(1) *Pressurized piping.* Underground piping that conveys regulated substances under pressure must:

1. Be equipped with an automatic line leak detector conducted in accordance with 135.5(5)“a”; and
2. Have an annual line tightness test conducted in accordance with 135.5(5)“b” or have monthly monitoring conducted in accordance with 135.5(5)“c.”

(2) *Suction piping.* Underground piping that conveys regulated substances under suction must either have a line tightness test conducted at least every three years and in accordance with 135.5(5)“b,” or use a monthly monitoring method conducted in accordance with 135.5(5)“c.” No release detection is required for suction piping that is designed and constructed to meet the following standards:

1. The below-grade piping operates at less than atmospheric pressure;
2. The below-grade piping is sloped so that the contents of the pipe will drain back into the storage tank if the suction is released;
3. Only one check valve is included in each suction line;
4. The check valve is located directly below and as close as practical to the suction pump; and
5. A method is provided that allows compliance with “2” through “4” to be readily determined.

135.5(3) Requirements for hazardous substance UST systems. Owners and operators of hazardous substance UST systems must provide release detection that meets the following requirements:

a. Release detection at existing UST systems must meet the requirements for petroleum UST systems in 135.5(2). By December 22, 1998, all existing hazardous substance UST systems must meet the release detection requirements for new systems in paragraph “b” below.

b. Release detection at new hazardous substance UST systems must meet the following requirements:

- (1) Secondary containment systems must be designed, constructed and installed to:
 1. Contain regulated substances released from the tank system until they are detected and removed;
 2. Prevent the release of regulated substances to the environment at any time during the operational life of the UST system; and
 3. Be checked for evidence of a release at least every 30 days.

NOTE: The provisions of 40 CFR 265.193, Containment and Detection of Releases, as of September 13, 1988, may be used to comply with these requirements.

- (2) Double-walled tanks must be designed, constructed, and installed to:
 1. Contain a release from any portion of the inner tank within the outer wall; and
 2. Detect the failure of the inner wall.
- (3) External liners (including vaults) must be designed, constructed, and installed to:
 1. Contain 100 percent of the capacity of the largest tank within its boundary;
 2. Prevent the interference of precipitation or groundwater intrusion with the ability to contain or detect a release of regulated substances; and
 3. Surround the tank completely (i.e., it is capable of preventing lateral as well as vertical migration of regulated substances).

(4) Underground piping must be equipped with secondary containment that satisfies the requirements of 135.5(3)“b”(1) above (e.g., trench liners, jacketing of double-walled pipe). In addition,

underground piping that conveys regulated substances under pressure must be equipped with an automatic line leak detector in accordance with 135.5(5)“a”;

(5) Other methods of release detection may be used if owners and operators:

1. Demonstrate to the department that an alternate method can detect a release of the stored substance as effectively as any of the methods allowed in 135.5(4)“b” to “h” can detect a release of petroleum;

2. Provide information to the department on effective corrective action technologies, health risks, and chemical and physical properties of the stored substance, and the characteristics of the UST site; and

3. Obtain approval from the department to use the alternate release detection method before the installation and operation of the new UST system.

135.5(4) Methods of release detection for tanks. Each method of release detection for tanks used to meet the requirements of 135.5(2) must be conducted in accordance with the following:

a. Inventory control. Product inventory control (or another test of equivalent performance) must be conducted monthly to detect a release of at least 1.0 percent of flow-through plus 130 gallons on a monthly basis in the following manner:

(1) Inventory volume measurements for regulated substance inputs, withdrawals, and the amount still remaining in the tank are recorded each operating day;

(2) The equipment used is capable of measuring the level of product over the full range of the tank’s height to the nearest 1/8 of an inch;

(3) The regulated substance inputs are reconciled with delivery receipts by measurement of the tank inventory volume before and after delivery;

(4) Deliveries are made through a drop tube that extends to within 1 foot of the tank bottom;

(5) Product dispensing is metered and recorded within the local standards for meter calibration or an accuracy of 6 cubic inches for every 5 gallons of product withdrawn; and

(6) The measurement of any water level in the bottom of the tank is made to the nearest 1/8 of an inch at least once a month.

NOTE: Practices described in the American Petroleum Institute Publication 1621, “Recommended Practice for Bulk Liquid Stock Control at Retail Outlets,” may be used, where applicable, as guidance in meeting the requirements of subrule 135.5(4), paragraph “a,” subparagraphs (1) to (6).

b. Manual tank gauging. Manual tank gauging must meet the following requirements:

(1) Tank liquid level measurements are taken at the beginning and ending of a period of at least 36 hours during which no liquid is added to or removed from the tank;

(2) Level measurements are based on an average of two consecutive stick readings at both the beginning and ending of the period;

(3) The equipment used is capable of measuring the level of product over the full range of the tank’s height to the nearest 1/8 of an inch;

(4) A leak is suspected and subject to the requirements of rule 135.6(455B) if the variation between beginning and ending measurements exceeds the weekly or monthly standards in the following table:

Nominal Tank Capacity	Weekly Standard (one test)	Monthly Standard (average of four tests)
550 gallons or less	10 gallons	5 gallons
551-1,000 gallons	13 gallons	7 gallons
1,001-2,000 gallons	26 gallons	13 gallons

(5) Only tanks of 550 gallons or less nominal capacity may use this as the sole method of release detection. Tanks of 551 to 2000 gallons may use the method in place of manual inventory control in 135.5(4)“a.” Tanks of greater than 2000 gallons nominal capacity may not use this method to meet the requirements of this rule.

c. Tank tightness testing. Tank tightness testing (or another test of equivalent performance) must be capable of detecting a 0.1 gallon-per-hour leak rate from any portion of the tank that routinely

contains product while accounting for the effects of thermal expansion or contraction of the product, vapor pockets, tank deformation, evaporation or condensation, and the location of the water table.

d. Automatic tank gauging. Equipment for automatic tank gauging that tests for the loss of product and conducts inventory control must meet the following requirements:

(1) The automatic product level monitor test can detect a 0.2 gallon-per-hour leak rate from any portion of the tank that routinely contains product; and

(2) Inventory control (or another test of equivalent performance) is conducted in accordance with the requirements of 135.5(4) "a."

e. Vapor monitoring. Testing or monitoring for vapors within the soil gas of the excavation zone must meet the following requirements:

(1) The materials used as backfill are sufficiently porous (e.g., gravel, sand, crushed rock) to readily allow diffusion of vapors from releases into the excavation area;

(2) The stored regulated substance, or a tracer compound placed in the tank system, is sufficiently volatile (e.g., gasoline) to result in a vapor level that is detectable by the monitoring devices located in the excavation zone in the event of a release from the tank;

(3) The measurement of vapors by the monitoring device is not rendered inoperative by the groundwater, rainfall, or soil moisture or other known interferences so that a release could go undetected for more than 30 days;

(4) The level of background contamination in the excavation zone will not interfere with the method used to detect releases from the tank;

(5) The vapor monitors are designed and operated to detect any significant increase in concentration above background of the regulated substance stored in the tank system, a component or components of that substance, or a tracer compound placed in the tank system;

(6) In the UST excavation zone, the site is assessed to ensure compliance with the requirements in 135.5(4) "e"(1) to (4) and to establish the number and positioning of monitoring wells that will detect releases within the excavation zone from any portion of the tank that routinely contains product; and

(7) Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering.

f. Groundwater monitoring. Testing or monitoring for liquids on the groundwater must meet the following requirements:

(1) The regulated substance stored is immiscible in water and has a specific gravity of less than 1;

(2) Groundwater is never more than 20 feet from the ground surface and the hydraulic conductivity of the soil(s) between the UST system and the monitoring wells or devices is not less than 0.01 cm/sec (e.g., the soil should consist of gravels, coarse to medium sands, coarse silts or other permeable materials);

(3) The slotted portion of the monitoring well casing must be designed to prevent migration of natural soils or filter pack into the well and to allow entry of regulated substance on the water table into the well under both high and low groundwater conditions;

(4) Monitoring wells shall be sealed from the ground surface to the top of the filter pack;

(5) Monitoring wells or devices intercept the excavation zone or are as close to it as is technically feasible;

(6) The continuous monitoring devices or manual methods used can detect the presence of at least 1/8 of an inch of free product on top of the groundwater in the monitoring wells;

(7) Within and immediately below the UST system excavation zone, the site is assessed to ensure compliance with the requirements in 135.5(4) "f"(1) to (5) and to establish the number and positioning of monitoring wells or devices that will detect releases from any portion of the tank that routinely contains product; and

(8) Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering.

g. Interstitial monitoring. Interstitial monitoring between the UST system and a secondary barrier immediately around or beneath it may be used, but only if the system is designed, constructed and installed to detect a leak from any portion of the tank that routinely contains product and also meets one of the following requirements:

(1) For secondary containment systems, the sampling or testing method must be able to detect a release through the inner wall in any portion of the tank that routinely contains product:

1. Continuously, by means of an automatic leak sensing device that signals to the operator the presence of any regulated substance in the interstitial space; or
2. Monthly, by means of a procedure capable of detecting the presence of any regulated substance in the interstitial space.
3. The interstitial space shall be maintained and kept free of liquid, debris or anything that could interfere with leak detection capabilities.

NOTE: The provisions outlined in the Steel Tank Institute's "Standard for Dual Wall Underground Storage Tanks" may be used as guidance for aspects of the design and construction of underground steel double-walled tanks.

(2) For UST systems with a secondary barrier within the excavation zone, the sampling or testing method used can detect a release between the UST system and the secondary barrier:

1. The secondary barrier around or beneath the UST system consists of artificially constructed material that is sufficiently thick and impermeable (at least 10^{-6} cm/sec for the regulated substance stored) to direct a release to the monitoring point and permit its detection;
2. The barrier is compatible with the regulated substance stored so that a release from the UST system will not cause a deterioration of the barrier allowing a release to pass through undetected;
3. For cathodically protected tanks, the secondary barrier must be installed so that it does not interfere with the proper operation of the cathodic protection system;
4. The groundwater, soil moisture, or rainfall will not render the testing or sampling method used inoperative so that a release could go undetected for more than 30 days;
5. The site is assessed to ensure that the secondary barrier is always above the groundwater and not in a 25-year flood plain, unless the barrier and monitoring designs are for use under such conditions; and
6. Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering.

(3) For tanks with an internally fitted liner, an automated device can detect a release between the inner wall of the tank and the liner, and the liner is compatible with the substance stored.

h. Other methods. Any other type of release detection method, or combination of methods, can be used if:

- (1) It can detect a 0.2 gallon-per-hour leak rate or a release of 150 gallons within a month with a probability of detection of 0.95 and a probability of false alarm of 0.05; or
- (2) The department may approve another method if the owner and operator can demonstrate that the method can detect a release as effectively as any of the methods allowed in paragraphs "c" to "h." In comparing methods, the department shall consider the size of release that the method can detect and the frequency and reliability with which it can be detected. If the method is approved, the owner and operator must comply with any conditions imposed by the department on its use to ensure the protection of human health and the environment.

135.5(5) Methods of release detection for piping. Each method of release detection for piping used to meet the requirements of 135.5(2) must be conducted in accordance with the following:

a. Automatic line leak detectors. Methods which alert the operator to the presence of a leak by restricting or shutting off the flow of regulated substances through piping or triggering an audible or visual alarm may be used only if they detect leaks of 3 gallons per hour at 10 pounds per square inch line pressure within one hour. An annual test of the operation of the leak detector must be conducted in accordance with the manufacturer's requirements.

b. Line tightness testing. A periodic test of piping may be conducted only if it can detect a 0.1 gallon-per-hour leak rate at one and one-half times the operating pressure.

c. Applicable tank methods. Any of the methods in 135.5(4) "e" through "h" may be used if they are designed to detect a release from any portion of the underground piping that routinely contains regulated substances.

d. Interstitial monitoring of secondary containment. Interstitial monitoring may be used for any piping with secondary containment designed for and capable of interstitial monitoring.

(1) Leak detection shall be conducted:

1. Continuously, by means of an automatic leak sensing device that signals to the operator the presence of any regulated substance in the interstitial space or containment sump; or

2. Monthly, by means of a procedure capable of detecting the presence of any regulated substance in the interstitial space or containment sump, such as visual inspection.

(2) The interstitial space or sump shall be maintained and kept free of water, debris or anything that could interfere with leak detection capabilities.

(3) At least every two years, any sump shall be visually inspected for integrity of sides and floor and tightness of piping penetration seals. Any automatic sensing device shall be tested for proper function.

135.5(6) Release detection record keeping. All UST system owners and operators must maintain records in accordance with 135.4(5) demonstrating compliance with all applicable requirements of this rule. These records must include the following:

a. All written performance claims pertaining to any release detection system used, and the manner in which these claims have been justified or tested by the equipment manufacturer or installer, must be maintained for five years, or for another reasonable period of time determined by the department, from the date of installation;

b. The results of any sampling, testing, or monitoring must be maintained for at least one year, or for another reasonable period of time determined by the department, except that the results of tank tightness testing conducted in accordance with 135.5(4)“c” must be retained until the next test is conducted; and

c. Written documentation of all calibration, maintenance, and repair of release detection equipment permanently located on-site must be maintained for at least one year after the servicing work is completed, or for another reasonable time period determined by the department. Any schedules of required calibration and maintenance provided by the release detection equipment manufacturer must be retained for five years from the date of installation.

[ARC 8469B, IAB 1/13/10, effective 2/17/10]

567—135.6(455B) Release reporting, investigation, and confirmation.

135.6(1) Reporting of suspected releases. Owners and operators of UST systems must report to the department within 24 hours, or within 6 hours in accordance with 567—Chapter 131 if a hazardous condition exists as defined in 567—131.1(455B), or another reasonable time period specified by the department, and follow the procedures in 135.8(1) for any of the following conditions:

a. The discovery by owners and operators or others of released regulated substances at the UST site or in the surrounding area (such as the presence of free product or vapors in soils, basements, sewer and utility lines, and nearby surface water);

b. Unusual operating conditions observed by owners and operators (such as the erratic behavior of product dispensing equipment, the sudden loss of product from the UST system, or an unexplained presence of water in the tank), unless system equipment is found to be defective but not leaking, and is immediately repaired or replaced; and

c. Monitoring results from a release detection method required under 135.5(2) and 135.5(3) that indicate a release may have occurred unless:

(1) The monitoring device is found to be defective, and is immediately repaired, recalibrated or replaced, and additional monitoring does not confirm the initial result; or

(2) In the case of inventory control, a second month of data does not confirm the initial result.

135.6(2) Investigation due to off-site impacts. When required by the department, owners and operators of UST systems must follow the procedures in 135.6(3) to determine if the UST system is the source of off-site impacts. These impacts include the discovery of regulated substances (such as the presence of free product or vapors in soils, basements, sewer and utility lines, and nearby surface and drinking waters) that has been observed by the department or brought to its attention by another party.

135.6(3) Release investigation and confirmation steps. Owners and operators must immediately investigate and confirm all suspected releases of regulated substances requiring reporting under 135.6(1)

within seven days, or another reasonable time period specified by the department, using either the following steps or another procedure approved by the department:

a. System test. Owners and operators must conduct tests (according to the requirements for tightness testing in 135.5(4)“c” and 135.5(5)“b”) that determine whether a leak exists in that portion of the tank that routinely contains product, or the attached delivery piping or both.

(1) Owners and operators must repair, replace or upgrade the UST system and begin corrective action in accordance with rule 135.9(455B) if the test results for the system, tank, or delivery piping indicate a leak exists.

(2) Further investigation is not required if the test results for the system, tank, and delivery piping do not indicate a leak exists and if environmental contamination is not the basis for suspecting a release.

(3) Owners and operators must conduct a site check as described in paragraph “b” of this subrule if the test results for the system, tank, and delivery piping do not indicate a leak exists but environmental contamination is the basis for suspecting a release.

b. Site check. A certified groundwater professional must conduct a site check in accordance with the tank closure in place procedures as provided in 135.15(3) or they may conduct a Tier 1 assessment in accordance with subrule 135.9(3). Under either procedure, the certified groundwater professional must follow the policies and procedures applicable to sites where bedrock is encountered before groundwater as provided in 135.8(5) to avoid creating a preferential pathway for soil or groundwater contamination to reach a bedrock aquifer. The certified groundwater professional must measure for the presence of a release where contamination is most likely to be present at the UST site. In selecting sample types, sample locations, and measurement methods, the certified groundwater professional must consider the nature of the stored substance, the type of initial alarm or cause for suspicion, the type of backfill, the depth of groundwater, and other factors appropriate for identifying the presence and source of the release.

(1) If the test results of the site check indicate action levels in 135.14(455B) have been exceeded, owners and operators must begin corrective action in accordance with rules 135.7(455B) to 135.12(455B).

(2) If the test results for the excavation zone or the UST site do not indicate a release has occurred, further investigation is not required.

135.6(4) Reporting and cleanup of spills and overfills.

a. Reportable releases. Owners and operators of UST systems must contain and immediately clean up a spill, overfill or any aboveground release, and report to the department within 24 hours, or within 6 hours in accordance with 567—Chapter 131 if a hazardous condition exists as defined in rule 567—131.1(455B) and begin corrective action in accordance with rules 135.7(455B) to 135.12(455B) in the following cases:

(1) Spill, overfill or any aboveground release of petroleum that results in a release to the environment that exceeds 25 gallons, causes a sheen on nearby surface water, impacts adjacent property, or contaminates groundwater; and

(2) Spill, overfill or any aboveground release of a hazardous substance that results in a release to the environment that equals or exceeds its reportable quantity under CERCLA (40 CFR 302) as of September 13, 1988.

b. Nonreportable releases. Owners and operators of UST systems must contain and immediately clean up a spill, overfill or any aboveground release of petroleum that is less than 25 gallons and a spill, overfill or any aboveground release of a hazardous substance that is less than the reportable quantity. If cleanup cannot be accomplished within 24 hours, owners and operators must immediately notify the department.

NOTE: Any spill or overfill that results in a hazardous condition as defined in rule 567—131.1(455B) must be reported within 6 hours. This includes the transporter of the product. A release of a hazardous substance equal to or in excess of its reportable quantity must also be reported immediately (rather than within 24 hours) to the National Response Center under Sections 102 and 103 of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 and to appropriate state and local authorities under Title III of the Superfund Amendments and Reauthorization Act of 1986.

567—135.7(455B) Release response and corrective action for UST systems containing petroleum or hazardous substances.

135.7(1) General. Owners and operators of petroleum or hazardous substance UST systems must, in response to a confirmed release from the UST system, comply with the requirements of this rule except for USTs excluded under 135.1(3) “b” and UST systems subject to RCRA Subtitle C corrective action requirements under Section 3004(u) of the Resource Conservation and Recovery Act, as amended.

135.7(2) Initial response. Upon confirmation of a release in accordance with 135.6(3) or after a release from the UST system is identified in any other manner, owners and operators must perform the following initial response actions within 24 hours of a release or within another reasonable period of time specified by the department:

- a. Report the release to the department (e.g., by telephone or electronic mail);
- b. Take immediate action to prevent any further release of the regulated substance into the environment; and
- c. Identify and mitigate fire, explosion, and vapor hazards.

135.7(3) Initial abatement measures and site check.

a. Unless directed to do otherwise by the department, owners and operators must perform the following abatement measures:

- (1) Remove as much of the regulated substance from the UST system as is necessary to prevent further release to the environment;
- (2) Visually inspect any aboveground releases or exposed below-ground releases and prevent further migration of the released substance into surrounding soils and groundwater;
- (3) Continue to monitor and mitigate any additional fire and safety hazards posed by vapors or free product that have migrated from the UST excavation zone and entered into subsurface structures (such as sewers or basements);
- (4) Remedy hazards posed by contaminated soils that are excavated or exposed as a result of release confirmation, site investigation, abatement, or corrective action activities. If these remedies include treatment or disposal of soils, the owner and operator must comply with applicable state and local requirements;
- (5) Rescinded IAB 7/17/96, effective 8/15/96.
- (6) Investigate to determine the possible presence of free product, and begin free product removal as soon as practicable and in accordance with 135.7(5).

b. Within 20 days after release confirmation, or within another reasonable period of time determined by the department, owners and operators must submit a report to the department summarizing the initial abatement steps taken under paragraph “a” and any resulting information or data.

135.7(4) Initial site characterization. Rescinded IAB 7/17/96, effective 8/15/96.

135.7(5) Free product assessment and removal. At sites where investigations under 135.7(3) “a”(6) indicate 0.01 ft. or more of free product, owners and operators must immediately initiate a free product recovery assessment and submit a report in accordance with paragraph “d” and initiate interim free product removal while continuing, as necessary, any actions initiated under 135.7(2) to 135.7(4), or preparing for actions required under 135.8(455B) to 135.12(455B). Owners and operators must immediately begin interim free product removal by bailing or by installation and maintenance of passive skimming equipment until an alternative removal method is required by or approved by the department. A certified groundwater professional must initially determine the frequency of bailing and proper installation and maintenance of the skimming equipment based on a determination of the recharge rate of the free product. The department may approve implementation of this interim removal process by persons not certified as groundwater professionals. For approval a certified groundwater professional must submit (1) sufficient documentation establishing that the bailing or skimming system has been adequately designed and tested, and (2) a written plan for regular maintenance, reporting and supervision by a certified groundwater professional. Interim free product recovery reports must be submitted to the department on a monthly basis and on forms provided by the department. In meeting the requirements of this subrule, owners and operators must:

a. Conduct free product removal at a frequency determined by the recharge rate of the product and in a manner that minimizes the spread of contamination into previously uncontaminated zones by using recovery and disposal techniques appropriate to the hydrogeologic conditions at the site, and that properly treats, discharges or disposes of recovery by-products in compliance with applicable local, state and federal regulations. Unless approved by the department, free product assessment and recovery activities must be conducted by a certified groundwater professional. Owners and operators must report the results of free product removal activities on forms designated by the department;

b. Use abatement of free product migration as a minimum objective for the design of the free product removal system. Free product recovery systems must be designed to remove free product to the maximum extent practicable;

c. Handle any flammable products in a safe and competent manner to prevent fires or explosions; and

d. Free product recovery assessment and report. Unless directed to do otherwise by the department, prepare and submit to the department, within 45 days after confirming a release, a free product recovery assessment report and a proposal for subsequent free product removal activities. The free product recovery assessment report and removal proposal must contain at least the following information:

(1) The name of the person(s) responsible for implementing the free product removal measures;

(2) The estimated quantity, type and thickness of free product observed or measured in monitoring wells, boreholes, and excavations, the recharge rate in all affected monitoring wells and a detailed description of the procedures used to determine the recharge rate;

(3) A detailed justification for the free product removal technology proposed for the site. Base the justification narrative on professional judgment considering the characteristics of the free product plume (i.e., estimated volume, type of product, thickness, extent), an assessment of cost effectiveness based on recovery costs compared to alternative methods, site hydrology and geology, when the release event occurred, testing conducted to verify design assumptions and the potential for petroleum vapors or explosive conditions to occur in enclosed spaces. Proposals for removal systems other than hand bailing or passive skimming systems must be completed and submitted on a format consistent with the department's corrective action design report.

(4) A schematic and narrative description of the free product recovery system used;

(5) Whether any discharge will take place on site or off site during the recovery operation and where this discharge will be located;

(6) A schematic and narrative description of the treatment system, and the effluent quality expected from any discharge;

(7) The steps that have been or are being taken to obtain necessary permits for any discharge;

(8) The disposition of the recovered free product;

(9) Free product plume definition and map. The extent of free product in groundwater must be assessed. The number and location of wells and separation distance between the wells used to define the free product plume must be based on the receptors present and the site hydrology and geology. A minimum of five monitoring wells are required to construct the plume map. If the groundwater professional can adequately define the plume using other technology as specified in department guidance, fewer than five wells may be used. The boundary of the plume may be determined by linear interpolation consistent with the methods described in 135.10(2) "f"(3); and

(10) The estimated volume of free product present, how the volume was calculated, recoverable volume and estimated recovery time.

e. The department will review the free product assessment report; and, if approved, the owner or operator must implement the installation of the approved recovery system within 60 days or other time period approved by the department.

f. Termination of free product recovery activities. Owners and operators may propose to the department to terminate free product recovery activities when significant amounts of hydrocarbons are not being recovered. The department will consider proposals to terminate free product recovery when the amount of product collected from a monitoring well is equal to or less than 0.1 gallon each month

for a year unless another plan is approved by the department. When free product activities have been terminated, owners and operators must inspect the monitoring wells monthly for at least a year. The department must be notified and free product recovery activities reinitiated if during the monthly well inspections it is determined the product thickness in a monitoring well exceeds 0.02 foot. The monthly well inspection records must be kept available for review by the department.

g. Unless directed to do otherwise by the department, prepare and submit to the department within 180 days after confirming a release, a Tier 2 site cleanup report.

567—135.8(455B) Risk-based corrective action.

135.8(1) General. The objective of risk-based corrective action is to effectively evaluate the risks posed by contamination to human health, safety and the environment using a progressively more site-specific, three-tiered approach to site assessment and data analysis. Based on the tiered assessment, a corrective action response is determined sufficient to remove or minimize risks to acceptable levels. Corrective action response includes a broad range of options including reduction of contaminant concentrations through active or passive methods, monitoring of contamination, use of technological controls or institutional controls.

a. *Tier 1.* The purpose of a Tier 1 assessment is to identify sites which do not pose an unreasonable risk to public health and safety or the environment based on limited site data. The objective is to determine maximum concentrations of chemicals of concern at the source of a release(s) in soil and groundwater. The Tier 1 assessment assumes worst-case scenarios in which actual or potential receptors could be exposed to these chemicals at maximum concentrations through certain soil and groundwater pathways. The point of exposure is assumed to be the source showing maximum concentrations. Risk-based screening levels (Tier 1 levels) contained in the Tier 1 Look-Up Table have been derived from models which use conservative assumptions to predict exposure to actual and potential receptors. (These models and default assumptions are contained in Appendix A.) If Tier 1 levels are not exceeded for a pathway, that pathway may not require further assessment. If the maximum concentrations exceed a Tier 1 level, the options are to conduct a more extensive Tier 2 assessment, apply an institutional control, or in limited circumstances excavate contaminated soil to below Tier 1 levels. If all pathways clear the Tier 1 levels, it is possible for the site to obtain a no action required classification.

b. *Tier 2.* The purpose of a Tier 2 assessment is to use site-specific data to assess the risk from chemicals of concern to existing receptors and potential receptors using fate and transport models in accordance with 135.10(455B). See 135.10(2)“a.”

c. *Tier 3.* Where site conditions may not be adequately addressed by Tier 2 procedures, a Tier 3 assessment may provide more accurate risk assessment. The purpose of Tier 3 is to identify reasonable exposure levels of chemicals of concern and to assess the risk of exposure to existing and potential receptors based on additional site assessment information, probabilistic evaluations, or sophisticated chemical fate and transport models in accordance with 135.11(455B).

d. *Notification.* Whenever the department requires a tiered site assessment and a public water supply well is within 2,500 feet of a leaking underground storage tank site, the department will notify the public water supply operator.

e. *Pathway reevaluation.* Prior to issuance of a no further action certificate in accordance with 135.12(10) and Iowa Code section 455B.474(1)“h”(3), if it is determined that the conditions for an individual pathway that has been classified as “no action required” no longer exist, or the site presents an unreasonable risk to a public water supply well and the model used to obtain the pathway clearance underpredicts the actual contaminant plume, the individual pathway shall be further assessed consistent with the risk-based corrective action provisions in rules 567—135.8(455B) through 567—135.12(455B).

135.8(2) Certified groundwater professional. All assessment, corrective action, data analysis and report development required under rules 135.6(455B) to 135.12(455B) must be conducted by or under the supervision of a certified groundwater professional in accordance with these rules and department guidance as specified.

135.8(3) Chemicals of concern. Soil and groundwater samples from releases of petroleum regulated substances must always be analyzed for the presence of benzene, ethylbenzene, toluene, and xylenes. In

addition, if the release is suspected to include any petroleum regulated substance other than gasoline or gasoline blends, or if the source of the release is unknown, the samples must be tested for the presence of Total Extractable Hydrocarbons (TEH). Appendices A and B and department Tier 2 guidance define a method for converting TEH values to a default concentration for naphthalene, benzo(a)pyrene, benz(a)anthracene and chrysene and conversion back to a representative TEH value. These default values must be used in order to apply Tier 2 modeling to these constituents in the absence of accurate laboratory analysis. At Tier 2 and Tier 3, owners and operators have the option of analyzing for these specific constituents and applying them to the specific target levels in Appendices A and B instead of using the TEH conversion method if an approved laboratory and laboratory technique are used.

135.8(4) *Boring depth for sampling.* When drilling for the placement of groundwater monitoring wells, if groundwater is encountered, drilling must continue to the maximum of 10 feet below the first encountered groundwater or to the bottom of soil contamination as estimated by field screening. If groundwater is not encountered, drilling must continue to the deeper of 10 feet below the soil contamination as estimated by field screening or 75 feet from the ground surface.

135.8(5) *Bedrock aquifer assessment.* Prior to conducting any groundwater drilling, a groundwater professional must determine if there is a potential to encounter bedrock before groundwater. These potential areas include (1) areas where karst features or outcrops exist in the vicinity and (2) areas with bedrock less than 50 feet from the surface as illustrated in Tier 1 and Tier 2 guidance. The purpose of this determination is to prevent drilling through contaminated subsurface areas thereby creating a preferential pathway to a bedrock aquifer. If the first encountered groundwater is above bedrock but near the bedrock surface or fluctuates above and below bedrock, the groundwater professional should evaluate the subsurface geology and aquifer characteristics to determine the potential for creating a preferential pathway. If it is determined that the aquifer acts like a nongranular aquifer as provided in 135.10(3) "a" or bedrock is encountered before groundwater, the groundwater professional must conduct a Tier 2 assessment for all pathways under 135.10(455B), including the specified bedrock procedures under 135.10(3).

If the first encountered groundwater is above bedrock with sufficient separation and aquifer characteristics to establish that it acts as a granular aquifer, site assessment may proceed under the site check procedure in 135.6(455B), the Tier 1 procedure in 135.9(455B) or the Tier 2 procedure in 135.10(455B) as would be customary regardless of the bedrock designation. However, even under this condition, drilling through bedrock should be avoided in contaminated areas.

[ARC 7621B, IAB 3/11/09, effective 4/15/09]

567—135.9(455B) Tier 1 site assessment policy and procedure.

135.9(1) *General.* The main objective of a Tier 1 site assessment is to reasonably determine the highest concentrations of chemicals of concern which would be associated with any suspected or confirmed release and an accurate identification of applicable receptors. In addition, the placement and depth of borings and the construction of monitoring wells must be sufficient to determine the sources of all releases, the vertical extent of contamination, an accurate description of site stratigraphy, and a reliable determination of groundwater flow direction.

a. Pathway assessment. The pathways to be evaluated at Tier 1 are the groundwater ingestion pathway, soil leaching to groundwater pathway, groundwater vapor to enclosed space pathway, soil vapor to enclosed space pathway, soil to plastic water line pathway, groundwater to plastic water line pathway and the surface water pathway. Assessment requires a determination of whether a pathway is complete, an evaluation of actual and potential receptors, a determination of whether conditions are satisfied for obtaining no further action clearance for individual pathways, or for obtaining a complete site classification of "no action required." A pathway is considered complete if a chemical of concern has a route which could be followed to reach an actual or potential receptor.

b. Pathway clearance. If field data for an individual pathway does not exceed the applicable Tier 1 levels or if a pathway is incomplete, no further action is required to evaluate the pathway unless otherwise specified in these rules. If the field data for a pathway exceeds the applicable Tier 1 level(s) in the "Iowa Tier 1 Look-up Table," the response is to conduct further assessment under Tier 2 or Tier 3 unless an

effective institutional control is approved. In limited circumstances excavation of contaminated soils may be used as an option to obtain pathway clearance. If further site assessment indicates site data exceeds an applicable Tier 1 level(s) for a previously cleared pathway or the conditions justifying a determination of pathway incompleteness change, that pathway must be reevaluated as part of a Tier 2 or Tier 3 assessment.

c. Chemical group clearance. If field data for all chemicals of concern within a designated group of chemicals is below the Tier 1 levels, no further action is required as to the group of chemicals unless otherwise specified in these rules. Group one consists of benzene, ethylbenzene, toluene, and xylenes (BTEX). Group two consists of naphthalene, benzo(a)pyrene, benz(a)anthracene and chrysene; TEH default values are incorporated into the Iowa Tier 1 Look-Up Table and Appendix A for group two chemicals.

d. Site classification. A site can be classified as no action required only after all pathways have met the conditions for pathway clearance as provided in this rule.

e. Groundwater sampling procedure. Groundwater sampling and field screening must be conducted in accordance with department Tier 1 guidance. A minimum of three properly constructed groundwater monitoring wells must be installed, subject to the limitations on maximum drilling depths, for the purpose of identifying maximum concentrations of groundwater contamination, suspected sources of releases, and groundwater flow direction.

(1) Field screening must be used to locate suspected releases and to determine locations with the greatest concentrations of contamination. Field screening is required as per department guidance at each former and current tank basin, each former and current pump island, along the piping, and at any other areas of actual or suspected releases. In placing monitoring wells, the following must be considered: field screening data, available current and historical information regarding the releases, tank and piping layout, site conditions, and drilling data available from sites in the vicinity. At least one well must be placed at each suspected source of release which shall include at a minimum: the pump island with the greatest field screening level, each current and former underground storage tank basin, and if field screening shows greater levels than at the pump islands or tank basins, at other suspected sources of releases. As a general rule, wells should be installed outside of the tank basin through native soils but as close to the tank basin as feasible. A well must be installed in a presumed downgradient direction and within 30 feet of the sample with the greatest field screening level. Three of the wells must be placed in a triangular arrangement to determine groundwater flow direction.

(2) Where the circumstances which prompt a Tier 1 assessment identify a discrete source and cause of a release, and the groundwater professional is able to rule out other suspected sources or contributing sources such as pump islands, piping runs and tank basins, the application of field screening and groundwater well placement may be limited to the known source.

f. Soil sampling procedure. The objective of soil sampling is to identify the maximum concentrations of soil contamination in the vadose and saturated zones and to identify sources of releases. The same principles stated above apply to soil sampling. Soil samples must be taken from borings with the greatest field screening levels even if the boring will not be converted to a monitoring well. At a minimum, soil and groundwater samples must be collected for analysis from all borings which are converted to monitoring wells.

Iowa Tier 1 Look-Up Table

Media	Exposure Pathway	Receptor	Group 1				Group 2: TEH	
			Benzene	Toluene	Ethylbenzene	Xylenes	Diesel*	Waste Oil
Groundwater (ug/L)	Groundwater Ingestion	actual	5	1,000	700	10,000	1,200	400
		potential	290	7,300	3,700	73,000	75,000	40,000
	Groundwater Vapor to Enclosed Space	all	1,540	20,190	46,000	NA	2,200,000	NA
	Groundwater to Plastic Water Line	all	290	7,300	3,700	73,000	75,000	40,000
	Surface Water	all	290	1,000	3,700	73,000	75,000	40,000
Soil (mg/kg)	Soil Leaching to Groundwater	all	0.54	42	15	NA	3,800	NA
	Soil Vapor to Enclosed Space	all	1.16	48	79	NA	47,500	NA
	Soil to Plastic Water Line	all	1.8	120	43	NA	10,500	NA

NA: Not applicable. There are no limits for the chemical for the pathway, because for groundwater pathways the concentration for the designated risk would be greater than the solubility of the pure chemical in water, and for soil pathways the concentration for the designated risk would be greater than the soil concentration if pure chemical were present in the soil.

TEH: Total Extractable Hydrocarbons. The TEH value is based on risks from naphthalene, benzo(a)pyrene, benz(a)anthracene, and chrysene. Refer to Appendix B for further details.

Diesel*. Standards in the Diesel column apply to all low volatile petroleum hydrocarbons except waste oil.

135.9(2) Conditions requiring Tier 1 site assessment. Unless owners and operators choose to conduct a Tier 2 assessment, the presence of bedrock requires a Tier 2 assessment as provided in 135.8(5), or these rules otherwise require preparation of a Tier 2 site assessment, a Tier 1 site assessment must be completed in response to release confirmation as provided in rule 135.6(455B), or tank closure investigation under 135.15(455B), or other reliable laboratory analysis which confirms the presence of contamination above the action levels in 135.14(455B).

135.9(3) Tier 1 assessment report. Unless directed to do otherwise by the department or the owners or operators choose to prepare a Tier 2 site cleanup report, owners and operators must assemble information about the site and the nature of the release in accordance with the department Tier 1 guidance, including information gained while confirming the release under 135.6(455B), tank closure under 135.15(455B) or completing the initial abatement measures in 135.7(1) and 135.7(2). This information must include, but is not necessarily limited to, the following:

- a. Data on the nature and estimated quantity of release.
- b. Results of any release investigation and confirmation actions required by subrule 135.6(3).
- c. Results of the free product investigations required under 135.7(3) "a"(6), to be used by owners and operators to determine whether free product must be recovered under 135.7(5).
- d. Chronology of property ownership and underground storage tank ownership, identification of the person(s) having control of, or having responsibility for the daily operation of the underground storage tanks and the operational history of the underground storage tank system. The operational history shall include, but is not limited to, a description of or suspected known subsurface or aboveground releases, past remediation or other corrective action, type of petroleum product stored, recent tank and piping tightness test results, any underground storage tank system repairs, upgrades or replacements and the underground storage tank and piping leak detection method being utilized. The operational history shall confirm that current release detection methods and record keeping comply with the requirements of 135.5(455B), that all release detection records have been reviewed and report any evidence that a release detection standard has been exceeded as provided in 135.5(4) and 135.5(5).

e. Appropriate diagrams of the site and the underground storage tank system and surrounding land use, identifying site boundaries and existing structures and uses such as residential properties, schools, hospitals, child care facilities and a general description of relevant land use restrictions and known future land use.

f. Current proof of financial responsibility as required by 136.19(455B) and 136.20(455B) and the status of coverage for corrective action under any applicable financial assurance mechanism or other financial assistance program.

g. A receptor survey including but not limited to the following: existing buildings, enclosed spaces (basements, crawl spaces, utility vaults, etc.), conduits (gravity drain lines, sanitary and storm sewer mains and service lines), plastic water lines and other utilities within 500 feet of the source. For conduits and enclosed spaces there must be a description of construction material, conduit backfill material, slope of conduit and trenches (include flow direction of sewers), burial depth of utilities or subsurface enclosed spaces, and the relationship to groundwater elevations.

h. An explosive vapor survey of enclosed spaces where there may be the potential for buildup of explosive vapors. The groundwater professional must provide a specific justification for not conducting an explosive vapor survey.

i. A survey of all surface water bodies within 200 feet of the source.

j. A survey of all active, abandoned and plugged groundwater wells within 1,000 feet of the source with a description of construction and present or future use.

k. Accurate and legible site maps showing the location of all groundwater monitoring wells, soil borings, field screening locations and screening values, and monitoring well and soil boring construction logs.

l. A tabulation of all laboratory analytical results for chemicals of concern and copies of the laboratory analytical reports.

m. Results of hydraulic conductivity testing and description of the procedures utilized.

n. A Tier 1 site assessment in accordance with the department's Tier 1 guidance. The Tier 1 report shall be submitted on forms and in a format prescribed by this guidance. The Tier 1 data analysis shall be performed by using computer software developed by the department or by using the computer software's hard-copy version.

135.9(4) Groundwater ingestion pathway assessment. The groundwater ingestion pathway addresses the potential for human ingestion of petroleum-regulated substances from existing groundwater wells or potential drinking water wells.

a. Pathway completeness. This pathway is considered complete if: (1) there is a drinking or non-drinking water well within 1,000 feet of the source(s) exhibiting the maximum concentrations of the chemicals of concern; or (2) the first encountered groundwater is a protected groundwater source.

b. Receptor evaluation. A drinking or non-drinking water well within 1,000 feet of the source(s) is an actual receptor. The Tier 1 levels for actual receptors apply to drinking water wells and the Tier 1 levels for potential receptors apply to non-drinking water wells. Potential receptor points of exposure exist if the first encountered groundwater is a protected groundwater source but no actual receptors presently exist within 1,000 feet of the source.

c. Pathway clearance. If the pathway is incomplete, no further action is required for this pathway. If the Tier 1 level for actual or potential receptors is not exceeded, no further action is required for this pathway. Groundwater wells that are actual or potential receptors may be plugged in accordance with 567—Chapter 39 and 567—Chapter 49 and may result in no further action clearance if the groundwater is not a protected groundwater source and the pathway is thereby incomplete.

d. Corrective action response. If maximum concentrations exceed the applicable Tier 1 levels for either actual or potential receptors, a Tier 2 assessment must be conducted unless effective institutional controls are implemented as provided below. Technological controls are not acceptable at Tier 1 for this pathway. Abandonment and plugging of drinking and non-drinking water wells in accordance with 567—Chapters 39 and 49 is an acceptable corrective action response.

e. Use of institutional controls. To apply an effective institutional control, if drinking or non-drinking water wells are present within 1,000 feet of the source, and the applicable Tier 1 level is

exceeded, the well(s) for which there is an exceedence must be properly plugged. If the groundwater is a protected groundwater source and the maximum concentrations do not exceed the Tier 1 level for potential receptors but do exceed the Tier 1 level for actual receptors, the owner or operator must provide notification of site conditions on a department form to the department water supply section, or if a county has delegated authority, then the designated county authority responsible for issuing private water supply construction permits or regulating non-public water well construction as provided in 567—Chapters 38 and 49.

If the groundwater is a protected source and the maximum concentrations exceed the Tier 1 level for potential receptors, the owner or operator must (1) implement an institutional control prohibiting the use of the groundwater for installation of drinking and non-drinking water wells within 1,000 feet of the source; and (2) provide notification as provided above. If an effective institutional control is not feasible, a Tier 2 assessment must be performed for this pathway in accordance with rule 135.10(455B).

f. Receptor evaluation for public water supply wells. Rescinded IAB 3/11/09, effective 4/15/09.

135.9(5) Soil leaching to groundwater pathway assessment. This pathway addresses the potential for soil contamination to leach to groundwater creating a risk of human exposure through the groundwater ingestion pathway.

a. Pathway completeness. If the groundwater ingestion pathway is complete, the soil leaching to groundwater pathway is considered complete.

b. Receptor evaluation. There is a single receptor type for this pathway and one applicable Tier 1 level.

c. Pathway clearance. If the pathway is incomplete or the pathway is complete and the maximum concentrations of chemicals of concern do not exceed the Tier 1 levels, no further action is required for assessment of this pathway.

d. Corrective action response. If the Tier 1 levels are exceeded for this pathway, a Tier 2 assessment must be conducted or alternatively, institutional controls or soil excavation may be undertaken in accordance with 135.9(7)“h.”

e. Use of institutional controls. Institutional controls must satisfy the conditions applicable to the groundwater ingestion pathway as provided in 135.9(4)“e.”

135.9(6) Groundwater vapor to enclosed space pathway assessment. This pathway addresses the potential for vapors from contaminated groundwater to migrate to enclosed spaces where humans could inhale chemicals of concern at unacceptable levels. This pathway assessment assumes the health-based Tier 1 levels will adequately protect against any associated short- and long-term explosive risks.

a. Pathway completeness. This pathway is always considered complete for purposes of Tier 1 and must be evaluated.

b. Explosive vapor survey. An explosive vapor survey must be conducted in accordance with procedures outlined in the department Tier 1 guidance. If potentially explosive levels are detected, the groundwater professional must notify the owner or operator with instructions to report the condition in accordance with 567—Chapter 131. The owner or operator must begin immediate response and abatement procedures in accordance with 135.7(455B) and 567—Chapter 133.

c. Receptor evaluation. For purposes of Tier 1, there is one receptor type for this pathway and the Tier 1 level applies regardless of the existence of actual or potential receptors.

d. Pathway clearance. No further action is required for this pathway, if the maximum groundwater concentrations do not exceed the Tier 1 levels for this pathway.

e. Corrective action response. If the maximum concentrations exceed the Tier 1 levels for this pathway, a Tier 2 assessment of this pathway must be conducted unless institutional controls are implemented. Technological controls are not acceptable at Tier 1 for this pathway.

f. Use of institutional controls. An institutional control must be effective to prohibit the placement of enclosed space receptors within 500 feet of the source.

135.9(7) Soil vapor to enclosed space pathway assessment. This pathway addresses the potential for vapors from contaminated soils to migrate to enclosed spaces where humans could inhale chemicals of concern at unacceptable levels. This pathway assessment assumes health-based screening levels at Tier 1 will adequately protect against short- and long-term explosive risks.

a. Pathway completeness. This pathway is always considered complete for purposes of Tier 1 and must be evaluated.

b. Explosive vapor survey. An explosive vapor survey must be conducted in accordance with procedures outlined in the department Tier 1 guidance. If potentially explosive levels are detected, the groundwater professional must notify the owner or operator with instructions to report the condition in accordance with 567—Chapter 131. The owner or operator must begin immediate response and abatement procedures in accordance with 135.7(455B) and 567—Chapter 133.

c. Receptor evaluation. For purposes of Tier 1, there is one receptor type for this pathway, and the Tier 1 level applies regardless of existing or potential receptors.

d. Pathway clearance. No further action is required for this pathway, if the maximum soil concentrations do not exceed the Tier 1 levels for this pathway. If the Tier 1 levels are exceeded, soil gas measurements may be taken in accordance with the Tier 2 guidance at the area(s) of maximum concentration. Subject to confirmation sampling, if the soil gas measurements do not exceed the target levels in 135.10(7)“f,” no further action is required for this pathway. If the Tier 1 level is not exceeded but the soil gas measurement exceeds the target level, further action is required for the pathway.

e. Soil gas samples. To establish that the soil gas measurement is representative of the highest expected levels, a groundwater professional must obtain two soil gas samples taken at least two weeks apart. One of the samples must be taken below the typical frostline depth during a seasonal period of lowest groundwater elevation.

f. Corrective action response. If the maximum concentrations exceed the Tier 1 levels and the soil gas measurements exceed target levels for this pathway, or if no soil gas measurement was taken, a Tier 2 assessment of this pathway must be conducted unless institutional controls are implemented or soil excavation is conducted as provided below. Technological controls are not acceptable at Tier 1 for this pathway.

g. Use of institutional controls. An institutional control must be effective to eliminate the placement of enclosed space receptors within 500 feet of the source.

h. Soil excavation. Excavation of contaminated soils for the purpose of removing soils contaminated above the Tier 1 levels is permissible as an alternative to conducting a Tier 2 assessment. Adequate field screening methods must be used to identify maximum concentrations during excavation. At a minimum, one soil sample must be taken for field screening every 100 square feet of the base and each sidewall. Soil samples must be taken for laboratory analysis at least every 400 square feet of the base and each sidewall of the excavated area to confirm that remaining concentrations are below Tier 1 levels. If the excavation is less than 400 square feet, a minimum of one sample must be analyzed for each sidewall and the base.

135.9(8) *Groundwater to plastic water line pathway assessment.* This pathway addresses the potential for creating a drinking water ingestion risk due to contact with plastic water lines and causing infusion to the drinking water.

a. Pathway completeness and receptor evaluation.

(1) Actual receptors. This pathway is considered complete for an actual receptor if there is an existing plastic water line within 200 feet of the source and the first encountered groundwater is less than 20 feet below ground surface.

(2) Potential receptors. This pathway is considered complete for a potential receptor if the first encountered groundwater is less than 20 feet below ground surface.

b. Pathway clearance. If the pathway is not complete, no further action is required for this pathway. If the pathway is complete and the maximum concentrations of all chemicals of concern do not exceed the Tier 1 levels for this pathway, no further action is required for this pathway.

c. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. Notification of potential plastic water line impacts may be postponed until completion of Tier 2 if a Tier 2 assessment is required.

d. Corrective action response.

(1) For actual receptors, if the Tier 1 levels are exceeded, all plastic water lines within 200 feet must be replaced with nonplastic lines or the plastic lines must be relocated beyond the 200-foot distance. A Tier 2 assessment must be conducted for this pathway if lines are not replaced or relocated.

(2) For potential receptors, upon utility company notification, no further action will be required for this pathway.

135.9(9) Soil to plastic water line pathway assessment. This pathway addresses the potential for creating a drinking water ingestion risk due to contact with plastic water lines and infusion into the drinking water.

a. Pathway completeness.

(1) Actual receptors. This pathway is considered complete for an actual receptor if a plastic water line exists within 200 feet of the source.

(2) Potential receptors. This pathway is always considered complete for potential receptors.

b. Pathway clearance. If the pathway is not complete for actual receptors, no further action is required for this pathway. If the pathway is complete for actual receptors and the maximum concentrations of all chemicals of concern do not exceed Tier 1 levels for this pathway, no further action is required. For potential receptors, upon utility company notification, no further action will be required for this pathway for potential receptors.

c. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. Notification of potential plastic water line impacts may be postponed until completion of Tier 2 if a Tier 2 assessment is required.

d. Corrective action response. For actual receptors, if the Tier 1 levels are exceeded for this pathway, the plastic water lines may be replaced with nonplastic lines or the plastic lines must be relocated to a distance beyond 200 feet of the source. Excavation of soils to below Tier 1 levels may be undertaken in accordance with 135.9(7)“h.” If none of these options is implemented, a Tier 2 assessment must be conducted for this pathway.

135.9(10) Surface water pathway assessment. This pathway addresses the potential for contaminated groundwater to impact surface water bodies creating risks to human health and aquatic life.

a. Pathway completeness. This pathway is considered complete if a surface water body is present within 200 feet of the source. For purposes of Tier 1, surface water bodies include both general use segments and designated use segments as provided in 567—subrule 61.3(1).

b. Receptor evaluation. The Tier 1 levels for this pathway only apply to designated use segments of surface water bodies as provided in 567—subrules 61.3(1) and 61.3(5). The point of compliance is the source with the highest concentrations of chemicals of concern. General use segments of surface water bodies as provided in 567—paragraph 61.3(1)“a” are only subject to the visual inspection criteria.

c. Visual inspection requirements. A visual inspection of all surface water bodies within 200 feet of the source must be conducted to determine if there is evidence of a sheen on the water or there is evidence of petroleum residue along the bank. If a sheen or residue is evident or has been reported to be present, the groundwater professional must make a sufficient investigation to reasonably determine its source. If in the opinion of the groundwater professional, the sheen is not associated with the underground storage tank site, the professional must report and reasonably justify this opinion. If in the opinion of the groundwater professional the sheen is not a petroleum-regulated substance, a sample must be laboratory tested in accordance with 135.16(455B) to confirm it is not a petroleum-regulated substance.

d. Pathway clearance. If the pathway is not complete or it is complete and the maximum concentrations of all chemicals of concern at the point of compliance do not exceed the Tier 1 levels and there is no petroleum sheen or residue attributable to the site, no further action is required for assessment of this pathway.

e. Corrective action response. If a Tier 1 level is exceeded for any chemical of concern for a designated use segment within 200 feet of the source, or the groundwater professional determines the presence of a petroleum-regulated substance sheen or residue, a Tier 2 assessment of this pathway must be conducted.

135.9(11) *Tier 1 submission and review procedures.*

a. Within 90 calendar days of release confirmation or another reasonable period of time determined by the department, owners and operators must submit to the department a Tier 1 report in a format prescribed by the department and in accordance with these rules and the department Tier 1 guidance.

b. If the owner or operator elects to prepare a Tier 2 site cleanup report instead of a Tier 1 assessment, the department must be notified in writing prior to the expiration of the Tier 1 submission deadline. The Tier 2 site cleanup report must be submitted to the department in accordance with rule 135.10(455B) within 180 calendar days of release confirmation or another reasonable period of time determined by the department.

c. Tier 1 report completeness and accuracy. A Tier 1 report is considered to be complete if it contains all the information and data required by this rule and the department Tier 1 guidance. The report is accurate if the information and data is reasonably reliable based first on application of the standards in these rules and department guidance and second, generally accepted industry standards.

d. The certified groundwater professional shall include the following certification with the Tier 1 site assessment report:

I, _____, Groundwater Professional Certification No. _____, am familiar with all applicable requirements of Iowa Code section 455B.474 and all rules and procedures adopted thereunder including, but not limited to, 567—Chapter 135 and the Department of Natural Resources Tier 1 guidance. Based on my knowledge of those documents and information I have prepared and reviewed regarding this site, UST Registration No. _____, LUST No. _____ I certify that this document is complete and accurate as provided in 567 IAC 135.9(11) “c” and meets the applicable requirements of the Tier 1 site assessment.

Signature:

Date:

e. Upon receipt of the Tier 1 report, the department may review it by reliance on the groundwater professional’s certification and a summary review for completeness and accuracy or may undertake a more complete review to determine completeness and accuracy and compliance with department rules and guidance. If the Tier 1 report proposes to classify the site “no action required,” the department may review the report as provided in 135.9(11) “g.”

f. If a “no action required” site classification is not proposed, the department must within 60 days approve the Tier 1 report for purposes of completeness or disapprove of the report upon a finding of incompleteness, inaccuracy or noncompliance with these rules. If no decision is made within this time period, the report is deemed to be accepted for purposes of completeness. The department retains the authority to review the report at the time a no action required site classification is proposed.

g. No action required site classification review. The department will review each Tier 1 report which proposes to classify a site as “no action required” to determine whether the data and information are complete and accurate, the data and information comply with department rules and guidance and the site classification proposal is reasonably supported by the data and information.

135.9(12) *Tier 1 site classification and corrective action response.*

a. No action required site classification. At Tier 1, a site is only eligible for a “no action required” classification. To be classified as no action required, each pathway must meet the requirements for pathway clearance as specified in this rule. If the department determines a no action required site classification is appropriate, a no further action certificate will be issued as provided in 135.12(10).

b. Where an individual pathway or a chemical group meets the requirements for clearance but the site is not entitled to a no action required classification, only those pathways and chemical groups which do not meet the no further action requirements must be evaluated as part of a Tier 2 assessment as provided in rule 135.10(455B).

c. Compliance monitoring and confirmation sampling. Compliance monitoring is not an acceptable corrective action at Tier 1. Except for soil gas sampling under 135.9(7), confirmation sampling to verify a sample does not exceed a Tier 1 level is not required. However, the department retains the authority to require confirmation sampling from existing groundwater monitoring wells if a no action required classification is being proposed at Tier 1 and the department has a reasonable basis

to question the representative validity of the samples based on, for example, the seasonal bias of the sampling, evidence of multiple sources of releases, marginal groundwater monitoring well locations and analytical variability.

d. Expedited corrective action. Expedited corrective action is permissible in accordance with 135.12(11).

[ARC 7621B, IAB 3/11/09, effective 4/15/09]

567—135.10(455B) Tier 2 site assessment policy and procedure.

135.10(1) General conditions. A Tier 2 site assessment must be conducted and a site cleanup report submitted for all sites which have not obtained a no action required site classification and for all pathways and chemicals of concern groups that have not obtained no further action clearance as provided in 135.9(455B). If in the course of conducting a Tier 2 assessment, data indicates the conditions for pathway clearance under Tier 1 no longer exist, the pathway shall be further assessed under this rule. The Tier 2 assessment and report must be completed whenever free product is discovered as provided in 135.7(455B). If the owner or operator elects to complete the Tier 2 site assessment without doing a Tier 1 assessment, all the Tier 1 requirements as provided in 135.9(455B) must be met in addition to requirements under this rule.

a. Guidance. The Tier 2 site assessment shall be conducted in accordance with the department's "Tier 2 Site Assessment Guidance" and these rules. The site cleanup report shall be submitted on forms and in a format prescribed by this guidance. The Tier 2 data analysis shall be performed by using computer software developed by the department or by using the computer software's hard-copy version.

b. Classification. At Tier 2, individual pathways may be classified as high risk or low risk or no action required and separate classification criteria may apply to actual and potential receptors for any pathway. A single pathway may have multiple classifications based on actual or potential receptor evaluations. A pathway must meet both the criteria for actual and potential receptors for the pathway to obtain a classification of no action required. Sites may have multiple pathway classifications. For a site to obtain a no action required classification, all pathways must meet the individual pathway criteria for no action required classification.

c. Public right-of-way. As a general rule, public right-of-way will not be considered an area of potential receptor exposure except for potential sanitary sewer evaluation under the soil and groundwater vapor pathways, subrules 135.10(6) and 135.10(7).

135.10(2) General Tier 2 assessment procedures.

a. Objectives. The objective of a Tier 2 assessment is to collect site-specific data and with the use of Tier 2 modeling determine what actual or potential receptors could be impacted by chemicals of concern and what concentrations at the source are predicted to achieve protection of these receptors. Both Tier 1 and Tier 2 are based on achieving similar levels of protection of human health, safety and the environment.

b. Groundwater modeling. Tier 2 uses fate and transport models to predict the maximum distance groundwater contamination is expected to move and the distribution of concentrations of chemicals of concern within this area. The model is used for two basic purposes. One, it is used to predict at what levels of concentration contamination would be expected to impact actual and potential receptors. Two, it is used to determine a concentration at the source which if achieved, and after dispersion and degradation, would protect actual and potential receptors at the point of exposure. In predicting the transport of contaminants, the models assume the contaminant plume is at "steady state" such that concentrations throughout the plume have reached a maximum level and are steady or decreasing. The Tier 2 models are only designed to predict transport in a direct line between the source and downgradient to a receptor. In order to more reasonably define a modeled plume in all directions, paragraph "i" defines a method of decreasing modeled concentrations as a percentage of their distance in degrees from the downgradient direction.

c. Soil vapor models. The soil vapor models are vertical transport models and do not use modeling to predict soil contaminant transport horizontally to receptors.

d. Soil leaching to groundwater modeling. The soil leaching to groundwater model is a model that predicts the maximum concentrations of chemicals of concern that would be expected in groundwater due to vertical leaching from the area of maximum soil concentrations and then incorporates the groundwater transport models to predict contaminant transport through groundwater pathways.

e. Modeling default parameters. The Tier 2 model formulas and applicable parameters are designated in Appendix B and must be followed unless otherwise specified in these rules. Unless otherwise specified, target levels at a point of exposure may be the Tier 1 level(s) or may be determined using site-specific parameters. The target level at a point of exposure is calculated using the Tier 1 formulas in Appendix A and either site-specific measurements or the default values for those parameters identified as “optional” and “site-specific” in Appendix B.

f. Source width. The source width and source length are variables used in modeling and must be determined by the following criteria and as specified in the department’s Tier 2 guidance. The following are not to be used as criteria for defining the extent of the contaminant plumes.

(1) Source width (equals S_w in models) for groundwater transport modeling. The sum of group one chemical (benzene, toluene, ethylbenzene, xylenes or “BTEX”) concentrations for each groundwater sample is determined and the location of the sample with the maximum total BTEX is identified. Linear interpolation is used to estimate the area where groundwater concentrations would be expected to exceed 50 percent of the maximum BTEX value, and this area is considered for the source width measurement. The same procedure is used to determine source width for group two chemicals, using TEH in groundwater. The width of the groundwater contamination perpendicular to estimated groundwater flow direction (S_w) is determined, and the larger of either group one or group two chemicals is used in the groundwater transport model.

(2) Source width (S_w) and source length (equals W in models) for soil leaching to groundwater transport modeling. Both the source width perpendicular to the estimated groundwater flow direction (S_w) and the source length parallel to the estimated groundwater flow direction (W) are used in the soil leaching to groundwater model. The sum of BTEX concentrations for each soil sample is determined and the location of the sample with the maximum total BTEX is identified. Concentrations from both the vadose zone and the saturated zone must be considered when determining the maximum. Linear interpolation is used to estimate the area where soil concentrations would be expected to exceed 50 percent of the maximum BTEX value, and this area is considered for the source width and source length measurements. The same procedure is used to determine source width for group 2 chemicals, using TEH in soil. Source width and source length measurements for BTEX in groundwater are also taken following the same linear interpolation criteria in “f”(1) above. The source width value used in the model is the greatest of either the soil source width measurements or the groundwater source width measurement. The source length value used in the model is the greatest of either of the soil source length measurements or the groundwater length measurement.

(3) Estimating source width when free product is present. Groundwater from wells with free product must be analyzed for BTEX and the source width and source length are estimated using the criteria in 135.10(2)“f”(1) and 135.10(2)“f”(2) above. For those sites with approved site cleanup reports and free product present in wells but actual BTEX values are not available, source width and source length may be estimated in accordance with 135.10(2)“f”(1) and 135.10(2)“f”(2) using the default BTEX values for groundwater in 135.18(4) or estimated by using the area representing half the distance between wells with free product and wells without free product, whichever method is greater.

g. Modeled simulation line. The simulation line represents the predicted maximum extent of groundwater contamination and distribution of contaminant concentrations between the source(s) and actual or potential receptor locations. The model calculates the simulation line using maximum concentrations at the source(s) and predicting the amount of dispersion and degradation. Modeled data in the simulation line are compared with actual field data to verify the predictive validity of the model and to make risk classification decisions.

h. Modeled site-specific target level (SSTL) line. The modeled SSTL line represents acceptable levels of contaminant concentrations at points between and including the source(s) and an applicable point(s) of exposure or other point(s) of compliance (ex. a potential receptor point of exposure). The

SSTL line is calculated by assuming an applicable target level concentration at the point(s) of exposure or point(s) of compliance and modeling back to the source to determine the maximum concentrations at the source (SSTL) that must be achieved to meet the target level at the point of exposure or compliance. Comparison of field data to this SSTL line is used to determine a risk classification and determine appropriate corrective action response.

i. Crossgradient and upgradient modeling. In determining the SSTL line and the simulation line in directions other than downgradient, the modeled contaminant concentrations are applied to reduced distances, as specified in the “Tier 2 Guidance.” The modeled results are applied to 100 percent of the distance within an angle of 30 degrees on either side of the range of downgradient directions, as specified in Tier 2 guidance. The modeled results are applied to 20 percent of the distance in the upgradient direction and directly proportional distances between these two outer limits. If the groundwater gradient is less than 0.005 or the groundwater contaminant plume shows no definitive direction or shows directional reversals, the modeled concentrations are applied to 100 percent of the distance in all directions from the source. As the downgradient velocity increases, the upgradient modeled distance is reduced to less than 20 percent of the downgradient modeled distance.

j. Plume definition. The purpose of plume definition at Tier 2 is to obtain sufficient data to determine the impact on actual and potential receptors, to determine and confirm the highest levels of contamination, to verify the validity of the models, and to determine groundwater flow direction. The number and location of borings and monitoring wells and the specificity of plume definition will depend on the pathway or pathways being assessed and the actual or potential receptors of concern. Unless otherwise specified, groundwater and soil contamination shall be defined to Tier 1 levels for the applicable pathways. Linear interpolation between two known concentrations must be used to delineate plume extent. Samples with no concentrations detected shall be considered one-half the detection limit for interpolation purposes.

k. Pathway completeness. Unless a pathway has obtained clearance under Tier 1, each pathway must be evaluated at Tier 2. Pathways are generally considered complete (unless otherwise specified) and receptors affected if actual receptors or potential receptor points of exposure exist within the modeled contaminant plume using the modeled simulation line calculated to the applicable target level at a point of exposure. If the actual contaminant plume exceeds the modeled plume, the pathway is complete and must be evaluated if actual or potential points of exposure exist within a distance extending 10 percent beyond the edge of the defined plume.

l. Points of exposure and compliance. For actual receptors, the point(s) of exposure is the receptor. For potential receptors, the potential receptor point(s) of exposure is determined by using actual plume definition or the modeled simulation line to determine all points which exceed the target level(s) for potential receptors. The potential receptor point(s) of exposure is the location(s) closest to the source where a receptor could reasonably exist and which is not subject to an institutional control; for example, the source is the potential receptor point of exposure if not subject to an institutional control or an adjoining property boundary line if that property is not subject to an institutional control. At Tier 2, the point(s) of exposure or potential receptor point(s) of exposure is a point of compliance unless otherwise specified. Other points of compliance are specified by rules and will generally include all points along the SSTL line for purposes of pathway and site classification and corrective action response.

m. Group two chemicals. At Tier 2, chemical-specific values for the four chemicals may be used or the largest of the four TEH default values. (Refer to Appendix B and department Tier 2 guidance for using the TEH conversion method for modeling.) If chemical-specific values are used, the analytical method must be approved by the department prior to its use.

135.10(3) Bedrock assessment.

a. General. As provided in 135.8(5), if bedrock is encountered before groundwater, special assessment procedures under this subrule apply. The Tier 2 assessment procedures apply to the extent they are not inconsistent with this subrule. The objectives of these special procedures are to avoid creating a preferential pathway for contamination through a confining layer to a bedrock aquifer; to avoid creating a preferential pathway to a fractured system, and to determine whether groundwater transport modeling can be used and, if not, what alternative procedures are required. The owner or

operator may choose to conduct a Tier 3 assessment under 135.11(455B) as an alternative to proceeding under this subrule. For sites where bedrock is encountered before groundwater, there are three general categories of site conditions which determine the assessment procedures that apply:

(1) *Nongranular bedrock.* Nongranular bedrock is bedrock which is determined to not act as a granular aquifer as provided in subparagraph (2). Nongranular bedrock generally has some type of fractured system where groundwater transport modeling cannot be applied and which makes it difficult to define the extent of contamination.

(2) *Granular bedrock.* Granular bedrock is bedrock which is determined to act as a granular aquifer and for which monitoring wells do not exist at the source as of August 15, 1996. For purposes of this rule, a granular aquifer is one that shows no extraordinary variations or inconsistencies in groundwater elevations across the site, groundwater flow, hydraulic conductivities, or total dissolved solid concentrations among monitoring wells. Although the extent of contamination can be defined in granular bedrock, groundwater transport modeling cannot be used because there are no monitoring wells at the source.

(3) *Exempt granular bedrock.* Exempt granular bedrock is bedrock which is determined to act as a granular aquifer as provided in subparagraph (2) and for which monitoring wells exist at the source as of August 15, 1996. Sites in exempt granular bedrock shall be evaluated using the normal Tier 1 or Tier 2 procedures in this rule. Nongranular bedrock is not exempt from this subrule even if groundwater monitoring wells exist at the source.

b. Exempt soil pathways. The soil vapor to enclosed space pathway and the soil to plastic water lines pathway shall be assessed under the normal Tier 2 procedures in subrules 135.10(7) and 135.10(9) respectively. In all cases, the normal assessment must comply with the policy of avoiding a preferential pathway to groundwater consistent with 135.8(5) and this subrule.

c. Soil and groundwater assessment. The vertical and horizontal extent of soil contamination shall first be defined to Tier 1 levels for the soil leaching to groundwater pathway without drilling into bedrock. A minimum of three groundwater monitoring wells shall be located and installed between 50 to 100 feet beyond the soil contamination Tier 1 levels to avoid creating a preferential pathway. Analytical data as normally required by these rules and guidance must be obtained.

d. Soil contamination remediation. For all sites where soil contamination exceeds the soil leaching to groundwater Tier 1 levels, soil excavation or other active soil remediation technology must be conducted in accordance with department guidance to reduce concentrations to below this Tier 1 level. Soil remediation monitoring must be conducted in accordance with 135.12(455B).

e. Groundwater plume definition. If it is determined the groundwater acts in a manner consistent with a granular aquifer as provided in subparagraph "a"(2) and guidance but does not meet the criteria for exemption under subparagraph "a"(3), the plume must be defined. The policy of avoiding the creation of a preferential pathway to the bedrock aquifer in accordance with 135.8(5) must be followed.

f. Soil leaching to groundwater ingestion pathway. Under this subrule, the soil leaching to groundwater pathway only need be evaluated in combination with the groundwater ingestion pathway. Because of the policies requiring soil remediation to the soil leaching to groundwater Tier 1 levels under paragraphs "d" and "k," the soil leaching pathway target levels applicable to other groundwater transport pathways and other soil pathways would not be exceeded. If a soil leaching to groundwater Tier 1 level is exceeded, the pathway is high risk.

g. Special procedures for the groundwater ingestion pathway.

(1) A protected groundwater source is assumed without measurements of hydraulic conductivity for all sites designated as granular or nongranular bedrock.

(2) Groundwater well receptor evaluation for granular and nongranular bedrock designations. All drinking and non-drinking water wells within 1,000 feet of the source must be identified and tested for chemicals of concern. All public water supply systems within one mile of the source must be identified and raw water tested for chemicals of concern. If no drinking water wells are located within 1,000 feet of the source, all the area within 1,000 feet is considered a potential receptor point of exposure.

(3) Target levels. The following target levels apply regardless of granular aquifer designation. If drinking water wells are within 1,000 feet of the source, the applicable target level is the groundwater

ingestion pathway Tier 1 level for actual receptors. If non-drinking water wells are within 1,000 feet of the source, the applicable target level is the groundwater ingestion pathway Tier 1 level for potential receptors. For potential wells, the applicable target level is the groundwater ingestion pathway Tier 1 level for potential receptors.

(4) Sentry well. If the Tier 1 level for actual receptors is exceeded at sites designated as granular bedrock and the receptor has not yet been impacted, a monitoring well shall be placed between the source and an actual receptor, outside the defined plume and approximately 200 feet from the actual receptor. For alternative well placement, the certified groundwater professional must provide justification and obtain department approval. This monitoring well is to be used for monitoring potential groundwater contamination of the receptor.

(5) High risk classification. A site where bedrock is encountered before groundwater shall be classified high risk for this pathway if any of the following conditions exist regardless of granular aquifer determination: The target level at any actual receptor is exceeded; drinking water well receptors are present within 1,000 feet and groundwater concentrations in any monitoring well exceed the groundwater ingestion Tier 1 level for actual receptors; non-drinking water wells are within 1,000 feet and groundwater concentrations in any monitoring well exceed the groundwater ingestion pathway Tier 1 level for potential receptors; or for sites designated nongranular bedrock, if groundwater concentrations for chemicals of concern from any public water system well within one mile of the source exceed 40 percent of the Tier 1 level for actual receptors, and groundwater concentrations in any monitoring well exceed the groundwater ingestion Tier 1 level for actual receptors. Corrective action shall be undertaken as provided in paragraph "k."

(6) Low risk classification. Sites without an actual receptor within 1,000 feet shall be classified as low risk for this pathway if no high risk conditions exist, and the Tier 1 level for potential receptors is exceeded. The site is subject to monitoring as provided in paragraph "l." If an actual receptor exists within 1,000 feet, a site designated as granular or nongranular bedrock shall be classified low risk for this pathway when soil contamination has been removed or remediated to below the soil leaching to groundwater Tier 1 levels, and all groundwater monitoring wells are non-detect or below the applicable target level for actual and potential receptors. A site may be reclassified to no action required for this pathway after all monitoring wells meet the exit monitoring criteria as specified in paragraph "l." (NOTE: Exit monitoring is required because groundwater monitoring wells are not located at the source or if they are, the data is highly unreliable given the nature of bedrock.) If actual receptors do not exist or have been properly plugged and concentrations exceed the Tier 1 level for potential receptors, institutional controls and notification to permitting authorities may be employed in accordance with 135.10(4) "i." The institutional control must prohibit use of groundwater for 1,000 feet.

h. Special procedures for the groundwater vapor to enclosed space pathway.

(1) Soil gas plume. Soil gas measurements must be taken regardless of granular aquifer determination and in accordance with Tier 2 guidance to determine a soil gas plume. Soil gas where practical should be measured at the soil-bedrock interface. At a minimum, soil gas must be measured at the suspected area of maximum contamination and near the three monitoring wells with the highest concentrations that exceed the Tier 1 level for the groundwater to enclosed space pathway. Where the plume has been defined, soil gas measurements should be taken near wells exceeding the Tier 1 level. Other soil gas measurements must be taken as needed to define the extent of contamination where soil gas measurements exceed the soil gas vapor target levels.

(2) The soil gas target levels are those defined in 135.10(7) "f."

(3) High risk classification. A site designated as granular or nongranular bedrock shall be classified high risk for this pathway if an actual confined space receptor exists within 50 feet of the soil gas plume based on the soil gas target level as defined in 135.10(6).

(4) Low risk classification. A site designated as granular or nongranular bedrock shall be classified as low risk for this pathway if the soil gas exceeds the vapor target level at any point and no actual confined space receptors exist within 50 feet of the soil gas contaminant plume.

i. Special procedure for the groundwater to plastic water line pathway.

(1) Target level. The applicable target level is the Tier 1 level for plastic water lines.

(2) High risk classification. A site designated as granular or nongranular bedrock shall be classified high risk for this pathway if the highest groundwater elevation is higher than three feet below the bottom of a plastic water line as provided in 135.10(8)“a”(1), risk classification cannot be determined as provided in 135.12(455B) due to limitations on placement of monitoring wells, and plastic water lines exist within 200 feet of a monitoring well which exceeds the Tier 1 level.

j. Special procedures for the surface water pathway. Any surface water body within 200 feet of the source must be evaluated under the following for sites designated as granular or nongranular bedrock. The provisions of 135.10(10) apply to the extent they are not inconsistent with the following, including the visual inspection requirements.

(1) Point of compliance. The monitoring well closest to the surface water body must be used as the point of compliance to evaluate impacts to designated use segments as described in 135.10(10) and for general use segments that fail the visual inspection criteria of 135.10(10)“b.” If the surface water criteria is exceeded for a designated use segment, an allowable discharge concentration must be calculated and met at the point of compliance. For general use segments failing the visual inspection criteria, the acutely toxic target level must be met at the point of compliance.

(2) High risk classification. A site designated as granular or nongranular bedrock shall be classified high risk for this pathway if the surface water body is within 200 feet of the source, risk classification cannot be determined as per 135.12(455B) due to limitations on placement of monitoring wells, and the monitoring well closest to the designated use segment exceeds the allowable discharge concentration. A general use segment failing the visual inspection criteria is high risk if, after the sheen is removed, the monitoring well closest to the general use segment exceeds the acutely toxic target level.

(3) Low risk classification. If the allowable discharge concentration is not exceeded at the point of compliance, the site shall be classified as low risk for this pathway and subject to monitoring under paragraph “l.” The monitoring well closest to the receptor shall serve as the sentry well for monitoring purposes.

k. High risk corrective action response. Owners and operators have the option to conduct a Tier 3 assessment in accordance with 135.11(455B).

(1) Groundwater ingestion pathway. For high risk sites, where soil exceeds the soil leaching to groundwater Tier 1 level for actual receptors, soil excavation or other active remediation of soils must be conducted in accordance with department guidance to reduce soil concentrations below the soil leaching Tier 1 level. Corrective action other than monitoring of groundwater is required at sites designated as nongranular bedrock if the actual receptor has been or is likely to be impacted. Corrective action other than monitoring of groundwater is required at sites designated as granular bedrock if the actual receptor has been impacted or the sentry well required by 135.10(3)“g”(4) has been impacted above Tier 1 levels. Acceptable corrective action for impacted or vulnerable groundwater wells may include active remediation, technological controls, institutional controls, well plugging, relocation, and well reinstallation with construction measures sufficient to prevent contaminant infiltration to the well and to prevent formation of a preferential pathway.

(2) Groundwater ingestion pathway high risk monitoring. For high risk sites designated as nongranular or granular bedrock, if the soil concentrations do not exceed the soil leaching to groundwater Tier 1 levels or have been reduced to this level by corrective action, and corrective action of groundwater is not required as in subparagraph (1), these sites shall be subject to groundwater monitoring as provided in paragraph “l.” Corrective action other than monitoring of groundwater is required at sites designated as granular bedrock if groundwater concentrations exceed the applicable target level less than 200 feet from an actual receptor. Reevaluation of the potential for impact to actual receptors is required at sites designated as nongranular bedrock if concentrations from monitoring wells increases more than 20 percent of the previous samples.

(3) Other pathways. For high risk sites other than groundwater ingestion, active remediation must be conducted to reduce concentrations below the applicable target levels including the use of institutional and technological controls.

l. Monitoring. For high and low risk sites, annual monitoring at a minimum is required as specified below, and potential receptor status for low risk sites must be confirmed. Annual monitoring

may be used to meet the exit requirements for no action required classification in accordance with paragraph “m.”

(1) Groundwater in nongranular bedrock designations. All groundwater monitoring wells must be monitored at least annually.

(2) Groundwater in granular bedrock designations. The following monitoring wells must be monitored at least annually: a well with detected levels of contamination closest to the leading edge of the groundwater plume between the source and the receptor, and a sentry well with concentrations below the applicable target level consistent with subparagraph “g”(4) and paragraph “j.”

(3) Soil gas. For sites where the soil gas target level is exceeded, annual monitoring of soil gas is required at the suspected area of maximum contamination and between the soil gas plume and any actual receptors within 100 feet of the soil gas plume.

m. No action required classification. A site may be given a no action required classification after conducting a Tier 2 assessment as provided in this subrule if maximum soil concentrations do not exceed the Tier 1 levels for the soil leaching pathway, and if groundwater exit monitoring criteria and soil gas confirmation sampling are met as specified below.

(1) Groundwater in nongranular bedrock designations. Exit monitoring requires that samples from all groundwater monitoring wells must not exceed the applicable target levels for annual sampling for three consecutive years.

(2) Groundwater in granular bedrock designations. Exit monitoring must be met in two ways: A monitoring well between the source and the receptor must not exceed applicable target levels for three sampling events, and samples must be separated by at least six months; and the three most recent consecutive groundwater samples from a monitoring well between the source and the receptor with detected levels of contamination must show a steady or declining trend and meet the following criteria: The first of the three samples must be more than detection limits, concentrations cannot increase more than 20 percent from the first of the three samples to the third sample; concentrations cannot increase more than 20 percent of the previous sample; and samples must be separated by at least six months.

(3) Soil gas. Confirmation sampling for soil gas must be conducted as specified in 135.12(6) “c.”

n. After receiving a no action required classification, all monitoring wells must be properly plugged in accordance with 567—Chapters 39 and 49.

135.10(4) Groundwater ingestion pathway assessment.

a. Pathway completeness. Unless cleared at Tier 1, this pathway is complete and must be evaluated under any of the following conditions: (1) the first encountered groundwater is a protected groundwater source; or (2) there is a drinking water well or a non-drinking water well within the modeled groundwater plume or the actual plume as provided in 135.10(2) “j” and 135.10(2) “k.”

b. Receptor evaluation. All drinking and non-drinking water wells located within 100 feet of the largest actual plume (defined to the appropriate target level for the receptor type) must be tested, at a minimum, for chemicals of concern as part of the receptor evaluation. Actual plumes refer to groundwater plumes for all chemicals of concern. Untreated or raw water must be collected for analysis unless it is determined to be infeasible or impracticable.

All existing drinking water wells and non-drinking water wells within the modeled plume or the actual plume as provided in paragraph “a” must be evaluated as actual receptors. Potential receptors only exist if the groundwater is a protected groundwater source. Potential receptor points of exposure are those points within the modeled plume or actual plume that exceed the potential point of exposure target level. The point(s) of compliance for actual receptor(s) is the receptor. The point(s) of compliance for potential receptor(s) is the potential receptor point of exposure as provided in 135.10(2) “j” and 135.10(2) “k.”

c. Target levels. For drinking water wells, the target level at the point(s) of exposure is the Tier 1 level for actual receptors. For non-drinking water wells, the target level at the point(s) of exposure is the Tier 1 levels for potential receptors. For potential receptors, the target level at the potential receptor point(s) of exposure is the Tier 1 level for potential receptors.

d. The soil leaching to groundwater pathway must be evaluated in accordance with 135.9(5) if this pathway is complete.

e. Modeling. At Tier 2, the groundwater well located within the modeled plume is assumed to be drawing from the contaminated aquifer, and the groundwater transport model is designed to predict horizontal movement to the well. If the groundwater professional determines that assessment of the vertical movement of contamination is advisable to determine the potential or actual impact to the well source, a Tier 3 assessment of this vertical pathway may be conducted. The groundwater professional shall submit a work plan to the department specifying the assessment methods and objectives for approval in accordance with 135.11(455B). Factors which should be addressed include, but are not limited to, well depth and construction, radius of influence, hydrogeologic separation of aquifer, preferential pathways, and differing water quality characteristics.

f. Public water supply well assessment. Rescinded IAB 3/11/09, effective 4/15/09.

g. Plume definition. The groundwater plume shall be defined to the applicable Tier 1 level for actual receptors except, where there are no actual receptors and the groundwater is a protected groundwater source, the plume shall be defined to the Tier 1 level for potential receptors.

h. Pathway classification. This pathway shall be classified as high risk, low risk or no action required in accordance with 135.12(455B).

i. Corrective action response. Corrective action must be conducted in accordance with 135.12(455B). Abandonment and plugging of wells in accordance with 567—Chapters 39 and 49 is an acceptable corrective action response.

j. Use of institutional controls. The use of institutional controls may be used to obtain no action required pathway classification. If the pathway is complete and the concentrations exceed the applicable Tier 1 level(s) for actual receptors, the drinking or non-drinking water well must be properly plugged in accordance with 567—Chapters 39 and 49 and the institutional control must prohibit the use of a protected groundwater source (if one exists) within the actual or modeled plume as provided in 135.10(2)“j” and 135.10(2)“k.” If the Tier 1 level is exceeded for potential receptors, the institutional control must prohibit the use of a protected groundwater source within the actual or modeled plume, whichever is greater. If concentrations exceed the Tier 1 level for drinking water wells and the groundwater is a protected groundwater source, the owner or operator must provide notification of the site conditions on a department form to the department water supply section, or if a county has delegated authority, then the designated county authority responsible for issuing private water supply construction permits or regulating non-public water well construction as provided in 567—Chapters 38 and 49.

k. Notification of well owners. Upon receipt of a Tier 2 site cleanup report and as soon as practicable, the department shall notify the owner of any public water supply well identified within the Tier 2 site cleanup report that a leaking underground storage tank site is within 2,500 feet and an assessment has been performed.

135.10(5) Soil leaching to groundwater pathway assessment.

a. General. The soil leaching to groundwater pathway is evaluated using a one-dimensional model which predicts vertical movement of contamination through soil to groundwater and transported by the groundwater to a receptor. The model is used to predict the maximum concentrations of chemicals of concern that would be present in groundwater beneath a source which is representative of residual soil contamination and maximum soil concentrations. The predicted groundwater concentrations then must be used as a groundwater source concentration to evaluate its impact on other groundwater transport pathways, including the groundwater ingestion pathway, the groundwater vapor pathway, the groundwater plastic line pathway and the surface water pathway.

b. Pathway completeness. This pathway is complete whenever a groundwater transport pathway is complete as provided in this rule.

c. Plume definition. The soil plume shall be defined to the Tier 1 levels for the soil leaching to groundwater pathway.

d. Receptor evaluation. Receptors for this pathway are the same as the receptors for each complete groundwater transport pathway.

e. Modeling and target levels. The soil and groundwater parameters shall be measured as provided in 135.10(2).

The soil leaching to groundwater model shall be used to calculate the predicted groundwater source concentration. Each applicable groundwater transport pathway model shall then be used in accordance with the rules for that pathway to predict potential impact to actual receptors, the location of potential receptor points of exposure and the site-specific target level (SSTL) in groundwater at the source. This SSTL then is used to calculate a SSTL for soil at the source. If the soil concentrations exceed the SSTL for soil, corrective action response shall be evaluated.

f. Corrective action response. If the maximum soil concentration at the source exceeds the SSTL for soil for actual or potential receptors, corrective action must be taken in accordance with 135.12(455B).

135.10(6) Groundwater vapor to enclosed space pathway assessment.

a. Pathway completeness. Unless cleared at Tier 1, this pathway is always considered complete for purposes of Tier 2.

b. Explosive vapor survey. If an explosive vapor survey has not been conducted as part of a Tier 1 assessment, an explosive vapor survey of enclosed spaces must be conducted during the Tier 2 assessment in accordance with 135.9(6) "b" and procedures outlined in the department's Tier 1 guidance.

c. Confined space receptor evaluation. Actual and potential receptors are evaluated at Tier 2 for this pathway.

(1) Actual receptors. An existing confined space within the modeled groundwater plume or the actual groundwater plume as provided in 135.10(2) "j" and 135.10(2) "k" is an actual receptor. For the purpose of Tier 2, a confined space is a basement in a building occupied by humans. Buildings constructed with a concrete slab on grade or buildings constructed without a concrete slab, but with a crawl space are not considered confined spaces. Sanitary sewers are considered confined space receptors and preferential pathways if an occupied building exists within 200 feet of where the sewer line crosses over or through actual or modeled groundwater contamination which exceeds the target levels calculated for sewers. The sanitary sewer includes its utility envelope. The point of exposure is the receptor and points of compliance include the locations where target level measurements may be taken as provided in paragraphs "f" and "g."

(2) Potential receptors. Potential receptors are confined spaces that do not presently exist but could exist in the future. Areas within the actual groundwater plume perimeter or modeled groundwater plume perimeter are considered potential receptor points of exposure. Potential receptors are evaluated and target levels established based on the current zoning as provided in paragraph "f." The potential receptor point of exposure is a point of compliance.

d. Owners and operators may be required to address vapor inhalation hazards in occupied spaces other than confined spaces as defined in these rules when evidence arises which would give the department a reasonable basis to believe vapor hazards are present or may occur.

e. Plume definition.

(1) The soil plume must be defined in accordance with 135.10(2) "f" for the purposes of estimating source width and source length used in soil leaching to groundwater and groundwater transport models.

(2) The groundwater plume must be defined to the target levels derived from site-specific data as provided in paragraph "f."

f. Target levels. Target levels can be based on groundwater concentrations, soil gas measurements, and indoor vapor measurements as provided below.

(1) For actual receptors and potential receptors, groundwater modeling as provided in 135.10(2) is used to calculate the groundwater concentration target level at the point of exposure. Default residential exposure factors, default residential building parameters, and a target risk of 10^{-4} are used to determine target levels for actual receptors and potential receptor points of exposure in residential areas and areas with no zoning. Default nonresidential exposure factors, default nonresidential building parameters, and a target risk of 10^{-4} are used to determine target levels for actual receptors and potential receptor points of exposure in nonresidential areas. Default values are provided in Appendices A and B.

(2) For actual receptors, the indoor vapor target levels are designated in 135.10(7) "f." For actual and potential receptors, the soil gas target levels are designated in 135.10(7) "f."

(3) Sanitary sewers are treated as human health receptors, and groundwater concentration target levels at the point of exposure are based on the application of a target risk of 2×10^{-4} for carcinogens and a hazard quotient of 2 for noncarcinogens.

g. Pathway evaluation and classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B).

(1) Actual receptors. If it can be demonstrated that the groundwater plume has reached steady state concentrations under a confined space, indoor vapor measurements at the point(s) of exposure and soil gas measurements at an alternative point(s) of compliance may be used for the pathway evaluation. When assessing sanitary sewers for pathway clearance, soil gas measurements may be evaluated against the soil gas target levels; however, indoor vapor cannot be used as criteria for pathway clearance. Soil gas measurements shall be taken and analyzed in accordance with 135.16(5) and the department's Tier 2 guidance, and at locations in the plume where measured groundwater concentrations exceed the levels which are projected by modeling to exist beneath the actual receptor. If measured groundwater concentrations beneath the actual receptor exceed the levels projected from modeling, then the soil gas measurements may be taken either adjacent to the actual receptor in areas expected to exhibit the greatest soil gas measurements or at an alternative point of compliance between the source and receptor where the actual groundwater concentrations exceed the groundwater concentrations which exist beneath the confined space. If the soil gas measurements and confirmation samples taken in accordance with 135.12(6) "c" do not exceed the soil gas target levels, the pathway as to actual receptors shall be classified no action required. If the soil gas target levels are exceeded, either the pathway shall be classified high risk, or indoor vapor measurements may be taken in accordance with the department's Tier 2 guidance. If indoor vapor measurements and confirmation samples do not exceed the indoor vapor target levels, the pathway as to actual confined space receptors shall be classified no action required. If the Tier 1 indoor vapor target levels are exceeded, the pathway shall be classified high risk.

(2) Potential receptors. If the potential receptor groundwater concentration target level(s) is exceeded at any potential receptor point of exposure based on actual data or modeling, the pathway shall be classified low risk. However, if soil gas measurements taken at the potential receptor point(s) of exposure and alternate point(s) of compliance and confirmation samples do not exceed the target levels in 135.10(7) "f," the pathway, as to potential receptors, shall be classified no action required. If the target level(s) for potential sanitary sewer receptors is exceeded, the pathway shall be classified as low risk. Where the area of potential receptor exposure includes public right-of-way, the pathway may be classified as no action required if the owner or operator provides sufficient documentation to establish that there are no foreseeable plans for construction of sanitary sewers through the area of potential receptor exposure. The municipal authority must acknowledge consent to the no action required classification whenever target levels are exceeded. If the municipal authority reports that it has confirmed plans for construction of sanitary sewers through the area of potential receptor exposure, the pathway shall be reevaluated as an actual receptor.

h. Corrective action response. Unless the pathway is classified as no action required, corrective action for this pathway must be conducted as provided in 135.12(455B). Actual receptors are subject to corrective actions which: (1) reduce groundwater concentrations beneath the enclosed space to below the target level; (2) reduce the measured soil gas levels to below the soil gas target levels; (3) reduce the indoor vapor concentrations to below the indoor vapor target level; or (4) reduce the vapor level to below 10 percent of the lower explosive limit (LEL), if applicable. Potential receptors are subject to the monitoring requirements in 135.12(5). Soil vapor monitoring may be conducted in lieu of groundwater monitoring for this pathway. Institutional or technological controls as provided in 135.12(455B) may be used.

i. Municipal authority notification for potential sewer receptors. The municipal authority responsible for sewer construction must be notified of the environmental conditions whenever target level(s) is exceeded for potential sanitary sewers. The notification must show the area where groundwater concentrations and soil gas samples exceed target levels. The owner or operator must acknowledge what plans, if any, exist for construction of sanitary sewers through the area of potential receptor exposure.

135.10(7) Soil vapor to enclosed space pathway assessment.

a. Pathway completeness. Unless cleared at Tier 1, this pathway is always considered complete for purposes of Tier 2.

b. Explosive vapor survey. If an explosive vapor survey has not been conducted as part of a Tier 1 assessment, an explosive vapor survey of enclosed spaces must be conducted during the Tier 2 assessment in accordance with 135.9(6)“b” and procedures outlined in the department’s Tier 1 guidance.

c. Confined space receptor evaluation. Actual and potential receptors are evaluated at Tier 2 for this pathway.

(1) Actual receptors. An existing confined space within 50 feet of the edge of the plume is an actual receptor. For the purpose of Tier 2, a confined space is a basement in a building occupied by humans. Buildings constructed with a concrete slab on grade or buildings constructed without a concrete slab, but with a crawl space are not considered receptors. Sanitary sewers are considered confined space receptors and preferential pathways if an occupied building exists within 200 feet of where the sewer line crosses over or through soil contamination which exceeds the target levels calculated for sewers. The sanitary sewer includes its utility envelope. The point of exposure is the receptor and points of compliance include the locations where target level measurements may be taken as provided in paragraphs “f” and “g.”

(2) Potential receptors. Potential receptors are confined spaces that do not presently exist but could exist in the future. Areas where soil concentrations are greater than the Tier 1 level applicable to residential areas or alternative target levels for nonresidential areas as specified in paragraph “f” are considered potential receptor points of exposure. Potential receptors are evaluated and target levels established based on the current zoning. An area with no zoning is considered residential. The potential receptor point of exposure is a point of compliance.

d. Owners and operators may be required to address vapor inhalation hazards in occupied spaces other than confined spaces as defined in these rules when evidence arises which would give the department a reasonable basis to believe vapor hazards are present or may occur.

e. Plume definition. The soil plume must be defined to the Tier 1 level for this pathway unless vapor measurements taken at the area(s) with the maximum levels of soil contamination do not exceed the soil gas target level in 135.10(7)“f.” If soil gas measurements taken from the area(s) of maximum soil concentration do not exceed target levels, confirmation sampling must be conducted in accordance with 135.12(6)“c” prior to proposing a no action pathway classification.

f. Target levels. Target levels can be based on soil concentrations, soil gas measurements, and indoor vapor measurements as provided below:

(1) For actual receptors, the soil concentration target level is the Tier 1 level. For potential receptors, the soil concentration target level for residential areas and areas with no zoning is the Tier 1 level. For areas zoned nonresidential, the target level is calculated using the default nonresidential exposure factors and building parameters from Appendix A and a target risk of 10^{-4} .

(2) The following indoor vapor target levels apply to actual receptors other than sanitary sewers and the soil gas target levels apply to all actual and potential receptors. These levels were derived from the ASTM indoor air inhalation and the soil vapor to enclosed space models designated in Appendix A.

	Indoor Vapor ($\mu\text{g}/\text{m}^3_{\text{air}}$)	Soil Gas ($\mu\text{g}/\text{m}^3$)
Benzene	39.2	600,000
Toluene	555	9,250,000

(3) Sanitary sewers are treated as human health receptors, and soil concentration target levels at the point of exposure are based on application of a target risk of 2×10^{-4} for carcinogens and hazard quotient of 2 for noncarcinogens.

g. Pathway evaluation and classification.

(1) Actual receptors. Confined space receptors may be evaluated using soil gas measurements and indoor vapor measurements. When assessing sanitary sewers for pathway clearance, soil gas

measurements may be evaluated against the soil gas target levels, however, indoor vapor cannot be used as criteria for pathway clearance. Soil gas measurements shall be taken adjacent to the actual receptor or at an alternative point of compliance between the source and receptor such as the property boundary, and in accordance with 135.16(5) and the department's Tier 2 guidance. If the soil gas measurements and confirmation samples taken in accordance with 135.12(6) "c" do not exceed the soil gas target levels, the pathway as to actual receptors shall be classified no action required. If the soil gas target levels are exceeded, either the pathway shall be classified high risk, or indoor vapor measurements may be taken in accordance with the department's Tier 2 guidance. If indoor vapor measurements and confirmation samples do not exceed the indoor vapor target levels, the pathway as to actual receptors shall be classified no action required. If the indoor vapor target levels are exceeded, the pathway shall be classified high risk.

(2) Potential receptors. If the potential receptor target level(s) based on soil concentrations is exceeded at any potential receptor point of exposure, the pathway shall be classified low risk. However, if soil gas measurements taken at the potential receptor point(s) of exposure and alternate point(s) of compliance and confirmation samples do not exceed the target levels in paragraph "f," the pathway shall be classified no action required as to potential receptors. If the target level(s) for potential sanitary sewer receptors is exceeded, the pathway shall be classified as low risk. Where the area of potential receptor exposure includes public right-of-way, the pathway may be classified as no action required if the owner or operator provides sufficient documentation to establish that there are no foreseeable plans for construction of sanitary sewers through the area of potential receptor exposure. The municipal authority must acknowledge consent to the no action required classification whenever target levels are exceeded. If the municipal authority reports that it has confirmed plans for construction of sanitary sewers through the area of potential receptor exposure, the pathway shall be reevaluated as an actual receptor.

h. Corrective action response. Unless the pathway is classified as no action required, corrective action for this pathway must be conducted as provided in 135.12(455B) and in accordance with department Tier 2 guidance. Actual receptors are subject to corrective actions which: (1) reduce the indoor vapor concentrations to below the target level; (2) reduce measured soil gas levels to below the soil gas target levels; and (3) if applicable, reduce the vapor level to below 10 percent of the lower explosive limit (LEL). Potential receptors are subject to monitoring requirements as provided in 135.12(5). Soil vapor monitoring may be conducted in lieu of soil monitoring for this pathway. Institutional or technological controls as provided in 135.12(455B) may be used.

i. Municipal authority notification for potential sewer receptors. The municipal authority responsible for sewer construction must be notified of the environmental conditions whenever target level(s) is exceeded for potential sanitary sewers. The notification must show the area where soil concentrations and soil gas samples exceed target levels. The owner or operator must acknowledge what plans, if any, exist for construction of sanitary sewers through the area of potential receptor exposure.

135.10(8) Groundwater to plastic water line pathway assessment.

a. Pathway completeness and receptor evaluation.

(1) Actual receptors include all plastic water lines where the highest groundwater elevation is higher than three feet below the bottom of the plastic line at the measured or predicted points of exposure. The highest groundwater elevation is the estimated average of the highest measured groundwater elevations for each year. All plastic water lines must be evaluated for this pathway regardless of distance from the source and regardless of the Tier 1 evaluation, if the lines are in areas with modeled data above the SSTL line. If actual data exceeds modeled data, then all plastic water lines are considered actual receptors if they are within a distance extending 10 percent beyond the edge of the contaminant plume defined by the actual data.

(2) Potential receptors include all areas where the first encountered groundwater is less than 20 feet deep and where actual data or modeled data are above Tier 1 levels.

(3) The point(s) of exposure is the plastic water line, and the points of compliance are monitoring wells between the source and the plastic water line which would be effective in monitoring whether the line has been or may be impacted by chemicals of concern.

b. Plume definition. If this pathway is complete for an actual receptor, the groundwater plume must be defined to the Tier 1 levels, with an emphasis between the source and any actual plastic water lines. The water inside the plastic water lines shall be analyzed for all chemicals of concern.

c. Target levels. Groundwater modeling as provided in 135.10(2) must be used to calculate the projected concentrations of chemicals of concern and site-specific target levels. The soil leaching to groundwater pathway must be evaluated to ensure contaminated soil will not cause future groundwater concentrations to exceed site-specific target levels. The target level at the point(s) of exposure is the Tier 1 level.

d. Pathway classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B). The water quality inside the plastic water lines is not a criteria for clearance of this pathway.

e. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. If the extent of contamination has been defined, this information must be included in utility company notification, and any previous notification made at Tier 1 must be amended to include this information.

f. Corrective action response.

(1) For actual receptors, unless the pathway is classified as no further action, corrective action for this pathway must be conducted as provided in 135.12(455B). If the concentrations of chemicals of concern in a water line exceed the Tier 1 levels for actual receptors for the groundwater ingestion pathway, immediate corrective action must be conducted to eliminate exposure to the water, including but not limited to replacement of the line with an approved nonplastic material.

(2) For potential receptors, upon utility company notification, no further action will be required for this pathway for potential receptors.

135.10(9) Soil to plastic water line pathway assessment.

a. Pathway completeness and receptor evaluation.

(1) Actual receptors include all plastic water lines within ten feet of the soil plume defined to the Tier 1 level. All plastic water lines must be evaluated for this pathway regardless of distance from the source, if the lines are in areas where Tier 1 levels are exceeded.

(2) Potential receptors include all areas where Tier 1 levels are exceeded.

b. Plume definition. The extent of soil contamination must be defined to Tier 1 levels for the chemicals of concern.

c. Target level. The point(s) of exposure include all areas within ten feet of the plastic water line. The target level at the point(s) of exposure is the Tier 1 level.

d. Pathway classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B). Measurements of water quality inside the plastic water lines may be required, but are not allowed as criteria to clear this pathway.

e. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. If the extent of contamination has been defined, this information must be included in utility company notification, and any previous notification made at Tier 1 must be amended to include this information.

f. Corrective action response.

(1) For actual receptors, unless the pathway is classified as no further action, corrective action for this pathway must be conducted as provided in 135.12(455B).

(2) For potential receptors, upon utility company notification, no further action will be required for this pathway for potential receptors.

135.10(10) Surface water pathway assessment.

a. Pathway completeness. Unless maximum concentrations are less than the applicable Tier 1 levels, this pathway is complete and must be evaluated under any of the following conditions: (1) there is a designated use surface water within the modeled groundwater plume or the actual plume as provided in 135.10(2) "f" and 135.10(2) "g"; or (2) any surface water body which failed the Tier 1 visual inspection as provided in 135.9(10).

b. Visual inspection. A visual inspection must be conducted according to 135.9(10) “c.” If a sheen or residue from a petroleum-regulated substance is present, soil and groundwater sampling must be conducted to identify the source of the release and to define the extent of the contaminant plume to the levels acutely toxic to aquatic life as provided in 567—subrule 61.3(2).

c. Receptor evaluation.

(1) Surface water criteria apply only to designated use segments of surface water bodies as provided in 567—subrules 61.3(1) and 61.3(5). If the surface water body is a designated use segment and if maximum groundwater concentrations exceed applicable surface water criteria, the extent of contamination must be defined as provided in paragraph “d.” The point of compliance for measuring chemicals of concern at the point of exposure is the groundwater adjacent to the surface water body because surface water must be protected for low flow conditions. In-stream measurements of concentrations are not allowed as a basis for no further action.

(2) If the visual inspection indicates the presence of a petroleum sheen in a general use segment within 200 feet of the source, as defined in 567—paragraph 61.3(1) “a,” the segment must be evaluated as an actual receptor. The point of compliance for measuring chemicals of concern at the point of exposure is the groundwater adjacent to the general use segment.

d. Plume definition. The groundwater plume must be defined to the surface water criteria levels for designated use segment receptors and to the acutely toxic levels for general use segment receptors, with an emphasis between the source and the surface water body.

e. Target levels. Determining target levels for this pathway involves a two-step process.

(1) Groundwater modeling as provided in 135.10(2) must be used to calculate the projected concentrations of chemicals of concern at the point of compliance. If the modeled concentrations or field data at the point of compliance exceed surface water criteria for designated use segments, an allowable discharge concentration must be calculated. If the projected concentrations and field data at the point of compliance do not exceed surface water criteria, no further action is required to assess this pathway.

(2) The department water quality section will calculate the allowable discharge concentration using information provided by the certified groundwater professional on a department form. Required information includes, at a minimum, the site location and a discharge flow rate calculated according to the department’s Tier 2 guidance. The allowable discharge concentration is the target level which must be met adjacent to the surface water body which is the point of compliance.

(3) The target level at the point of exposure/compliance for general use segments subject to evaluation is the acutely toxic levels established by the department under 567—Chapter 61 and 567—subrule 62.8(2). If the modeled concentrations of field data at the point of exposure/compliance exceed the acutely toxic levels, modeling must be used to determine site classifications and corrective action in accordance with 135.12(455B).

f. Pathway classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B).

(1) For general use segments, as defined in 567—subrule 61.3(1), if the groundwater professional determines there is no sheen or residue present or if the site is not the source of the sheen or residue or if the sheen does not consist of petroleum-regulated substances, no further action is required for assessment of this pathway. If a petroleum-regulated substance sheen is present, the pathway is high risk and subject to classification in accordance with 135.12(455B).

(2) For designated use segments, as provided in 567—subrules 61.3(1) and 61.3(5), if projected concentrations of chemicals of concern and field data at the point of compliance do not exceed the target level adjacent to the surface water, and the groundwater professional determines there is no sheen or residue present, no further action is required for assessment of this pathway.

g. Corrective action response. Unless the pathway is classified as no further action, corrective action for this pathway must be conducted as provided in 135.12(455B). For surface water bodies failing the visual inspection criteria, corrective action must eliminate the sheen and reduce concentrations to below the site specific target level in accordance with 135.12(455B).

135.10(11) Tier 2 submission and review procedures.

a. Owners and operators must submit a Tier 2 site cleanup report within 180 days of the date the department approves or is deemed to approve a Tier 1 assessment report under 135.9(12). If the owner or operator has elected to conduct a Tier 2 assessment instead of a Tier 1, or a Tier 2 assessment is required due to the presence of free product under 135.7(5), the Tier 2 site cleanup report must be submitted within 180 days of the date the release was confirmed. The department may establish an alternative schedule for submittal.

b. Site cleanup report completeness and accuracy. A Tier 2 site cleanup report is considered to be complete if it contains all the information and data required by this rule and the department's Tier 2 guidance. The report is considered accurate if the information and data are reasonably reliable based first on the standards in these rules and department guidance, and second, on generally accepted industry standards.

c. The certified groundwater professional responsible for completion of the Tier 2 site assessment and preparation of the report must accompany each Tier 2 site cleanup report with a certification as set out below:

I, _____, groundwater professional certification number _____, am familiar with all applicable requirements of Iowa Code section 455B.474 and all rules and procedures adopted thereunder including, but not limited to, the Department of Natural Resources' Tier 2 guidance. Based on my knowledge of those documents and the information I have prepared and reviewed regarding this site, UST registration number _____, LUST No. _____, I certify that this document is complete and accurate as provided in 135.10(11) and meets the applicable requirements of the Tier 2 site cleanup report.

Signature

Date

d. *Review.* Unless the report proposes to classify the site as no action required, the department must approve the report within 60 days for purposes of completeness or disapprove the report upon a finding of incompleteness, inaccuracy or noncompliance with these rules. If no decision is made within this 60-day period, the report is deemed to be approved for purposes of completeness. The department retains the authority to review the report at any time a no action required site classification is proposed.

e. *No action required site classification review.* The department will review each Tier 2 site cleanup report which proposes to classify a site as no action required to determine the data and information are complete and accurate, the data and information comply with department rules and guidance and the site classification proposal is reasonably supported by the data and information.

f. Upon approval of the Tier 2 site cleanup report or as directed by the department, owners and operators must either implement the corrective action recommendations, including any modifications required by the department, or prepare a Tier 3 site analysis. Owners and operators must monitor, evaluate, and report the results of corrective action activities in accordance with the schedule and on a form or in a format required by the department.

g. The department may, in the interest of minimizing environmental or public health risks and promoting a more effective cleanup, require owners and operators to begin cleanup of soil and groundwater before the Tier 2 site cleanup report is approved.

h. *Review of the public water supply receptor risk assessment.* Rescinded IAB 3/11/09, effective 4/15/09.

[ARC 7621B, IAB 3/11/09, effective 4/15/09]

567—135.11(455B) Tier 3 site assessment policy and procedure.

135.11(1) General. Tier 3 site assessment. Unless specifically limited by rule or an imminent hazard exists, an owner or operator may choose to prepare a Tier 3 site assessment as an alternative to completion of a Tier 2 assessment under 135.10(455B) or as an alternative to completion of a corrective action design report under 135.12(455B). Prior to conducting a Tier 3 site assessment, a groundwater professional must submit a work plan to the department for approval. The work plan must contain an evaluation of the specific site conditions which justify the use of a Tier 3 assessment, an outline of the proposed

Tier 3 assessment procedures and reporting format and a method for determining a risk classification consistent with the policies underlying the risk classification system in 135.12(455B). Upon approval, the groundwater professional may implement the assessment plan and submit a report within a reasonable time designated by the department.

135.11(2) Tier 3 site assessment. A Tier 3 assessment may include but is not limited to the use of more site-specific or multidimensional models and assessment data, methods for calibrating Tier 2 models to make them more predictive of actual site conditions, and more extensive assessment of receptor construction and vulnerability to contaminant impacts. If use of Tier 2 models is proposed with substitution of other site-specific data (as opposed to the Tier 2 default parameters), the groundwater professional must adequately justify how site-specific data is to be measured and why it is necessary. The groundwater professional must demonstrate that the proposal has a proven applicability to underground storage tank sites or similar conditions or has a strong theoretical basis for applicability and is not biased toward underestimating assessment results. The Tier 3 assessment report shall make a recommendation for site classification as high risk, low risk or no action required, at least two corrective action response technologies and provide justification consistent with the standards and policies underlying risk classification and corrective action response under 135.12(455B) and Iowa Code chapter 455B, Division 4, Part 8.

135.11(3) Review and submittal. The department will review the Tier 3 assessment for compliance with the terms of the approved work plan and based on principles consistent with these rules and Iowa Code chapter 455B, Division IV, Part 8. Upon approval of the Tier 3 assessment, the department may require corrective action in accordance with 135.12(455B).

567—135.12(455B) Tier 2 and 3 site classification and corrective action response.

135.12(1) General. 1995 Iowa Code section 455B.474(1)“d”(2) provides that sites shall be classified as high risk, low risk and no action required. Risk classification is accomplished by comparing actual field data to the concentrations that are predicted by the use of models. Field data must be compared to the simulation model which uses the maximum concentrations at a source and predicts at what levels actual or potential receptors could be impacted in the future. Field data must also be compared to the site-specific target level line which assumes a target level concentration at the point of exposure and is used to predict the reduction in concentration that must be achieved at the source in order to meet the applicable target level at the point of exposure. These models not only predict concentrations at points of exposure or a point of compliance at a source but also predict a distribution of concentrations between the source and the point of exposure which may also be points of compliance. The comparison of field data with these distribution curves primarily is considered for purposes of judging whether the modeled data is reasonably predictive and what measures such as monitoring are prudent to determine the reliability of modeled data and actual field data.

For the soil vapor to enclosed pathway and soil to plastic water line pathways, there are no horizontal transport models to use predicting future impacts. Therefore, for these pathways, sites are classified as high risk, low risk or no action based on specified criteria below and in 135.10(455B).

135.12(2) High risk classification. Except as provided below, sites shall be classified as high risk if, for any pathway, any actual field data exceeds the site-specific target level line at any point for an actual receptor.

a. For the soil vapor to enclosed space and soil to plastic water line pathways, sites shall be classified as high risk if the target levels for actual receptors are exceeded as provided in 135.10(7) and 135.10(9).

b. For the soil vapor or groundwater vapor to enclosed space pathways, sites shall be classified as high risk if the explosivity levels at applicable points of compliance are exceeded as provided in 135.10(6) and 135.10(7).

c. Generally, sites are classified as low risk if only potential receptor points of compliance are exceeded. The following is an exception. For the soil leaching to groundwater ingestion pathway for potential receptor conditions, the site shall be classified as high risk if the groundwater concentration(s)

exceeds the groundwater Tier 1 level for potential receptor and the soil concentration exceeds the soil leaching site-specific target level at the source.

135.12(3) High risk corrective action response.

a. Objectives. The primary objectives of corrective action in response to a high risk classification are both short-term and long-term. The short-term goal is to eliminate or reduce the risk of exposure at actual receptors which have been or are imminently threatened with exposure above target levels. The longer term goal is to prevent exposure to actual receptors which are not currently impacted or are not imminently threatened with exposure. To achieve these objectives, it is the intent of these rules that concentrations of applicable chemicals of concern be reduced by active remediation to levels below the site-specific target level line at all points between the source(s) and the point(s) of exposure as well as to undertake such interim corrective action as necessary to eliminate or prevent exposure until concentrations below the SSSL line are achieved. If it is shown that concentrations at all applicable points have been reduced to below the SSSL line, the secondary objective is to establish that the field data can be reasonably relied upon to predict future conditions at points of exposure rather than reliance on the modeled data. Reliance on field data is achieved by establishing through monitoring that concentrations within the contaminant plume are steady or declining. Use of institutional control and technological controls may be used to sever pathways or control the risk of receptor impacts.

b. For the soil vapor and soil to plastic water line, these objectives are achieved by active remediation of soil contamination below the target level at the point(s) of exposure or other designated point(s) of compliance using the same measurement methods for receptor evaluation under 135.10(7) and 135.10(9).

c. For a site classified as high risk or reclassified as high risk for the soil leaching to groundwater ingestion pathway, these objectives are achieved by active remediation of soil contamination to reduce the soil concentration to below the site-specific target level at the source.

d. A corrective action design report (CADR) must be submitted by a certified groundwater professional for all high risk sites unless the terms of a corrective action plan are formalized in a memorandum of agreement within a reasonable time frame specified by the department. The CADR must be submitted on a form provided by the department and in accordance with department CADR guidance within 60 days of site classification approval as provided in 135.10(11). The CADR must identify at least two principally applicable corrective action options designed to meet the objectives in 135.12(3), an outline of the projected timetable and critical performance benchmarks, and a specific monitoring proposal designed to verify its effectiveness and must provide sufficient supporting documentation consistent with industry standards that the technology is effective to accomplish site-specific objectives. The CADR must contain an analysis of its cost-effectiveness in relation to other options. The department will review the CADR in accordance with 135.12(9).

e. *Interim monitoring.* From the time a Tier 2 site cleanup report is submitted and until the department determines a site is classified as no action required, interim monitoring is required at least annually for all sites classified as high risk. Groundwater samples must be taken: (1) from a monitoring well at the maximum source concentration; (2) from a transition well, meaning a monitoring well with detected levels of contamination closest to the leading edge of the groundwater plume as defined to the pathway-specific target level, and between the source(s) and the point(s) of exposure; and (3) from a guard well, meaning a monitoring well between the source(s) and the point(s) of exposure with concentrations below the SSSL line. If a receptor is located within an actual plume contoured to the applicable target level for that receptor, the point of exposure must be monitored. If concentrations at the receptor already exceed the applicable target level for that receptor, corrective actions must be implemented as soon as practicable. Monitoring conducted as part of remediation or as a condition of establishing a no action required classification may be used to the extent it meets these criteria. Soil monitoring is required at least annually for all applicable pathways in accordance with 135.12(5)“d.” All drinking water wells and non-drinking water wells within 100 feet of the largest actual plume (defined to the appropriate target level for the receptor type) must be tested annually for chemicals of concern. Actual plumes refer to groundwater plumes for all chemicals of concern.

f. Remediation monitoring. Remediation monitoring during operation of a remediation system is required at least four times each year to evaluate effectiveness of the system. A remediation monitoring schedule and plan must be specified in the corrective action design report and approved by the department.

g. Technological controls. The purpose of a technological control is to effectively sever a pathway by use of technologies such that an applicable receptor could not be exposed to chemicals of concern above an applicable target risk level. Technological controls are an acceptable corrective action response either alone or in combination with other remediation systems. The purpose of technological controls may be to control plume migration through use of containment technologies, barriers, etc., both as an interim or permanent corrective action response or to permanently sever a pathway to a receptor. Controls may also be appropriate to treat or control contamination at the point of exposure. Any technological control proposed as a permanent corrective action option without meeting the reduction in contaminant concentrations objectives must establish that the pathway to a receptor will be permanently severed or controlled. The effectiveness of a technological control must be monitored under a department approved plan until concentrations fall below the site-specific target level line or its effectiveness as a permanent response is established, and no adverse effects are created.

h. Following completion of corrective action, the site must meet exit monitoring criteria to be reclassified as no action required as specified in 135.12(6)“*b.*” At any point where an institutional or technological control is implemented and approved by the department, the site may be reclassified as no action required consistent with 135.12(6).

135.12(4) *Low risk classification.* A site shall be classified as low risk if none of the pathways are high risk and if any of the pathways are low risk. A pathway shall be classified low risk if it meets one of the following conditions:

a. For actual and potential receptors, if the modeled data and the actual field data are less than the site-specific target level line, and any of the field data is greater than the simulation line.

b. For potential receptors, if any actual field data exceeds the site-specific target level line at any point.

c. For the soil leaching to groundwater ingestion pathway where modeling predicts that the Tier 1 levels for potential receptors would be exceeded in groundwater at applicable potential receptor points of compliance and the soil concentration exceeds the soil leaching to groundwater site-specific target level but groundwater concentrations are currently below the Tier 1 level for potential receptors, the site shall be initially classified as low risk and subject to monitoring under 135.12(5)“*d*”(2). If at any time during the three-year monitoring period, groundwater concentrations exceed the Tier 1 level for potential receptors, the site shall be classified as high risk requiring soil remediation in accordance with 135.12(3)“*c.*”

135.12(5) *Low risk corrective action response.*

a. Purpose. For sites or pathways classified as low risk, the purpose of monitoring is to determine if concentrations are decreasing such that reclassification to no action required may be appropriate or if concentrations are increasing above the site-specific target level line such that reclassification to high risk is appropriate. Monitoring is necessary to evaluate impacts to actual receptors and assess the continued status of potential receptor conditions. Low risk monitoring shall be conducted and reported by a certified groundwater professional.

b. For sites or pathways classified as low risk, provide a best management practices plan. The plan must include maintenance procedures, schedule of activities, prohibition of practices, and other management practices, or a combination thereof, which, after problem assessment, are determined to be the most effective means of monitoring and preventing additional contamination of the groundwater and soil. The plan will also contain a contamination monitoring proposal containing sufficient sampling points to ensure the detection of any significant movement of or increase in contaminant concentration.

c. Groundwater monitoring. For groundwater pathways, samples must be taken at a minimum of once per year: (1) from a monitoring well at the maximum source concentration; (2) a transitional well meaning a well with detected levels of contamination closest to the leading edge of the groundwater plume as defined to the pathway-specific target level and between the source and the receptor; and (3) a

guard well meaning a monitoring well between the source and the point of exposure with concentrations below the SSTL line. (NOTE: Monitoring under this provision may be used to satisfy exit monitoring if it otherwise meets the criteria in 135.12(6).)

d. Soil monitoring.

(1) For the soil vapor to enclosed space pathway potential receptors, soil gas samples must be taken at a minimum of once per year in the area(s) of expected maximum vapor concentrations where an institutional control is not in place.

(2) For the soil leaching to groundwater pathway potential receptors, annual groundwater monitoring is required for a minimum of three years as provided in “c” above. If groundwater concentrations are below the applicable SSTL line for all three years and a final soil sample taken from the source shows no significant vertical movement, no further action is required. If groundwater concentrations exceed the applicable SSTL line in any of the three years, corrective action is required to reduce soil concentrations to below the Tier 1 levels for soil leaching to groundwater. Therefore, annual monitoring of soil is not applicable.

(3) For the soil to plastic water line pathway potential receptors, notification of the utility company is required. Notification will result in reclassification to no action required. Therefore, annual monitoring of soil is not applicable.

e. Receptors must be evaluated at least annually to ensure no actual or modeled data are above the site-specific target level line for any actual receptors. Potential receptor areas of concern must be evaluated at least annually and the presence of no actual receptors confirmed. If actual receptors are present or reasonably expected to be brought into existence, the owner or operator must report this fact to the department as soon as practicable. Annual monitoring which also meets the exit criteria under 135.12(6) may be used for that purpose.

f. The site or pathway must meet exit monitoring criteria to be reclassified as no action required as specified in 135.12(6) “b.” If concentrations for actual receptors increase above the site-specific target level line or potential receptor status changes to actual receptor status, the site must be reclassified as high risk and further corrective action required in accordance with 135.12(3).

135.12(6) No action required classification. A site shall be classified as no action required if all of the pathways are classified as no action required as provided below:

a. Soil pathways shall be classified as no action required if samples are less than the applicable target levels as defined for each pathway and confirmational sampling requirements have been met.

b. For initial classification, groundwater pathways shall be classified as no action required if the field data is below the site-specific target level line and all field data is at or less than the simulation line, and confirmation monitoring has been completed successfully. Confirmation sampling for groundwater and soil is a second sample which confirms the no action required criteria.

c. For reclassification from high or low risk, a pathway shall be classified as no action required if all field data is below the site-specific target level line and if exit monitoring criteria have been met. Exit monitoring criteria means the three most recent consecutive groundwater samples from all monitoring wells must show a steady or declining trend and the most recent samples are below the site-specific target level line. Other criteria include the following: The first of the three samples for the source well and transition well must be more than detection limits; concentrations cannot increase more than 20 percent from the first of the three samples to the third sample; concentrations cannot increase more than 20 percent of the previous sample; and samples must be separated by at least six months.

d. Confirmation sampling for soil gas and indoor vapor. For the enclosed space pathways, confirmation sampling is required to reasonably establish that the soil gas and indoor vapor samples represent the highest expected levels. A groundwater professional must obtain two samples taken at least two weeks apart. One of the samples must be taken during a seasonal period of lowest groundwater elevation and soil gas samples must be taken below the frost line.

e. Upon site classification as no action required, all groundwater monitoring wells must be properly plugged in accordance with 567—Chapters 39 and 49 unless the department requires selected wells to be maintained or written approval to maintain the well is obtained by the department.

135.12(7) *Reclassification.* Any site or pathway which is classified as high risk may be reclassified to low risk if in the course of corrective action the criteria for low risk classification are established. Any site or pathway which is classified as low risk may be reclassified to high risk if in the course of monitoring the conditions for high risk classification are established. Sites subject to department-approved institutional or technological controls are classified as no action required if all other criteria for no action required classification are satisfied.

135.12(8) *Use of institutional and technological controls.*

a. Purpose. The purpose of an institutional control is to restrict access to or use of property such that an applicable receptor could not be exposed to chemicals of concern for as long as the target level is exceeded at applicable points of exposure and compliance. Institutional controls include:

1. A law of the United States or the state;
2. A regulation issued pursuant to federal or state laws;
3. An ordinance or regulation of a political subdivision in which real estate subject to the institutional control is located;
4. An environmental covenant as provided in 2005 Iowa Code Supplement section 455B.474(1)“f”(4)(f) and in accordance with the provisions of 2005 Iowa Code Supplement chapter 455I and 567—Chapter 14;
5. Any other institutional control the owner or operator can reasonably demonstrate to the department will reduce the risk from a release throughout the period necessary to ensure that no applicable target level is likely to be exceeded.

b. Modification or termination of institutional and technological controls. At a point when the department determines that an institutional or technological control has been removed or is no longer effective for the purpose intended, regardless of the issuance of a no further action certification or previous site classification, it may require owners and operators to undertake such reevaluation of the site conditions as necessary to determine an appropriate site classification and corrective action response. If the owner or operator is in control of the affected property, the department may require reimplementing of the institutional or technological control or may require a Tier 2 assessment of the affected pathway(s) be conducted to reevaluate the site conditions and determine alternative corrective action response. An owner or operator subject to an institutional or technological control may request modification or termination of the control by conducting a Tier 2 assessment of the affected pathway or conduct such other assessment as required by the department to establish that the control is no longer required given current site conditions.

c. If the owner or operator is not in control of the affected property or cannot obtain control and the party in control refuses to continue implementation of an institutional control, the department may require the owner or operator to take such legal action as available to enforce institution of the control or may require the owner or operator to undertake a Tier 2 assessment to determine site classification and an alternative corrective action response. If a person in control of the affected property appears to be contractually obligated to maintain an institutional or technological control, the department may, but is not required to, attempt enforcement of the contractual obligation as an alternative to requiring corrective action by the owner or operator.

d. If a site is classified no action required, subject to the existence of an institutional control or technological control, the holder of the fee interest in the real estate subject to the institutional control or technological control may request, at any time, that the department terminate the institutional control or technological control requirement. The department shall terminate the requirement for an institutional control if the holder demonstrates by completion of a Tier 2 assessment of the applicable pathway or other assessment as required by the department that the site conditions warranting the control no longer exist and that the site or pathway has met exit criteria for no action required classification under 135.12(6).

135.12(9) *Corrective action design report submission and review procedures.*

a. Owners and operators must submit a corrective action design report (CADR) within 60 days of the date the department approves or is deemed to approve a Tier 2 assessment report under 135.10(11) or a Tier 3 assessment is to be conducted. The department may establish an alternative schedule for submittal. As an alternative to submitting a CADR, owners or operators may participate in a corrective action

meeting process to develop a corrective action plan which would be incorporated into a memorandum of agreement or other written agreement approved by the department. Owners or operators shall implement the terms of an approved CADR, memorandum of agreement or other corrective action plan agreement.

b. Corrective action design report completeness and accuracy. A CADR is considered to be complete if it contains all the information and data required by this rule and the department's guidance. The report is considered accurate if the information and data are reasonably reliable based first on the standards in these rules and department guidance, and second, on generally accepted industry standards.

c. The certified groundwater professional responsible for completion of the CADR must provide the following certification with the CADR:

I, _____, groundwater professional certification number _____, am familiar with all applicable requirements of Iowa Code section 455B.474 and all rules and procedures adopted thereunder including, but not limited to, the Department of Natural Resources' guidance and specifications for corrective action design reports. Based on my knowledge of those documents and the information I have prepared and reviewed regarding this site, UST registration number _____, LUST No. _____, I certify that this document is complete and accurate as provided in 135.12(9) and meets the applicable requirements of the corrective action design report, and that the recommended corrective action can reasonably be expected to meet its stated objectives.

Signature

Date

d. Review. Unless the report proposes to classify the site as no action required, the department must approve the report within 60 days for purposes of completeness or disapprove the report upon a finding of incompleteness, inaccuracy or noncompliance with these rules. If no decision is made within this 60-day period, the report is deemed to be approved for purposes of completeness. The department retains the authority to review the report at any time a no action required site classification is proposed. Owners or operators who fail to implement actions or meet the activity schedule in a memorandum of agreement resulting from a corrective action meeting or other written corrective action plan agreement or who fail to implement the actions or schedule outlined in an approved CADR are subject to legal action.

e. No action required site classification review. The department will review each CADR which proposes to classify a site as no action required to determine the data and information are complete and accurate, the data and information comply with department rules and guidance and the site classification proposal is reasonably supported by the data and information.

135.12(10) *Monitoring certificates and no further action certificates.*

a. Monitoring certificate. The department of natural resources will issue a monitoring certificate to the owner or operator of an underground storage tank from which a release has occurred, the current property owner, or other responsible party who has undertaken the corrective action warranting issuance of the certificate. Sites classified as low risk or sites classified as high risk/monitoring shall be eligible for a monitoring certificate. The monitoring certificate will be valid until the site is reclassified to a high risk requiring active remediation or no action required site. A site which has been issued a monitoring certificate shall not be eligible to receive a certificate evidencing completion of remediation until the site is reclassified as no action required. The monitoring certificate will be invalidated and the site reclassified to high risk if it is determined by the department that the owner of the site is not in compliance with the requirements specified in the monitoring certificate.

b. No further action certificate. The department will issue a no further action certificate to an owner or operator of an underground storage tank from which a release has occurred, the current property owner or other responsible party who has undertaken the corrective action warranting classification of the site as no action required. The person requesting the certificate shall provide the department with an accurate legal description of the property on which the underground storage tanks are or were formerly located. The following conditions apply:

(1) The site has been determined by a certified groundwater professional to not present an unreasonable risk to the public health and safety or the environment;

(2) A person issued the certificate or a subsequent purchaser of the site cannot be required to perform further corrective action solely because action standards are changed at a later date. Action standards refer to applicable site-specific standards under this rule;

(3) The certificate shall not prevent the department from ordering remediation of a new release or a release of a regulated substance from an unregulated tank;

(4) The certificate will not constitute a warranty of any kind to any person as to the condition, marketability or value of the described property;

(5) The certificate shall reflect any institutional control utilized to ensure compliance with any applicable Tier 2 level; and may include a notation that the classification is based on the fact that designated potential receptors are not in existence;

(6) The certificate shall be in a form which is recordable in accordance with Iowa Code section 558.1 et seq. and substantially in the form as provided in Appendix C.

c. The department shall modify any issued no further action certificates containing institutional controls once the owner, operator or their successor or assign has demonstrated that the institutional control is no longer necessary to meet the applicable Tier 2 level as provided in 135.12(10).

135.12(11) Expedited corrective action. An owner, operator or responsible party of a site at which a release of regulated substance is suspected to have occurred may carry out corrective actions at the site so long as the department receives notice of the expedited cleanup activities within 30 calendar days of their commencement; the owner, operator, or responsible party complies with the provisions of these rules; and the corrective action does not include active treatment of groundwater other than:

a. As previously approved by the department; or

b. Free product recovery pursuant to subrule 135.7(5).

c. Soil excavation. When undertaking excavation of contaminated soils, adequate field screening methods must be used to identify maximum concentrations during excavation. At a minimum one soil sample must be taken for field screening every 100 square feet of the base and each sidewall. Soil samples must be taken for laboratory analysis at least every 400 square feet of the base and each sidewall of the excavated area to confirm remaining concentrations are below Tier 1 levels. If the excavation is less than 400 square feet, a minimum of one sample must be analyzed for each sidewall and the base. The owner or operator must maintain adequate records of the excavation area to document compliance with this procedure unless submitted to the department and must provide it to the department upon request.

567—135.13(455B) Public participation.

135.13(1) For each confirmed release that is classified as high or low risk, the department must provide notice to the public by means designated to reach those members of the public directly affected by the release and the recommended corrective action response. This notice may include, but is not limited to, public notice in local newspapers, block advertisements, public service announcements, publication in a state register, letters to individual households, or personal contacts by the staff.

135.13(2) The department must ensure site release information and decisions concerning the Tier 1 assessment report, Tier 2 and Tier 3 site cleanup reports are made available to the public for inspection upon request.

135.13(3) Before approving the Tier 2 or Tier 3 site cleanup report, the department may hold a public meeting to consider comments on the proposed corrective action response if there is sufficient public interest, or for any other reason.

135.13(4) The department must give a public notice that complies with subrule 135.13(1) above if the implementation of the approved Tier 2 or Tier 3 site cleanup report does not achieve the established cleanup levels in the report and the termination of that report is under consideration by the department.

567—135.14(455B) Action levels. The following corrective action levels apply to petroleum regulated substances as regulated by this chapter. These action levels shall be used to determine if further corrective action under 135.6(455B) through 135.12(455B) or 135.15(455B) is required as the result of tank closure sampling under 135.15(3) or other analytical results submitted to the department. The contaminant concentrations must be determined by laboratory analysis as stated in 135.16(455B). Final

cleanup determination is not limited to these contaminants. The contamination corrective action levels are:

	Soil (mg/kg)	Groundwater (ug/L)
Benzene	0.54	5
Toluene	42	1,000
Ethylbenzene	15	700
Xylenes	No limit	10,000
Total Extractable Hydrocarbons	3,800	1,200

567—135.15(455B) Out-of-service UST systems and closure.

135.15(1) Temporary closure.

a. When a UST system is temporarily closed, owners and operators must continue operation and maintenance of corrosion protection in accordance with 135.4(2), any release detection in accordance with rule 135.5(455B), and financial responsibility in accordance with 567—Chapter 136. Rules 135.6(455B) to 135.12(455B) must be complied with if a release is suspected or confirmed. However, release detection is not required as long as the UST system is empty. The UST system is empty when all materials have been removed using commonly employed practices so that no more than 2.5 centimeters (1 inch) of residue, or 0.3 percent by weight of the total capacity of the UST system, remain in the system.

b. When a UST system is temporarily closed for three months or more, owners and operators must notify the department in writing of the temporary closure and comply with the following requirements:

- (1) Leave vent lines open and functioning; and
- (2) Cap and secure all other lines, pumps, accesses, and ancillary equipment.

c. When a UST system is temporarily closed for more than 12 months, owners and operators must return the tank tags and permanently close the UST system if it does not meet either the performance standards in 135.3(1) for new UST systems or the upgrading requirements in 135.3(2), except that the spill and overfill equipment requirements do not have to be met. Owners and operators must permanently close the substandard UST systems at the end of this 12-month period in accordance with 135.15(2) to 135.15(5), unless the department provides an extension of the 12-month temporary closure period. Owners and operators must complete a site assessment in accordance with 135.15(3) before such an extension can be applied for.

135.15(2) Permanent closure and changes-in-service.

a. At least 30 days before beginning either permanent closure or a change-in-service under paragraphs “*b*” and “*c*” below, owners and operators must notify the department of their intent to permanently close or make the change-in-service. An owner or operator must seek prior approval to permanently close a tank in a time frame shorter than the 30-day notice. The required assessment of the excavation zone under 135.15(3) must be performed after notifying the department but before completion of the permanent closure or a change-in-service.

b. To permanently close a tank or piping, owners and operators must empty and clean them by removing all liquids and accumulated sludge. All tanks taken out of service permanently must also be either removed from the ground or filled with an inert solid material. Piping must either be removed from the ground or have the ends plugged with an inert solid material.

When permanently closing a tank by filling with inert solid material, the tank may not be filled until a closure report is approved by the department. The tank must be filled within 30 days after department approval. The owner and operator must notify the department within 15 days after filling the tank with inert solid material.

c. Continued use of a UST system to store a nonregulated substance is considered a change-in-service. Before a change-in-service, owners and operators must empty and clean the tank by removing all liquid and accumulated sludge and conduct a site assessment in accordance with 135.15(3).

d. Permanent closure procedures must be followed in the replacement of tanks or piping. Notification must be made using DNR Form 542-1308, "Notification of Tank Closure or Change-in-Service." The form must include the date scheduled for the closure. Oral confirmation of the closure date must be given to the DNR field office 24 hours prior to the actual closure. The required assessment of the excavation zone under 139.15(3) must be performed after notifying the department but before completion of the permanent closure or change-in-service.

NOTE: The following cleaning and closure procedures may be used to comply with subrule 135.15(2): American Petroleum Institute Recommended Practice 1604, "Removal and Disposal of Used Underground Petroleum Storage Tanks"; American Petroleum Institute Publication 2015, "Cleaning Petroleum Storage Tanks"; American Petroleum Institute Recommended Practice 1631, "Interior Lining of Underground Storage Tanks," may be used as guidance for compliance with this subrule; and the National Institute for Occupational Safety and Health "Criteria for a Recommended Standard . . . Working in Confined Space" may be used as guidance for conducting safe closure procedures at some hazardous substance tanks.

135.15(3) *Assessing the site at closure or change-in-service.*

a. Before permanent closure or a change-in-service is completed, owners or operators must measure for the presence of a release where contamination is most likely to be present at the UST site. This soil and groundwater closure investigation must be conducted or supervised by a groundwater professional certified under 567—Chapter 134, Part A, unless the department in its discretion grants an exemption and provides direct supervision of the closure investigation. In selecting the sample types, sample locations, and measurement methods, owners and operators must consider the method of closure, the nature of the stored substance, the type of backfill, the depth to groundwater, and other factors appropriate for identifying the presence of a release.

At UST sites with a history of petroleum storage, soil and groundwater samples shall in every case be analyzed for benzene, toluene, ethylbenzene, and xylenes (BTEX) with each compound reported separately in accordance with 135.16(455B). If there has been a history or suspected history of petroleum storage other than gasoline or gasoline blends (i.e., all grades of diesel fuels, fuel oil, kerosene, oil and mineral spirits), or such storage history is unknown or uncertain, soil and groundwater samples shall also be analyzed for total extractable hydrocarbons in accordance with 135.16(455B).

All such samples shall be collected separately and shipped to a laboratory certified under 567—Chapter 42, Part C, within 72 hours of collection. Samples shall be refrigerated and protected from freezing during shipment to the laboratory.

When a UST is removed from an area of confirmed contamination, the department may waive closure sampling if written documentation is submitted with the closure notification. Documentation should include laboratory analytical reports and a site map showing tank and piping locations along with contamination plume and sampling locations.

b. For all permanent tank and piping closures or changes-in-service, at least one water sample must be taken from the first saturated groundwater zone via a monitoring well or borehole except as provided in paragraph "g." The well or borehole must be located downgradient from and as close as possible to the excavation but no farther away than 20 feet.

If, however, the first saturated groundwater zone is not encountered within 10 feet below the lowest elevation of the tank excavation, the requirement for groundwater sampling shall not apply unless:

(1) Sands or highly permeable soils are encountered within 10 feet below the lowest level of the tank excavation which together with the underlying geology would, in the judgment of the department, pose the reasonable possibility that contamination may have reached groundwaters deeper than 10 feet below the lowest level of the tank excavation. The method of determining highly permeable soil is found in the departmental guidance documents entitled "Underground Storage Tank Closure Procedures for Tank and Piping Removal" and "Underground Storage Tank Closure for Filling in Place."

(2) Indications of potential groundwater contamination, including petroleum products in utility lines, petroleum products in private wells, petroleum product vapors in basements or other structures, occur in the area of the tank installation undergoing closure or change-in-service.

c. For permanent closure by tank removal, the departmental guidance document entitled “Underground Storage Tank Closure Procedures for Tank and Piping Removal” must be followed. The minimum number of soil samples that must be taken depends on the tank size and length of product piping. Samples must be taken at a depth of 1 to 2 feet beneath the tank fill area below the base of the tank along the tank’s centerline. Soil samples must also be taken at least every 10 feet along the product piping at a depth of 1 to 2 feet beneath the piping fill area below the piping.

If sands or other highly permeable soils are encountered, alternative sampling methods may be required.

If contamination is suspected or found in any area within the excavation (i.e., sidewall or bottom), a soil sample must be taken at that location.

The numbers of samples required for tanks are as follows:

Nominal Tank Capacity (gallons)	Number of Samples	Location on Centerline
1,000 or less	1	center of tank
1,001 - 8,000	2	1/3 from ends
8,001 - 30,000	3	5 feet from ends and at center of tank
30,001 - 40,000	4	5 and 15 feet from ends
40,001 and more	5	5 and 15 feet from ends and at center of tank

d. For closing a tank in place by filling with an inert solid material or for a change-in-service, the departmental guidance document entitled “Underground Storage Tank Closure for Filling in Place” must be followed. The minimum number of soil borings required for sampling depends on the size of the tank and the length of the product piping. Soil samples must be taken within 5 feet of the sides and ends of the tank at a depth of 2 to 4 feet below the base of the tank, but outside the backfill material, at equal intervals around the tank. Soil samples must also be taken at least every 10 feet along the product piping at a depth of 1 to 2 feet beneath the piping fill area below the piping. If sands or other highly permeable soils are encountered, alternative sampling methods may be required.

The minimum numbers of soil borings and samples required are as follows:

Nominal Tank Capacity (gallons)	Number of Samples	Location of Samples
6,000 or less	4	1 each end and each side
6,001 - 12,000	6	1 each end and 2 each side
12,001 or more	8	1 each end and 3 each side

e. A closure report must be submitted to the department within 45 days of the tank removal or sampling for a closure in place. The report must include all laboratory analytical reports, soil boring and well or borehole construction details and stratigraphic logs, and a dimensional drawing showing location and depth of all tanks, piping, sampling, and wells or boreholes, and contaminated soil encountered. The tank tags must be returned with the closure report.

f. The requirements of this subrule are satisfied if one of the external release detection methods allowed in 135.5(4) “*e*” and “*f*” is operating in accordance with the requirements in 135.5(4) at the time of closure and indicates no release has occurred.

g. If contaminated soils, contaminated groundwater, or free product as a liquid or vapor is discovered during the site assessment or by any other manner, contact the department in accordance with 135.6(1). Normal closure procedures no longer apply. Owners and operators must begin corrective action in accordance with rules 135.7(455B) to 135.12(455B).

Identification of free product requires immediate response in accordance with 135.7(5). If contamination appears extensive or the groundwater is known to be contaminated, a full assessment of the contamination will be required. When a full assessment is required or anticipated, collection of the

required closure samples is not required. If contamination appears limited to soils, overexcavation of the contaminated soils in accordance with 135.15(4) may be allowed at the time of closure.

135.15(4) *Overexcavation of contaminated soils at closure.*

a. If contaminated soils are discovered while assessing a site at closure in accordance with 135.15(3), owners and operators may overexcavate up to one foot of the contaminated soils surrounding the tank pit. The contamination and overexcavation must be reported to the department in accordance with the requirements of 135.6(4) “*a*” prior to backfilling the excavation. If excavation is limited to one foot of contaminated soils, a soil sample shall be taken and laboratory analyzed in accordance with 135.16(455B) from the area showing the greatest contamination. Any overexcavation of contaminated soils beyond one foot of contaminated soils is considered expedited corrective action and must be conducted by a certified groundwater professional in accordance with the procedures in 135.12(11).

b. Excavated contaminated soils must be properly disposed in accordance with 567—Chapters 100, 101, 102, 120, and 121, Iowa Administrative Code.

c. A report must be submitted to the department within 30 days of completion of the laboratory analysis. The report must include the requirements of 135.15(3) “*e*” and a dimensional drawing showing the depth and area of the excavation prior to and after overexcavation. The area of contamination must be shown.

135.15(5) *Applicability to previously closed UST systems.* When directed by the department, the owner and operator of a UST system permanently closed before October 24, 1988, must assess the excavation zone and close the UST system in accordance with this rule if releases from the UST may, in the judgment of the department, pose a current or potential threat to human health and the environment.

135.15(6) *Closure records.* Owners and operators must maintain records in accordance with 135.4(5) that are capable of demonstrating compliance with closure requirements under this rule. The results of the excavation zone assessment required in 135.15(3) must be maintained for at least three years after completion of permanent closure or change-in-service in one of the following ways:

a. By the owners and operators who took the UST system out of service;

b. By the current owners and operators of the UST system site; or

c. By mailing these records to the department if they cannot be maintained at the closed facility.

135.15(7) *Applicability to pre-1974 USTs.* The closure provisions of rule 135.15(455B) are not applicable to USTs which have been out of operation as of January 1, 1974. For purposes of this subrule, out of operation means that no regulated substance has been deposited into or dispensed from the tanks and that the tanks do not currently contain an accumulation of regulated substances other than a de minimus amount as provided in 135.15(1) “*a*.”

Owners and operators or other interested parties are not required to submit documentation that USTs meet the exemption conditions and may rely on this subrule as guidance. However, should a question arise as to whether USTs meet the exemption, or owners and operators or other interested parties request acknowledgment by the department that USTs are exempt, they must submit an affidavit on a form provided by the department. The affiant must certify that based on a reasonable investigation and to the best of the affiant’s knowledge, the USTs were taken out of operation prior to January 1, 1974, the USTs have not contained a regulated substance since January 1, 1974, and the USTs do not currently contain an accumulation of regulated substances.

If the department has a reasonable basis to suspect a release has occurred, the release investigation and confirmation steps of subrule 135.8(1) and the corrective action requirements as provided in 135.7(455B) to 135.8(455B) shall apply.

[ARC 8124B, IAB 9/9/09, effective 10/14/09]

567—135.16(455B) Laboratory analytical methods for petroleum contamination of soil and water.

135.16(1) *General.* When having soil or water analyzed for petroleum or hazardous substances, owners and operators of UST systems must use a laboratory certified under 567—Chapter 83. In addition they must ensure that all soil and groundwater samples are properly preserved and shipped within 72 hours of collection to a laboratory certified under 567—Chapter 83, for UST petroleum analyses. This

rule provides acceptable analytical procedures for petroleum substances and required information that must be provided in all laboratory reports.

135.16(2) Laboratory report. All laboratory reports must contain the following information:

a. Laboratory name, address, telephone number and Iowa laboratory certification number. If analytical work is subcontracted to another laboratory, the analytical report from the certified lab which analyzed the sample must be submitted and include the information required in this subrule.

b. Medium sampled (soil, water).

c. Client submitting sample (name, address, telephone number).

d. Sample collector (name, telephone number).

e. UST site address.

f. Client's sample location identifier.

g. Date sample was collected.

h. Date sample was received at laboratory.

i. Date sample was analyzed.

j. Results of analyses and units of measure.

k. Detection limits.

l. Methods used in sample analyses (preparation method, sample detection method, and quantitative method).

m. Laboratory sample number.

n. Analyst name.

o. Signature of analyst's supervisor.

p. Condition in which the sample was received at the laboratory and whether it was properly sealed and preserved.

q. Note that analytical results are questionable if a sample exceeded an established holding time or was improperly preserved. (The recommended holding time for properly cooled and sealed petroleum contaminated samples is 14 days, except for water samples containing volatile organic compounds which have a 7-day holding time unless acid-preserved.)

r. Laboratory reports required by this chapter for tank closure investigations under 135.15(455B) and site checks under 135.6(3) or Tier 1 or Tier 2 assessments under 135.9(455B) to 135.11(455B) must include a copy of the chromatograms and associated quantitation reports for the waste oil, diesel and gasoline standard used by the laboratory in analyzing submitted samples. The laboratory analytical report for each sample must state whether the sample tested matches the laboratory standard for waste oil, diesel or gasoline or that the sample cannot be reliably matched with any of these standards. A copy of the chromatograms and associated quantitation reports for only the soil and groundwater samples with the maximum concentrations of BTEX and TEH must be included.

135.16(3) Analysis of soil and water for high volatile petroleum compounds (i.e., gasoline, benzene, ethylbenzene, toluene, xylene). Sample preparation and analysis shall be by Method OA-1, "Method for Determination of Volatile Petroleum Hydrocarbons (gasoline)," revision 7/27/93, University Hygienic Laboratory, Iowa City, Iowa. This method is based on U.S. EPA methods 5030, 8000, and 8015, SW-846, "Test Methods for Evaluating Solid Waste," 3rd Edition. Copies of Method OA-1 are available from the department.

135.16(4) Analysis of soil and water for low volatile petroleum hydrocarbon contamination (i.e., all grades of diesel fuel, fuel oil, kerosene, oil, and mineral spirits). Sample preparation and analysis shall be by Method OA-2, "Determination of Extractable Petroleum Products (and Related Low Volatility Organic Compounds)," revision 7/27/93, University Hygienic Laboratory, Iowa City, Iowa. This method is based on U.S. EPA methods 3500, 3510, 3520, 3540, 3550, 8000, and 8100, SW-846, "Test Methods for Evaluating Solid Waste," 3rd Edition. Copies of Method OA-2 are available from the department.

135.16(5) Analysis of soil gas for volatile petroleum hydrocarbons. Analysis of soil gas for volatile petroleum hydrocarbons shall be conducted in accordance with the National Institute for Occupational Safety and Health (NIOSH) Method 1501, or a department-approved equivalent method.

567—135.17(455B) Evaluation of ability to pay.

135.17(1) General. The ability to pay guidance procedures referenced in this rule will be used by the department when an owner or operator of an underground storage tank (UST) claims to be financially unable to comply with corrective action requirements under 135.7(455B) to 135.12(455B) or closure investigation requirements under 135.15(455B). If an owner or operator of a regulated UST claims to be financially unable to meet these departmental requirements, that responsible party must provide documentation of the party's finances on forms provided by the department in order for the department to act on the claim of financial inability. The department may request additional financial documentation to verify or supplement reported information.

135.17(2) Individual claims. The financial ability of individual owners and operators of USTs, with or without an active business (including but not limited to sole proprietorships and general partnerships), shall be evaluated using the "Individual Ability to Pay Guidance" document dated June 19, 1992, and generally accepted principles of financial analysis. This guidance is only one tool the department may use in evaluating claims of financial inability.

135.17(3) Corporate claims. The financial ability of corporate owners and operators of USTs shall be evaluated using the June 1992 version of "ABEL" developed by the U.S. Environmental Protection Agency and generally accepted principles of financial analysis. This guidance is only one tool the department may use in evaluating claims of financial inability.

135.17(4) Federal LUST Trust Fund. The financial ability of owners and operators of USTs shall be evaluated for the purpose of determining if the department is authorized to use Federal LUST Trust Fund moneys as provided in the current cooperative agreement with the U.S. Environmental Protection Agency, Region VII. A determination of financial inability does not create an entitlement or any expectation interest on behalf of an owner or operator that Federal LUST Trust Fund moneys will be used for corrective action at any individual site.

135.17(5) The evaluation of financial ability will also be used by the department in making other administrative planning decisions including but not limited to decisions as to whether to pursue and when to pursue administrative or judicial enforcement of regulatory and statutory duties and the assessment of penalties. A determination of financial inability does not create an entitlement or expectation interest that enforcement actions will be deferred or suspended. The evaluation of this factor is only one of many affecting the department's fully discretionary decisions regarding enforcement options and program planning.

135.17(6) An evaluation of financial inability as provided in this rule does not relieve any owner or operator of legal liability to comply with department rules or Iowa Code chapter 455B or provide a defense to any legal actions to establish liability or enforce compliance.

567—135.18(455B) Transitional rules.

135.18(1) *Transitional rules.* Guidance for implementing these transitional rules is contained in the department's guidance entitled "Transition Policy Statement" dated June 6, 1996.

135.18(2) *Site cleanup reports and corrective action design reports accepted before August 15, 1996.* Any owner or operator who had a site cleanup report or corrective action design report approved by the department before August 15, 1996, may elect to submit a Tier 1 Site Assessment or Tier 2 Site Cleanup Report to the department. If the owner, operator, or responsible party so elects, the site shall be assessed, classified, and, if necessary, remediated, in accordance with the rules of the department as of August 15, 1996. To the extent that data collected for the site cleanup report does not include all information necessary for the Tier 1 Site Assessment or Tier 2 Site Cleanup Report, the owner or operator shall utilize the default parameters set out in subrule 135.18(4) or provide site-specific parameters.

135.18(3) *Site cleanup reports in the process of preparation or review prior to August 15, 1996.* The department will complete a Tier 1 or a Tier 2 risk analysis for any site cleanup report received but not approved by the department by November 15, 1996. To the extent that data collected for the site cleanup report does not include all information necessary for the Tier 2 site cleanup report and the owner or operator elects to not complete a Tier 2 site cleanup report the department shall utilize the default

parameters set out in subrule 135.18(4). If the owner or operator wishes that site-specific data, rather than any default parameter, be used, the owner or operator shall notify the department by October 15, 1996, or in accordance with a schedule specified by the department. Following notification, the owner or operator shall be responsible for preparation of the Tier 1 site assessment or Tier 2 site cleanup report.

135.18(4) *Default parameters for use in converting a site cleanup report to a Tier 2 site cleanup report.*

a. As to sites for which the owner or operator has collected and submitted only TPH (“total petroleum hydrocarbons”) data regarding soil contamination, TPH levels shall be converted to a risk associated factor by using: (1) previously acquired data regarding benzene, toluene, ethyl benzene, and xylenes data for the samples; (2) newly collected benzene, toluene, ethylbenzene, and xylenes data for the site; or (3) the assumptions that 1 percent of the total petroleum hydrocarbon (TPH) is benzene, 7 percent of the TPH is toluene, 2 percent of the TPH is ethylbenzene, and 8 percent of the TPH is xylenes.

b. As to sites for which the owner or operator has, to date, submitted only TEH (“total extractable hydrocarbons”) data regarding soil contamination, TEH levels should be converted to a risk-associated factor by using: (1) previously acquired benzene, toluene, ethylbenzene and xylenes data for the samples; (2) newly collected benzene, toluene, ethylbenzene and xylenes data for the site; or (3) the assumption that 0.004 percent of the TEH is benzene, 0.05 percent of the TEH is toluene, 0.03 percent of the TEH is ethylbenzene and 0.3 percent of the TEH is xylenes. In addition, TEH levels should be compared to the TEH default levels in the Tier 1 Table. If, as of August 15, 1996, only TEH data for soil is available, and it does not exceed Tier 1 levels, additional sampling for TEH in groundwater is not required. Otherwise, groundwater samples must be collected and analyzed for TEH in accordance with 135.8(3).

c. Data required for preparing a Tier 2 site cleanup report shall be taken from the site cleanup report. If the site cleanup report lacks any of the data, site-specific data subsequently obtained may be used. The following assumptions shall be used if no site cleanup report or site-specific data is provided:

(1) If the site cleanup report is unclear as to neighboring land use, assume the land residential land use;

(2) Use the larger resulting default if both TPH and TEH data are available.

(3) For sites with free product gasoline range constituents, the default values in groundwater are 17,500 ug/l for benzene, 3,040 ug/l for ethylbenzene, 37,450 ug/l for toluene and 15,840 ug/l for xylenes. For sites with free product consisting of diesel range constituents, the default values are 370 ug/l benzene, 640 ug/l toluene, 140 ug/l ethylbenzene, 580 ug/l xylenes, and 260 ug/l naphthalene or 130,000 ug/l TEH.

135.18(5) *Risk-based corrective action assessment reports, corrective action plans, and corrective action design reports accepted before August 6, 2008.* Any owner or operator who had a Tier 2 site cleanup report, Tier 3 report, or corrective action design report approved by the department before August 6, 2008, may elect to submit a Tier 2 site cleanup report using the Appendix B revised model, department-developed software and rules in effect as of August 6, 2008. The owner or operator shall notify the department that the owner or operator wishes to evaluate the leaking underground storage tank site with the Appendix B revised model, software and rules. If the owner or operator so elects, the site shall be assessed, classified, and, if necessary, remediated, in accordance with the rules of the department as of August 6, 2008. If the leaking underground storage tank site is undergoing active remediation, the remediation system shall remain operating until the reevaluation is completed and accepted or as otherwise approved by the department. Once a site has been evaluated using the Appendix B revised model, software and rules in effect as of August 6, 2008, it can no longer be evaluated with the Appendix B-1 old model and software and rules in effect prior to August 6, 2008.

135.18(6) *Risk-based corrective action assessment reports, corrective action plans, and corrective action design reports in the process of preparation with a submittal schedule established prior to August 6, 2008.* The owner or operator shall notify the department that the owner or operator wishes to use the Appendix B revised model and department software and rules in effect as of August 6, 2008, to evaluate the leaking underground storage tank site before submitting the next report, and prior to expiration of the previously established submittal schedule. Once a site has been evaluated using the Appendix B revised model, software and rules in effect as of August 6, 2008, it can no longer be evaluated with the Appendix B-1 old model, software and rules existing just prior to August 6, 2008.

135.18(7) *Risk-based corrective action assessment reports, corrective action plans, and corrective action design reports received by the department but not yet reviewed.* The owner or operator will notify the department within 60 days of August 6, 2008, whether the owner or operator is electing to complete a risk-based corrective action assessment using Appendix B revised model, department software and rules effective as of August 6, 2008, or proceeding with the risk-based corrective action assessment using Appendix B-1 old model and department software and rules existing prior to August 6, 2008. Once a site has been evaluated using the Appendix B revised model, software and rules it can no longer be evaluated with the previous Appendix B-1 old model, software and rules.

567—135.19(455B) Analyzing for methyl tertiary-butyl ether (MTBE) in soil and groundwater samples.

135.19(1) *General.* The objective of analyzing for MTBE is to determine its presence in soil and water samples collected as part of investigation and remediation of contamination at underground storage tank facilities.

135.19(2) *Required MTBE testing.* Soil and water samples must be analyzed for MTBE when collected for risk-based corrective action as required in rules 135.8(455B) through 135.12(455B). These sampling requirements include but are not limited to:

- a. Risk-based corrective action (RBCA) evaluations required for Tier 1, Tier 2, and Tier 3 assessments and corrective action design reports.
- b. Site monitoring.
- c. Site remediation monitoring.

135.19(3) *MTBE testing not required.* Soil and water samples for the following actions are not required to be analyzed for MTBE:

- a. Closure sampling under rule 135.15(455B) unless Tier 1 or Tier 2 sampling is being performed.
- b. Site checks under subrule 135.7(3) unless Tier 1 or Tier 2 sampling is being performed.
- c. If prior analysis at a site under 135.19(2) has not shown MTBE present in soil or groundwater.
- d. If the department determines MTBE analysis is no longer needed at a site.

135.19(4) *Reporting.* The analytical data must be submitted in a format prescribed by the department.

135.19(5) *Analytical methods for methyl tertiary-butyl ether (MTBE).* When having soil or water analyzed for MTBE from contamination caused by petroleum or hazardous substances, owners and operators of UST systems must use a laboratory certified under 567—Chapter 83 for petroleum analyses. In addition, the owners and operators must ensure all soil and water samples are properly preserved and shipped within 72 hours of collection to a laboratory certified under 567—Chapter 83 for petroleum analyses.

- a. Sample preparation and analysis shall be by:
 - (1) GC/MS version of OA-1, “Method for Determination of Volatile Petroleum Hydrocarbons (gasoline),” revision 7/27/93, University Hygienic Laboratory, Iowa City, Iowa; or
 - (2) U.S. Environmental Protection Agency Method 8260B, SW-846, “Test Methods for Evaluating Solid Waste,” Third Edition.
- b. Laboratories performing the analyses must run standards for MTBE on a routine basis, and standards for other possible compounds like ethyl tertiary-butyl ether (ETBE), tertiary-amyl methyl ether (TAME), diisopropyl ether (DIPE), and tertiary-butyl alcohol (TBA) to be certain of their identification should they be detected.
- c. Laboratories must run a method detection limit study and an initial demonstration of capability for MTBE. These records must be kept on file.
- d. The minimum detection level for MTBE in soil is 15 ug/kg. The minimum detection level for MTBE in water is 15 ug/l.

567—135.20(455B) Compliance inspection of UST system.

135.20(1) The owner or operator must have the UST system inspected and an inspection report submitted to the department by a UST compliance inspector certified by the department under

567—Chapter 134. An initial compliance site inspection shall be conducted no later than December 31, 2007. All subsequent compliance site inspections conducted after the compliance site inspection for the 2008-2009 biennial period shall be conducted within 24 months of the prior compliance site inspection. Compliance site inspections must be separated by at least six months.

135.20(2) Compliance inspection requirements. The owner or operator is responsible to ensure the department receives ten days' prior notice by the compliance inspector of the date of a site inspection and the name of the inspector as provided in 567—134.14(455B). The owner and operator must comply with the following as part of the inspection process.

a. Review and respond to the inspection report provided by the certified compliance inspector and complete the corrective actions specified in the compliance inspection report within the specified time frames.

b. Provide all records and documentation required by the certified compliance inspector and this chapter.

c. Upon notification of a suspected release by the certified compliance inspector pursuant to 567—subrule 134.14(1), report the condition to the department and undertake steps to investigate and confirm the suspected release as provided in 567—135.6(455B).

d. Ensure that the compliance inspector completes and submits an electronic inspection form in accordance with 567—134.14(455B).

135.20(3) The owner and operator shall do the following upon receipt of a compliance inspection report as provided in 567—subrule 134.14(1) which finds violations of the department's rules:

a. Take all actions necessary to correct any compliance violations or deficiencies in accordance with this chapter. Corrective action must be taken within the time frame established by rule or, if no time frames are established by rule, within 60 days of receipt of the inspector's report or another reasonable time period approved by the department. The granting of time to remedy a violation does not preclude the department from exercising its discretion to assess penalties for the violation.

b. Within 60 days of receipt of the inspector's report, provide documentation to the compliance inspector that the violation or deficiencies have been corrected.

c. Conduct a follow-up inspection in instances where there are serious problems or a history of repeated violations when required by the department.

135.20(4) Conflict of interest. A compliance site inspection must be conducted by a certified compliance inspector who is not the owner or operator of the UST system being inspected, an employee of the owner or operator of the UST system being inspected, or a person having daily on-site responsibility for the operation and maintenance of the UST system.

[ARC 8124B, IAB 9/9/09, effective 10/14/09]

Appendix A - Tier 1 Table, Assumptions, Equations and Parameter Values

Iowa Tier 1 Look-Up Table

Media	Exposure Pathway	Receptor	Group 1				Group 2: TEH	
			Benzene	Toluene	Ethylbenzene	Xylenes	Diesel*	Waste Oil
Groundwater (ug/L)	Groundwater Ingestion	actual	5	1,000	700	10,000	1,200	400
		potential	290	7,300	3,700	73,000	75,000	40,000
	Groundwater Vapor to Enclosed Space	all	1,540	20,190	46,000	NA	2,200,000	NA
	Groundwater to Plastic Water Line	all	290	7,300	3,700	73,000	75,000	40,000
	Surface Water	all	290	1,000	3,700	73,000	75,000	40,000
Soil (mg/kg)	Soil Leaching to Groundwater	all	0.54	42	15	NA	3,800	NA
	Soil Vapor to Enclosed Space	all	1.16	48	79	NA	47,500	NA
	Soil to Plastic Water Line	all	1.8	120	43	NA	10,500	NA

NA: Not applicable. There are no limits for the chemical for the pathway, because for groundwater pathways the concentration for the designated risk would be greater than the solubility of the pure chemical in water, and for soil pathways the concentration for the designated risk would be greater than the soil concentration if pure chemical were present in the soil.

TEH: Total Extractable Hydrocarbons. The TEH value is based on risks from naphthalene, benzo(a)pyrene, benz(a)anthracene, and chrysene. Refer to Appendix B for further details.

Diesel*: Standards in the Diesel column apply to all low volatile petroleum hydrocarbons except waste oil.

Assumptions Used for Iowa Tier 1 Look-Up Table Generation

1. Groundwater ingestion pathway. The maximum contaminant levels (MCLs) were used for Group 1 chemicals. The target risk for carcinogens for actual receptors is 10^{-6} and for potential receptors is 10^{-4} . A hazard quotient of one, and residential exposure and building parameters are assumed.
2. Groundwater vapor to enclosed space pathway. Residential exposure and residential building parameters are assumed; no inhalation reference dose is used for benzene; the capillary fringe is assumed to be the source of groundwater vapor; and the hazard quotient is 1 and target risk for carcinogens is 1×10^{-4} .
3. Groundwater to plastic water line. This pathway uses the same assumptions as the groundwater ingestion pathway for potential receptors, including a target risk for carcinogens of 10^{-4} .
4. Surface water. This pathway uses the same assumptions as the groundwater ingestion pathway for potential receptors, including a target risk for carcinogens of 10^{-4} , except for toluene which has a chronic level for aquatic life of 1,000 as in the definition for surface water criteria in 567—135.2.
5. Soil leaching to groundwater. This pathway assumes the groundwater will be protected to the same levels as the groundwater ingestion pathway for potential receptors, using residential exposure and a target risk for carcinogens of 10^{-4} .
6. Soil vapor to enclosed space pathway. The target risk for carcinogens is 1×10^{-4} ; the hazard quotient is 1; no inhalation reference dose is used for benzene; residential exposure factors are assumed; and the average of the residential and nonresidential building parameters are assumed.
7. Soil to plastic water line pathway. This pathway uses the soil leaching to groundwater model with nonresidential exposure and a target risk for carcinogens of 10^{-4} .

In addition to these assumptions, the equations and parameter values used to generate the Iowa Tier 1 Look-Up Table are described below.

Groundwater Ingestion Equations

Carcinogens:

$$\text{RBSL}_w \left[\frac{\text{mg}}{\text{L} - \text{H}_2\text{O}} \right] = \frac{\text{TR} \times \text{BW} \times \text{AT}_c \times \frac{365 \text{ days}}{\text{year}}}{\text{SF}_o \times \text{IR}_w \times \text{EF} \times \text{ED}}$$

Noncarcinogens:

$$\text{RBSL}_w \left[\frac{\text{mg}}{\text{L} - \text{H}_2\text{O}} \right] = \frac{\text{THQ} \times \text{RfD}_o \times \text{BW} \times \text{AT}_n \times \frac{365 \text{ days}}{\text{year}}}{\text{IR}_w \times \text{EF} \times \text{ED}}$$

Soil Leaching to Groundwater Equations

$$\text{RBSL}_{sl} \left[\frac{\text{mg}}{\text{kg} - \text{soil}} \right] = \frac{\text{RBSL}_w \left[\frac{\text{mg}}{\text{L} - \text{H}_2\text{O}} \right]}{\text{LF}}$$

$$\text{LF} \left[\frac{\text{mg/L} - \text{H}_2\text{O}}{\text{mg/kg} - \text{soil}} \right] = \frac{\rho_s}{(\theta_{ws} + k_s \rho_s + H \theta_{as}) \left(1 + \frac{U \delta}{IW} \right)}$$

Soil Vapor to Enclosed Space Equations

$$\text{RBSL}_{\text{sv}} \left[\frac{\text{mg}}{\text{kg} - \text{soil}} \right] = \frac{\text{RBSL}_{\text{air}} \left[\frac{\mu\text{g}}{\text{m}^3 - \text{air}} \right]}{\text{VF}_{\text{sv}}} \left(\frac{\text{mg}}{1000 \mu\text{g}} \right)$$

$$\text{VF}_{\text{sv}} \left[\frac{(\text{mg}/\text{m}^3 - \text{air})}{(\text{mg}/\text{kg} - \text{soil})} \right] = \frac{\frac{H\rho_s}{(\theta_{\text{ws}} + K_s\rho_s + H\theta_{\text{as}})} \left[\frac{D_s^{\text{eff}}/L_s}{ER L_B} \right]}{1 + \left[\frac{D_s^{\text{eff}}/L_s}{ER L_B} \right] + \left[\frac{D_{\text{crack}}^{\text{eff}}/L_{\text{crack}}}{\eta} \right]} \left(10^3 \frac{\text{cm}^3 - \text{kg}}{\text{m}^3 - \text{g}} \right)$$

$$D_{\text{crack}}^{\text{eff}} \left[\frac{\text{cm}^2}{\text{s}} \right] = D_{\text{air}} \frac{\theta_{\text{acrack}}^{3.33}}{\theta_{\text{T}}^2} + D_{\text{wat}} \frac{1}{H} \frac{\theta_{\text{wcrack}}^{3.33}}{\theta_{\text{T}}^2}$$

$$D_s^{\text{eff}} \left[\frac{\text{cm}^2}{\text{s}} \right] = D_{\text{air}} \frac{\theta_{\text{as}}^{3.33}}{\theta_{\text{T}}^2} + D_{\text{wat}} \frac{1}{H} \frac{\theta_{\text{ws}}^{3.33}}{\theta_{\text{T}}^2}$$

Indoor Air Inhalation Equations

Carcinogens:

$$\text{RBSL}_{\text{air}} \left[\frac{\mu\text{g}}{\text{m}^3 - \text{air}} \right] = \frac{\text{TR} \times \text{BW} \times \text{AT}_c \times \frac{365 \text{ days}}{\text{year}} \times \frac{1000 \mu\text{g}}{\text{mg}}}{\text{SF}_i \times \text{IR}_{\text{air}} \times \text{EF} \times \text{ED}}$$

Noncarcinogens:

$$\text{RBSL}_{\text{air}} \left[\frac{\mu\text{g}}{\text{m}^3 - \text{air}} \right] = \frac{\text{THQ} \times \text{RfD}_i \times \text{BW} \times \text{AT}_n \times \frac{365 \text{ kdays}}{\text{year}} \times \frac{1000 \mu\text{g}}{\text{mg}}}{\text{IR}_{\text{air}} \times \text{EF} \times \text{ED}}$$

Groundwater Vapor to Enclosed Space Equations

$$\text{RBSL}_{\text{gw}} \left[\frac{\text{mg}}{\text{L} - \text{H}_2\text{O}} \right] = \frac{\text{RBSL}_{\text{air}} \left[\frac{\mu\text{g}}{\text{m}^3 - \text{air}} \right]}{\text{VF}_{\text{gw}}} \left(\frac{\text{mg}}{1000 \mu\text{g}} \right)$$

$$\text{VF}_{\text{gw}} \left[\frac{(\text{mg}/\text{m}^3 - \text{air})}{(\text{mg}/\text{L} - \text{H}_2\text{O})} \right] = \frac{H \left[\frac{D_s^{\text{eff}}/L_{\text{gw}}}{\text{ER} L_B} \right]}{1 + \left[\frac{D_s^{\text{eff}}/L_{\text{gw}}}{\text{ER} L_B} \right] + \left[\frac{D_s^{\text{eff}}/L_{\text{gw}}}{(D_{\text{crack}}^{\text{eff}}/L_{\text{crack}}) \eta} \right]} \left(\frac{10^3 \text{L}}{\text{m}^3} \right)$$

Variable Definitions

δ	groundwater mixing zone thickness (cm)
η	areal fraction of cracks in foundation/wall (cm ² -cracks/cm ² -area)
ρ_s	soil bulk density (g/cm ³)
θ_{crack}	volumetric air content in foundation/wall cracks (cm ³ -air/cm ³ -soil)
θ_{as}	volumetric air content in vadose zone (cm ³ -air/cm ³ -soil)
θ_T	total soil porosity (cm ³ -voids/cm ³ -soil)
θ_{wcrack}	volumetric water content in foundation/wall cracks (cm ³ -H ₂ O/cm ³ -soil)
θ_{ws}	volumetric water content in vadose zone (cm ³ -H ₂ O/cm ³ -soil)
AT_c	averaging time for carcinogens (years)
AT_n	averaging time for noncarcinogens (years)
BW	body weight (kg)
D_{air}	chemical diffusion coefficient in air (cm ² /s)
D_{wat}	chemical diffusion coefficient in water (cm ² /s)
$D_{\text{crack}}^{\text{eff}}$	effective diffusion coefficient through foundation cracks (cm ² /s)
D_s^{eff}	effective diffusion coefficient in soil based on vapor-phase concentration (cm ² /s)
ED	exposure duration (years)
EF	exposure frequency (days/year)
ER	enclosed space air exchange rate (s ⁻¹)
f_{oc}	fraction organic carbon in the soil (kg-C/kg-soil)
H	henry's law constant (L-H ₂ O)/(L-air)
i	groundwater head gradient (cm/cm)
I	infiltration rate of water through soil (cm/year)
IR_{air}	daily indoor inhalation rate (m ³ /day)
IR_w	daily water ingestion rate (L/day)
K	hydraulic conductivity (cm/year)
K_{oc}	carbon-water sorption coefficient (L-H ₂ O/kg-C)
k_s	soil-water sorption coefficient (L-H ₂ O/kg-soil), $f_{\text{oc}} \times K_{\text{oc}}$
L_B	enclosed space volume/infiltration area ratio (cm)
L_{crack}	enclosed space foundation or wall thickness (cm)
LF	leaching factor from soil to groundwater ((mg/L-H ₂ O)/(mg/kg-soil))
L_{gw}	depth to groundwater from the enclosed space foundation (cm)
L_s	depth to subsurface soil sources from the enclosed space foundation (cm)
$RBSL_{\text{air}}$	Risk-Based Screening Level for indoor air ($\mu\text{g}/\text{m}^3\text{-air}$)
$RBSL_{\text{gw}}$	Risk-Based Screening Level for vapor from groundwater to enclosed space air inhalation (mg/L-H ₂ O)
$RBSL_{\text{sl}}$	Risk-Based Screening Level for soil leaching to groundwater (mg/kg-soil)
$RBSL_{\text{sv}}$	Risk-Based Screening Level for vapors from soil to enclosed space air inhalation (mg/kg-soil)
$RBSL_w$	Risk-Based Screening Level for groundwater ingestion (mg/L-H ₂ O)
RfD_i	inhalation chronic reference dose ((mg)/(kg-day))
RfD_o	oral chronic reference dose ((mg)/(kg-day))
SF_i	inhalation cancer slope factor ((kg-day)/mg)
SF_o	oral cancer slope factor ((kg-day)/mg)
THQ	target hazard quotient for individual constituents (unitless)
TR	target excess individual lifetime cancer risk (unitless)
U	groundwater Darcy velocity (cm/year), $U=Ki$
VF_{gw}	volatilization factor for vapors from groundwater to enclosed space ((mg/m ³ -air)/(mg/L-H ₂ O))
VF_{sv}	volatilization factor for vapors from soil to enclosed space ((mg/m ³ -air)/(mg/kg-soil))
W	width of soil source area parallel to groundwater flow direction (cm)

Soil and Groundwater Parameter Values Used for Iowa Tier 1 Table Generation

Parameter		Iowa Tier 1 Table Value
K	hydraulic conductivity	16060 cm/year
i	groundwater head gradient	0.01 cm/cm
W	width of soil source area parallel to groundwater flow direction	1500 cm
I	infiltration rate of water through soil	7 cm/year
δ	groundwater mixing zone thickness	200 cm
ρ_s	soil bulk density	1.86 g/cm ³
θ_{as}	volumetric air content in vadose zone	0.2 cm ³ -air/cm ³ -soil
θ_{ws}	volumetric water content in vadose zone	0.1 cm ³ -H ₂ O/cm ³ -soil
θ_{acrack}	volumetric air content in foundation/wall cracks	0.2 cm ³ -air/cm ³ -soil
θ_{wcrack}	volumetric water content in foundation/wall cracks	0.1 cm ³ -H ₂ O/cm ³ -soil
θ_T	total soil porosity	0.3 cm ³ -voids/cm ³ -soil
f_{oc}	fraction organic carbon in the soil	0.01 kg-C/kg-soil
L_s	depth to subsurface soil sources from the enclosed space foundation	1 cm
L_{gw}	depth to groundwater from the enclosed space foundation	1 cm

Exposure Factors Used in Iowa Tier 1 Table Generation

Parameter		Residential	Nonresidential
AT _c (years)	averaging time for carcinogens	70	70
AT _n (years)	averaging time for noncarcinogens	30	25
BW (kg)	body weight	70	70
ED (years)	exposure duration	30	25
EF (days/year)	exposure frequency	350	250
IR _{air} (m ³ /day)	daily indoor inhalation rate	15	20
IR _w (L/day)	daily water ingestion rate	2	1
THQ (unitless)	target hazard quotient for individual constituents	1.0	1.0

Building Parameters Used in Iowa Tier 1 Table Generation

Parameter		Residential	Nonresidential
ER (s ⁻¹)	enclosed space air exchange rate	0.00014	0.00023
L _B (cm)	enclosed space volume/infiltration area ratio	200	300
L _{crack} (cm)	enclosed space foundation or wall thickness	15	15
η	areal fraction of cracks in foundation/wall	0.01	0.01

Chemical-Specific Parameter Values Used for Iowa Tier 1 Table Generation

Chemical	D ^{air} (cm ² /s)	D ^{wat} (cm ² /s)	H (L-air/L-water)	log(K _{oc}), L/kg
Benzene	0.093	1.1e-5	0.22	1.58
Toluene	0.085	9.4e-6	0.26	2.13
Ethylbenzene	0.076	8.5e-6	0.32	1.98
Xylenes	0.072	8.5e-6	0.29	2.38
Naphthalene	0.072	9.4e-6	0.049	3.11
Benzo(a)pyrene	0.050	5.8e-6	5.8e-8	5.59
Benz(a)anthracene	0.05	9.0e-6	5.74e-7	6.14
Chrysene	0.025	6.2e-6	4.9e-7	5.30

Saturation Values Used to Determine “NA” for the Iowa Tier 1 Table

Chemical	Solubility in Water (mg/L) S	Saturation in Soil (mg/kg) C _s ^{sat}
Benzene	1,750	801
Toluene	535	765
Ethylbenzene	152	159
Xylenes	198	492
Naphthalene	31	401
Benzo(a)pyrene	0.0012	4.69
Benz(a)anthracene	0.014	193.3
Chrysene	0.0028	5.59

The maximum solubility of the pure chemical in water is listed in the table above. The equation below is used to calculate the soil concentration (C_s^{sat}) at which dissolved pore-water and vapor phases become saturated. Tier 1 default values are used in the equation. “NA” (for not applicable) is used in the Tier 1 table when the risk-based value exceeds maximum solubility for water (S) or maximum saturation for soil (C_s^{sat}).

$$C_s^{\text{sat}}(\text{mg/kg-soil}) = S/\rho_s \times (H\theta_{\text{as}} + \theta_{\text{ws}} + k_s \rho_s)$$

Slope Factors and Reference Doses Used for Iowa Tier 1 Table Generation

Chemical	SF _i ((kg-day)/mg)	SF _o ((kg-day)/mg)	RfD _i (mg/(kg-day))	RfD _o (mg/(kg-day))
Benzene	0.029	0.029	—	—
Toluene	—	—	0.114	0.2
Ethylbenzene	—	—	0.286	0.1
Xylenes	—	—	2.0	2.0
Naphthalene	—	—	0.004	0.004
Benzo(a)pyrene	6.1	7.3	—	—
Benz(a)anthracene	0.61	0.73	—	—
Chrysene	0.061	0.073	—	—

Appendix B – Tier 2 Equations and Parameter Values (Revised Model)

All Tier 1 equations and parameters apply at Tier 2 except as specified below.

Equation for Tier 2 Groundwater Contaminant Transport Model

Equation (1)

$$C(x) = C_s \exp\left(\frac{x_m}{2\alpha_x} \left[1 - \sqrt{1 + \frac{4\lambda\alpha_x}{u}}\right]\right) \operatorname{erf}\left(\frac{S_w}{4\sqrt{\alpha_y x_m}}\right) \operatorname{erf}\left(\frac{S_d}{4\sqrt{\alpha_z x_m}}\right)$$

Equation (2)

Where $x_m = ax + bx^c$

The value of X_m is computed from Equation (2), where the values for a, b and c in Equation (2) are given in Table 1.

Table 1. Parameter Values for Equation (2)

Chemical	a	b	c
Benzene	1	0.000000227987	3.929438689
Toluene	1	0.000030701	3.133842393
Ethylbenzene	1	0.0001	2.8
Xylenes	1	0.0	0.0
TEH-Diesel	1	0.000000565	3.625804634
TEH-Waste Oil	1	0.000000565	3.625804634
Naphthalene	1	0	0

Variable definitions

x: distance in the x direction downgradient from the source

erf (): the error function

C(x): chemical concentration in groundwater at x

C_s : Source concentration in groundwater (groundwater concentration at x=0)

S_w : width of the source (perpendicular to x)

S_d : vertical thickness of the source

u: groundwater velocity (pore water velocity); $u=Ki/\theta e$

K: hydraulic conductivity

i: groundwater head gradient

θe : effective porosity

λ : first order decay coefficient, chemical specific

$\alpha_x, \alpha_y, \alpha_z$: dispersivities in the x, y and z directions, respectively

For the following lists of parameters, one of three is required: site-specific measurements, defaults or the option of either (which means the default may be used or replaced with a site-specific measurement).

Soil parameters

Parameter	Default Value	Required	
ρ_s	soil bulk density	1.86 g/cm ³	option
f_{oc}	fraction organic carbon in the soil	0.01 kg-C/kg-soil	option
θ_T	total soil porosity	0.3cm ³ -voids/cm ³ -soil	option
θ_{as}	volumetric air content in vadose zone	0.2cm ³ -air/cm ³ -soil	default
θ_{ws}	volumetric water content in vadose zone	0.1cm ³ -H ₂ O/cm ³ -soil	default
θ_{acrack}	volumetric air content in foundation/wall cracks	0.2cm ³ -air/cm ³ -soil	default

Parameter		Default Value	Required
θ_{wcrack}	volumetric water content in foundation/wall cracks	0.1cm ³ -H ₂ O/cm ³ -soil	default
l	infiltration rate of water through soil	7 cm/year	default

If the total porosity is measured, assume 1/3 is air filled and 2/3 is water filled for determining the water and air fraction in the vadose zone soil and floor cracks.

Groundwater Transport Modeling Parameters

Parameter		Default Value	Required
K	hydraulic conductivity	16060 cm/year	site-specific
i	groundwater head gradient	0.01 cm/cm	site-specific
S_w	width of the source	use procedure specified in 135.10(2)	site-specific
S_d	vertical thickness of the source	3 m	default
α_x	dispersivity in the x direction	0.1x	default
α_y	dispersivity in the y direction	0.33 α_x	default
α_z	dispersivity in the z direction	0.05 α_x	default
θ_e	effective porosity	0.1	default

where $u=Ki/\theta_e$

First-order Decay Coefficients

Chemical	Default Value λ (d-1)	Required
Benzene	0.000127441	default
Toluene	0.0000208066	default
Ethylbenzene	0.0	default
Xylenes	0.0005	default
Naphthalene	0.00013	default
TEH-Diesel	0.0000554955	default
TEH-Waste Oil	0.0000554955	default

Other Parameters for Groundwater Vapor to Enclosed Space

Parameter		Default Value	Required
L_{gw}	depth to groundwater from the enclosed space foundation	1 cm	option
L_B	enclosed space volume/infiltration area ratio	200 cm	option
ER (s-1)	enclosed space air exchange rate	0.00014	default
L_{crack}	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

Other Parameters for Soil Vapor to Enclosed Space

Parameter		Default Value	Required
L_s	depth to subsurface soil sources from the enclosed space foundation	1 cm	option
L_B	enclosed space volume/infiltration area ratio	250 cm *	option
ER (s-1)	enclosed space air exchange rate	0.000185 *	default
L_{crack}	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

*These values are an average of residential and nonresidential factors.

Soil Leaching to Groundwater

Parameter		Default Value	Required
δ	groundwater mixing zone	2 m	default

Building Parameters for Iowa Tier 2

Parameter		Residential	Nonresidential
ER (s-1)	enclosed space air exchange rate	0.00014	0.00023
L_B	enclosed space volume/infiltration area ratio	200 cm	300 cm

Other Parameters

For Tier 2, the following are the same as Tier 1 values (refer to Appendix A): chemical-specific parameters, slope factors and reference doses, and exposure factors (except for those listed below).

Exposure Factors for Tier 2 Groundwater Vapor to Enclosed Space Modeling:

Potential Residential: use residential exposure and residential building parameters.

Potential Nonresidential: use nonresidential exposure and nonresidential building parameters.

Diesel and Waste Oil

Diesel and Waste Oil			Chemical-Specific Values for Tier 1			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	150	0.012	0.12	1.2
		potential	150	1.2	12.0	NA
	Groundwater Vapor to Enclosed Space	all	4,440	NA	NA	NA
	Groundwater to Plastic Water Line	all	150	1.2	12.0	NA
	Surface Water	all	150	1.2	12.0	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	7.6	NA	NA	NA
	Soil Vapor to Enclosed Space	all	95	NA	NA	NA
	Soil to Plastic Water Line	all	21	NA	NA	NA

Due to difficulties with analytical methods for the four individual chemicals listed in the above table, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that

diesel contains 0.2% naphthalene, 0.001% benzo(a)pyrene, 0.001% benz(a)anthracene, and 0.001% chrysene. Resulting TEH Default Values are shown in the following table.

Diesel			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	75,000	1,200	12,000	120,000
		potential	75,000	120,000	1,200,000	NA
	Groundwater Vapor to Enclosed Space	all	2,200,000	NA	NA	NA
	Groundwater to Plastic Water Line	all	75,000	120,000	1,200,000	NA
	Surface Water	all	75,000	120,000	1,200,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	3,800	NA	NA	NA
	Soil Vapor to Enclosed Space	all	47,500	NA	NA	NA
	Soil to Plastic Water Line	all	10,500	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

Due to difficulties with analytical methods for the four individual chemicals, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that waste oil contains no naphthalene, 0.003% benzo(a)pyrene, 0.003% benz(a)anthracene, and 0.003% chrysene. Resulting TEH Default Values are shown in the following table.

Waste Oil			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	NA	400	4,000	40,000
		potential	NA	40,000	400,000	NA
Groundwater (ug/L)	Groundwater Vapor to Enclosed Space	all	NA	NA	NA	NA
	Groundwater to Plastic Water Line	all	NA	40,000	400,000	NA
	Surface Water	all	NA	40,000	400,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	NA	NA	NA	NA
	Soil Vapor to Enclosed Space	all	NA	NA	NA	NA
	Soil to Plastic Water Line	all	NA	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

Appendix B-1 – Tier 2 Equations and Parameter Values (Old Model)

All Tier 1 equations and parameters apply at Tier 2 except as specified below.

Equation for Tier 2 Groundwater Contaminant Transport Model

$$C(x) = C_s \exp \left(\frac{x}{2\alpha_x} \left[1 - \sqrt{1 + \frac{4\lambda\alpha_x}{u}} \right] \right) \operatorname{erf} \left(\frac{S_w}{4\sqrt{\alpha_y x}} \right) \operatorname{erf} \left(\frac{S_d}{4\sqrt{\alpha_z x}} \right)$$

Variable definitions

x: distance in the x direction downgradient from the source

erf(): the error function

C(x): chemical concentration in groundwater at x

C_s: Source concentration in groundwater (groundwater concentration at x=0)

S_w: width of the source (perpendicular to x)

S_d: vertical thickness of the source

u: groundwater velocity (pore water velocity); u=Ki/θe

K: hydraulic conductivity

i: groundwater head gradient

θe: effective porosity

λ: first-order decay coefficient, chemical specific

α_x, α_y, α_z: dispersivities in the x, y and z directions, respectively

For the following lists of parameters, one of three is required: site-specific measurements, defaults or the option of either (which means the default may be used or replaced with a site-specific measurement).

Soil parameters

Parameter		Default Value	Required
ρ _s	soil bulk density	1.86 g/cm ³	option
f _{oc}	fraction organic carbon in the soil	0.01 kg-C/kg-soil	option
θ _T	total soil porosity	0.3cm ³ -voids/cm ³ -soil	option
θ _{as}	volumetric air content in vadose zone	0.2cm ³ -air/cm ³ -soil	default
θ _{ws}	volumetric water content in vadose zone	0.1cm ³ -H ₂ O/cm ³ -soil	default
θ _{acrack}	volumetric air content in foundation/wall cracks	0.2cm ³ -air/cm ³ -soil	default
θ _{wcrack}	volumetric water content in foundation/wall cracks	0.1cm ³ -H ₂ O/cm ³ -soil	default
l	infiltration rate of water through soil	7 cm/year	default

If the total porosity is measured, assume 1/3 is air filled and 2/3 is water filled for determining the water and air fraction in the vadose zone soil and floor cracks.

Groundwater Transport Modeling Parameters

Parameter		Default Value	Required
K	hydraulic conductivity	16060 cm/year	site-specific
i	groundwater head gradient	0.01 cm/cm	site-specific
S _w	width of the source	use procedure specified in 135.10(2)	site-specific
S _d	vertical thickness of the source	3 m	default
α _x	dispersivity in the x direction	0.1x	default
α _y	dispersivity in the y direction	0.33α _x	default
α _z	dispersivity in the z direction	0.05α _x	default
θ _e	effective porosity	0.1	default

where $u=Ki/\theta_e$

First-order Decay Coefficients

Chemical	Default Value λ (d ⁻¹)	Required
Benzene	0.0005	default
Toluene	0.0007	default
Ethylbenzene	0.00013	default
Xylenes	0.0005	default
Naphthalene	0.00013	default
Benzo(a)pyrene	0	default
Benz(a)anthracene	0	default
Chrysene	0	default

Other Parameters for Groundwater Vapor to Enclosed Space

Parameter		Default Value	Required
L _{gw}	depth to groundwater from the enclosed space foundation	1 cm	option
L _B	enclosed space volume/infiltration area ratio	200 cm	option
ER (s ⁻¹)	enclosed space air exchange rate	0.00014	default
L _{crack}	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

Other Parameters for Soil Vapor to Enclosed Space

Parameter		Default Value	Required
L _s	depth to subsurface soil sources from the enclosed space foundation	1 cm	option
L _B	enclosed space volume/infiltration area ratio	250 cm *	option
ER (s ⁻¹)	enclosed space air exchange rate	0.000185 *	default
L _{crack}	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

*These values are an average of residential and nonresidential factors.

Soil Leaching to Groundwater

Parameter		Default Value	Required
δ	groundwater mixing zone	2 m	default

Building Parameters for Iowa Tier 2

Parameter		Residential	Nonresidential
ER (s-1)	enclosed space air exchange rate	0.00014	0.00023
L_B	enclosed space volume/infiltration area ratio	200 cm	300 cm

Other Parameters

For Tier 2, the following are the same as Tier 1 values (refer to Appendix A): chemical-specific parameters, slope factors and reference doses, and exposure factors (except for those listed below).

Exposure Factors for Tier 2 Groundwater Vapor to Enclosed Space Modeling:

Potential Residential: use residential exposure and residential building parameters.

Potential Nonresidential: use nonresidential exposure and nonresidential building parameters.

Diesel and Waste Oil

Diesel and Waste Oil			Chemical-Specific Values for Tier 1			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a)pyrene	Benz(a)anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	150	0.012	0.12	1.2
		potential	150	1.2	12.0	NA
	Groundwater Vapor to Enclosed Space	all	4,440	NA	NA	NA
	Groundwater to Plastic Water Line	all	150	1.2	12.0	NA
	Surface Water	all	150	1.2	12.0	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	7.6	NA	NA	NA
	Soil Vapor to Enclosed Space	all	95	NA	NA	NA
	Soil to Plastic Water Line	all	21	NA	NA	NA

Due to difficulties with analytical methods for the four individual chemicals listed in the above table, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that diesel contains 0.2% naphthalene, 0.001% benzo(a)pyrene, 0.001% benz(a)anthracene, and 0.001% chrysene. Resulting TEH Default Values are shown in the following table.

Diesel			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	75,000	1,200	12,000	120,000
		potential	75,000	120,000	1,200,000	NA
	Groundwater Vapor to Enclosed Space	all	2,200,000	NA	NA	NA
	Groundwater to Plastic Water Line	all	75,000	120,000	1,200,000	NA
	Surface Water	all	75,000	120,000	1,200,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	3,800	NA	NA	NA
	Soil Vapor to Enclosed Space	all	47,500	NA	NA	NA
	Soil to Plastic Water Line	all	10,500	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

Due to difficulties with analytical methods for the four individual chemicals, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that waste oil contains no naphthalene, 0.003% benzo(a)pyrene, 0.003% benz(a)anthracene, and 0.003% chrysene. Resulting TEH Default Values are shown in the following table.

Waste Oil			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	NA	400	4,000	40,000
		potential	NA	40,000	400,000	NA
Groundwater (ug/L)	Groundwater Vapor to Enclosed Space	all	NA	NA	NA	NA
	Groundwater to Plastic Water Line	all	NA	40,000	400,000	NA
	Surface Water	all	NA	40,000	400,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	NA	NA	NA	NA
	Soil Vapor to Enclosed Space	all	NA	NA	NA	NA
	Soil to Plastic Water Line	all	NA	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

APPENDIX C**DECLARATION OF RESTRICTIVE COVENANTS**

Rescinded IAB 7/19/06, effective 8/23/06

APPENDIX D**IOWA DEPARTMENT OF NATURAL RESOURCES****NO FURTHER ACTION CERTIFICATE**

This document certifies that the referenced underground storage tank site has been classified by the Iowa Department of Natural Resources (IDNR) as “no action required” as provided in the 1995 Iowa Code Supplement 455B.474(1)“h”(1). This certificate may be recorded as provided by law.

ISSUED TO: OWNERS/OPERATORS OF TANKS
 DATE OF ISSUANCE:
 IDNR FILE REFERENCES: LUST # REGISTRATION #
 LEGAL DESCRIPTION OF UNDERGROUND STORAGE TANK SITE:

Issuance of this certificate does not preclude the IDNR from requiring further corrective action due to new releases and is based on the information available to date. The department is precluded from requiring additional corrective action solely because governmental action standards are changed. See 1995 Iowa Code Supplement 455B.474(1)“h”(1).

This certificate does not constitute a warranty or a representation of any kind to any person as to the environmental condition, marketability or value of the above referenced property other than that certification required by 1995 Iowa Code Supplement 455B.474(1)“h”.

These rules are intended to implement Iowa Code sections 455B.304, 455B.424 and 455B.474.

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¹ July 15, 1987, effective date of 135.9(4) delayed 70 days by Administrative Rules Review Committee at its June 1987 meeting.

² August 6, 2008, effective date of **ARC 6892B** delayed 70 days by Administrative Rules Review Committee at its July 2008 meeting. At its meeting held October 14, 2008, the Committee delayed until adjournment of the 2009 Session of the General Assembly the following provisions: **567—135.2(455B)**, definition of “Sensitive area”; **135.9(4)“f”**; **135.10(4)“a,”** last sentence: “A public water supply screening and risk assessment must be conducted in accordance with 135.10(4)“f” for this pathway” and **135.10(4)“b,”** last sentence of the first paragraph: “The certified groundwater professional or the department may request additional sampling of drinking water wells and non-drinking water wells as part of its evaluation”; **135.10(4)“f”**; **135.10(11)“h.”**

NATURAL RESOURCE COMMISSION[571]

[Prior to 12/31/86, see Conservation Commission [290], renamed Natural Resource Commission[571]
under the "umbrella" of Department of Natural Resources by 1986 Iowa Acts, chapter 1245]

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CHAPTER 15
GENERAL LICENSE REGULATIONS

[Prior to 12/31/86, see Conservation Commission[290] Chs 17, 66, 67, and 75]

571—15.1(483A) Scope. The purposes of this chapter are to provide rules for license sales, refunds and administration; implement the wildlife violator compact and penalties for multiple offenses; administer special licenses available for hunting and fishing; and describe and implement certification and education programs of the department of natural resources.
[ARC 7852B, IAB 6/17/09, effective 7/22/09]

DIVISION I
LICENSE SALES, REFUNDS AND ADMINISTRATION

571—15.2(483A) Definitions. For the purposes of this division, the following definitions shall apply:

“*Administration fee*” means the fee collected by the department to pay a portion of the cost of administering the sale of licenses through electronic means.

“*Department*” means the department of natural resources.

“*Director*” means the director of the department of natural resources.

“*License*” means any license or privilege issued by the department to an individual for hunting or fishing in the state of Iowa. Multiple types of licenses are described in these rules.

“*License agent*” means an individual, business, or governmental agency authorized to sell a license.

“*Licensee*” means the person who applies for and receives a license under these rules from the department.

“*Retail*” means the sale of goods or commodities to the ultimate consumer, as opposed to the sale of goods or commodities for further distribution or processing.

“*Wholesale*” means the sale of goods or commodities for resale by a retailer, as opposed to the sale of goods or commodities to the ultimate consumer.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.3(483A) Form of licenses. Every license shall contain a general description of the licensee. At the time of application, the applicant for a license must provide the applicant's date of birth and either a social security number or a valid Iowa driver's license number. The license shall be signed by the applicant and shall clearly indicate the privilege granted.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.4(483A) Administration fee. An administration fee of \$1.50 per privilege purchased shall be collected from the purchaser at the time of purchase, except upon the issuance of free landowner deer and turkey hunting licenses, free annual hunting and fishing licenses, free annual fishing licenses, free group home fishing licenses, and boat registrations, renewals, transfers, and duplicates. An administrative fee of \$3.65 will be collected from the purchaser at the time of boat registration, renewal, transfer, and duplicate purchases.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 8104B, IAB 9/9/09, effective 10/14/09; ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.5(483A) Electronic license sales.

15.5(1) Designation as license agent. The director may designate a retail business establishment, an office of a governmental entity, or a nonprofit corporation as an agent of electronically issued licenses in accordance with the provisions of this rule. The provisions of 571—15.6(483A) shall not apply to a license agent engaging in, or applying to engage in, the electronic sale and issuance of licenses.

15.5(2) Application. Application forms to sell electronically issued licenses may be secured by a written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. The following information must be provided on the application form:

- a. The legal name, address, and telephone number of the entity applying for designation;
- b. The hours open for business and general service to the public;

- c.* A brief statement of the nature of the business or service provided by the applicant;
- d.* Type of Internet connection (dial up or high speed) used for accessing the electronic licensing system; and
- e.* A signature by an owner, partner, authorized corporate official, or public official of the entity applying for designation.

15.5(3) Application review.

a. The director shall approve or deny the application to sell electronically issued licenses based upon the following criteria:

- (1) The need for a license agent in the area;
- (2) The hours open for business or general service to the public;
- (3) The potential volume of license sales;
- (4) The apparent financial stability and longevity of the applicant;
- (5) The number of point-of-sale (POS) terminals available to the department; and
- (6) Type of Internet connection (dial up or high speed) used for accessing the electronic licensing system.

b. If necessary, the department may utilize a waiting list for license agent designation. The order of priority for the waiting list will be determined by the time of submittal of a complete and correct application and receipt of the required security deposit, as outlined in the application.

15.5(4) Issuance of electronic licensing equipment. Upon the director's approval of an application under this rule and designation of a license agent for electronic license sales, the equipment necessary to conduct such sales will be issued to the license agent by the department subject to the following terms and conditions:

a. Prior to the issuance of the electronic licensing equipment, the approved license agent shall furnish to the department an equipment security deposit in an amount to be determined by the department.

b. Prior to the issuance of the electronic licensing equipment, the approved license agent shall enter into an electronic license sales agreement with the department which sets forth the terms and conditions of such sales, including the authorized amounts to be retained by the license agent.

c. Prior to the issuance of the electronic licensing equipment, the approved license agent shall furnish to the department a signed authorization agreement for electronic funds transfer pursuant to subrule 15.5(5).

d. Electronic licensing equipment and supplies must be stored in a manner to provide protection from damage, theft, and unauthorized access. Any damage to or loss of equipment or loss of moneys derived from license sales is the responsibility of the license agent.

e. Upon termination of the agreement by either party, all equipment and supplies, as outlined in the agreement, must be returned to the department. Failure to return equipment and supplies in a usable condition, excluding normal wear and tear, will result in the forfeiture of deposit in addition to any other remedies available to the department by law.

15.5(5) License fees. All moneys received from the sale of licenses, less and except the agreed-upon service fee, must be immediately deposited and held in trust for the department.

a. All license agents must furnish to the department a signed authorization agreement for electronic funds transfer authorizing access by the department to a bank account for electronic transfer of license fees received by the license agent.

b. The amount of money due for accumulated sales will be drawn electronically by the department on a weekly basis. The license agent shall be given notice of the amount to be withdrawn at least two business days before the actual transfer of funds occurs. The license agent is responsible for ensuring that enough money is in the account to cover the amount due.

c. License agents may accept or decline payment in any manner other than cash, such as personal checks or credit cards, at their discretion. Checks or credit payments must be made payable to the license agent, not to the department. The license agent shall be responsible for ensuring that the license fee is deposited in the electronic transfer account, regardless of the payment or nonpayment status of any check accepted by the license agent.

15.5(6) Upon the termination of the electronic license sales agreement pursuant to subrule 15.5(7) or 15.5(8), the department may disconnect or otherwise block the license agent's access to the electronic licensing system.

15.5(7) Equipment shut down and termination. The department reserves the right to disconnect the license agent's access to the electronic licensing system or terminate the license agent's electronic license sales agreement for cause. Cause shall include, but is not limited to, the following:

- a. Failing to deposit license fees into the electronic transfer account in a sum sufficient to cover the amount due for accumulated sales;
- b. Charging or collecting any fees in excess of those authorized by law;
- c. Discriminating in the sale of a license in violation of state or federal law;
- d. Knowingly making a false entry concerning any license sold or knowingly issuing a license to a person who is not eligible for the license issued;
- e. Using license sale proceeds, other than the service fee, for personal or business purposes;
- f. Disconnecting or blocking access to the electronic licensing system for a period of 30 days or more; or
- g. Violating any of these rules or the terms of the electronic license sales agreement. Repeated violations of these rules may result in termination of the license agent's electronic license sales agreement.

15.5(8) Voluntary termination. A license agent may terminate its designation and the electronic license sales agreement at its discretion by providing written notice to the department. Voluntary termination shall become effective 30 days after the department's receipt of notice.
[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.6(483A) Paper license sales. Paper licenses shall be sold only in the event that the electronic licensing system is no longer available.

15.6(1) *Depository designation.* The director may designate a retail business establishment, an office of a governmental entity, or a nonprofit corporation as a depository for the sale of hunting and fishing licenses in accordance with the provisions of this rule.

15.6(2) *Application.*

a. An application form to act as a depository may be secured by a written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. Requests for an application form may be made through department field staff or field officers. The applicant must provide the following information on the form:

- (1) The name of the retail business establishment, governmental entity, or nonprofit corporation, and location(s) and telephone numbers.
- (2) A general description of the type of retail business establishment, governmental entity, or nonprofit corporation.
- (3) The form of ownership if a retail business establishment. If a partnership, the full names and addresses of all partners must be provided. If a corporation, the date and state of incorporation must be provided.
- (4) If a governmental entity, the name and title of the responsible official.
- (5) If a nonprofit corporation, the date and state of incorporation.
- (6) The hours and days open to the public.
- (7) The contact information of the person signing the application.
- (8) The name, address, and telephone number of three credit references, including the bank used by the retail business establishment, governmental entity, or nonprofit corporation.

b. The application form contains a statement by which the applicant agrees to the terms and conditions as set forth in this rule. The application form must be signed by the owner if a sole proprietorship; by a partner if a partnership; by an authorized corporate official if a corporation; or by the elected or appointed official administratively in charge of the governmental entity. The signature must be attested to by a notary public.

15.6(3) Security. The applicant under this rule must provide security, either a surety bond from an association or corporation whose business is assuring the fidelity of others and which has the authority by law to do business in this state, a collateral assignment of a certificate of deposit, or a letter of credit.

a. Condition of security. A surety bond required by this rule shall generally provide that the applicant render a true account of and turn over all moneys, license blanks, and duplicates when requested to do so by the director or an authorized representative and that the applicant comply with all applicable provisions of the application, the Iowa Administrative Code, and the Iowa Code.

b. Amount of security. All forms of security required by this rule shall be in the amount of \$5,000 each or a larger amount as jointly agreed to by the department and the depository.

c. Term of bond. The bond required by this rule shall run continuously from the date the application is approved.

d. Termination of bond. The surety or principal may terminate the bond at any time by sending written notice by certified mail, return receipt requested, to the Director, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. The termination shall become effective 30 days after the receipt of the notice by the director.

e. Collateral assignment of a certificate of deposit and letters of credit. Collateral assignments of certificates of deposit and letters of credit shall be subject to the following terms and conditions:

(1) Certificates of deposit shall be assigned, in writing, to the department, and the assignment shall be recorded on the books of the bank issuing the certificate.

(2) Banks issuing these certificates shall waive all rights of setoff or liens which they have or might have against these certificates.

(3) Certificates of deposit shall be automatically renewed unless the director approves, in writing, release of the funds. Letters of credit shall be without reservation and shall remain in effect continuously, or as otherwise agreed to by the director.

(4) The director will release the certificates of deposit or approve the cancellation of a letter of credit upon termination of a license agent agreement if all licenses and moneys have been accounted for satisfactorily or if the depository provides a satisfactory surety bond in lieu thereof.

15.6(4) Multiple establishment locations. An application and security may be submitted for retail business establishments with multiple locations. For purposes of reporting and for determining the amount of the security, each application will be considered on a case-by-case basis and as mutually agreed upon by the depository and the director.

15.6(5) Approval of application and security. The director will approve the application upon the receipt of a satisfactory bond, collateral assignment of deposit, or letter of credit and a determination that the credit references are satisfactory. However, the director reserves the right not to approve any application received from a party whose depository agreement has previously been terminated by the department for cause. Upon approval by the director, the department will provide the depository with license blanks, reporting forms, and instructions.

15.6(6) Depository reporting standards. All depositories shall comply with the following reporting standards:

a. Monthly reports. A full and complete monthly sales report, including duplicate copies of the licenses sold and a check or other monetary instrument in the amount due, shall be remitted to the department the following month on a prescheduled due date. A depository that does not provide the monthly report to the department within 10 days after the due date shall be considered seriously delinquent. However, if the depository's office or business is operated on a seasonal basis, a monthly report is not required for any month that the office or business is not open to the public.

b. Annual report. An annual report for all sales for the calendar year and all unused license blanks for the year shall be remitted to the department by January 31 of each year. A depository will be considered seriously delinquent if the annual report is not received by February 15. An annual report shall also be submitted at the time a depository agreement is terminated for any reason during the calendar year. This report must be received within 15 days after the director issues or, in the case of a voluntary termination, receives the notice of termination.

15.6(7) *Accountability.* The depository shall be fully accountable to the state for all proceeds collected from the sale of licenses. This accountability shall not be diminished by reason of bankruptcy, fire loss, theft loss, or other similar reason.

15.6(8) *Probation.*

a. A depository shall be placed on probation under any of the following circumstances:

(1) The depository is seriously delinquent for the second time during any consecutive six-month period.

(2) The depository fails to correct a serious delinquency within ten days.

(3) A check is returned by the bank due to insufficient funds.

b. Notice of probation shall be sent to the depository by certified mail, return receipt requested.

c. The probation will be automatically canceled after six months of satisfactory performance by the depository.

15.6(9) *Termination of depository agreement.* A depository may terminate the agreement at any time by notifying the director by certified mail, return receipt requested. The termination shall be effective 30 days after the receipt of the notice by the director and after the depository has fully accounted for all moneys and unused license blanks. The director may terminate the depository agreement and require an immediate and full accounting of all moneys and unused license blanks under any of the following circumstances:

a. The occurrence of a third serious delinquency during any consecutive six-month period.

b. When an insufficient funds check is received by the department, not correcting the deficiency within 10 days after proper notice by the director.

c. Failing to correct a serious delinquency within 15 calendar days.

d. Knowingly placing a date, other than the correct date, on any license.

e. Knowingly selling a resident license to a nonresident or selling a license to a person not qualified for such license.

f. Charging more than the statutory writing fee.

g. Refusing to sell a license to any individual by reason of creed, sexual orientation, gender identity, religion, pregnancy or public accommodation.

h. Canceling a bond, certificate of deposit, or letter of credit or allowing one to expire.

i. Failing to make a full and complete monthly sales report and monthly remittance.

j. Knowingly making a false entry on any license being sold or knowingly issuing any license to a person to whom issuance of that license is improper.

15.6(10) *Forms available from the department.* Copies of the forms required for application, bond, monthly reports, and collateral as assignment may be obtained by written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.7(483A) Lost or destroyed license blanks.

15.7(1) *Accountability for license blanks.* Whenever a depository or county recorder requests to be relieved from accountability for license blanks that have been lost or destroyed, the depository or county recorder (recorder) shall file a bond for the face value of such lost or destroyed license blanks and provide an explanation to the director.

15.7(2) *Explanation.*

a. The depository or recorder shall submit a written statement in the form of an affidavit regarding the facts and circumstances surrounding the alleged loss or destruction. Pictures, drawings, or other pertinent information may be attached and referenced in the statement. The loss or destruction must relate to one or a combination of the following reasons:

(1) Loss or destruction by fire.

(2) Loss from theft.

(3) Loss while in transit.

(4) Loss from natural causes, including but not limited to floods, tornadoes, and severe storms.

(5) Loss or accidental destruction during the course of normal business operations or facility maintenance and repair.

b. The statement must also include a specific description of the precautions and procedures normally utilized by the recorder or depository to prevent or to guard against the loss or destruction described, and a further statement as to why the precautions or procedures failed in this particular instance.

c. The director shall consider the written explanation as provided. The director shall also consider the past record of the depository or recorder regarding losses and destructions and the past record of the depository or recorder regarding prompt and accurate reporting. The director may direct department staff to further investigate the circumstances and facts.

(1) If the director determines that the depository or recorder exercised reasonable and prudent care, the director shall relieve the depository or recorder of accountability upon the filing of a bond.

(2) If the director determines that there was gross negligence by the depository or recorder and holds the depository or recorder accountable, the depository or recorder may file a request for a contested case proceeding as provided in 571—Chapter 7 of the Iowa Administrative Code.

15.7(3) Bond. The depository or recorder shall provide a bond in the amount of the face value of the lost or destroyed licenses. The bond shall be on a bond form provided by the department. The bond shall be conditioned to the effect that the depository or recorder agrees to surrender the subject licenses to the department in the event that they are located at any future time; or in the event of proof showing that any or all of the subject licenses have been issued, the depository, recorder, or sureties jointly and severally agree to pay the state the face value of all licenses covered by the bond.

a. For a face amount of \$500 or less, the personal bond of the depository or recorder is sufficient. One additional personal surety is required for a face amount up to \$1,000; and two personal sureties, in addition to the depository or recorder, are required if the face amount is more than \$1,000.

b. A corporate surety authorized to do business in Iowa may be provided in lieu of the personal sureties required, in addition to the depository or recorder.

c. The value assigned to a lost or destroyed blank license form shall be \$25. This amount will be paid by the depository to the department, except as relief from such payment is provided according to this rule.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.8(483A) Refund or change requests for special deer and turkey hunting licenses and general licenses.

15.8(1) Invalid applications. Deer and turkey hunting license applications that are received after the closing date for acceptance of applications and applications that are invalid on their face will be returned unopened to the applicant. Any license fee related to an application determined invalid by a computer analysis or other analysis after the application has been processed will be refunded to the applicant, less a \$10 invalid application fee to compensate for the additional processing cost related to an invalid application.

15.8(2) Death of licensee. The fee for a deer or turkey hunting license will be refunded to the licensee's estate when the licensee's death predates the season for which the license was issued and a written request from the licensee's spouse, executor or estate administrator is received by the department within 90 days of the last date of the season for which the license was issued.

15.8(3) National or state emergency. The fee for a deer or turkey hunting license will be refunded if the licensee is a member of the National Guard or a reserve unit and is activated for a national or state emergency which occurs during the season for which the license was issued. A written refund request must be received by the department within 90 days of the last date of the season for which the license was issued.

15.8(4) License changes. The department will attempt to change an applicant's choice of season or type of license if a written or telephonic request is received by the licensing section in sufficient time (usually 20 days) before the license is printed and if the requested change does not result in disadvantage to another applicant. A change request made by telephone must be verified in writing by the requester

before the change request will be honored. The department's ability to accommodate requests to change the season or license type is dependent on workload and processing considerations. If the department cannot accommodate a request to change a season or license type, the license will be issued as originally requested by the applicant. No refund will be allowed. The department will not change the name on the license from that submitted on the application.

15.8(5) Duplicate purchases of general hunting and fishing licenses. Upon a showing of sufficient documentation (usually a photocopy of the licenses) that more than one hunting or fishing license was purchased by or for a single person, the department will refund the amount related to the duplicate purchase. A written request for refund, with supporting documentation, must be received by the licensing section within 90 days of the date on the face of the duplicate licenses.

15.8(6) Other refund requests. Except as previously described in this rule, the department will not issue refunds for any licenses as defined in 571—15.2(483A).

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.9 to 15.15 Reserved.

DIVISION II
MULTIPLE OFFENDER AND WILDLIFE VIOLATOR COMPACT

571—15.16(481A,481B,482,483A,484A,484B) Multiple offenders—revocation and suspension of hunting, fishing, and trapping privileges from those persons who are determined to be multiple offenders.

15.16(1) Definitions. For the purpose of this rule, the following definitions shall apply:

“*Department*” means the Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034.

“*License*” means any paid or free license, permit, or certificate to hunt, fish, or trap listed in Iowa Code chapters 481A, 481B, 482, 483A, 484A, 484B, and 716, including the authorization to hunt, fish, or trap pursuant to any reciprocity agreements with neighboring states.

“*Licensee*” means the holder of any license.

“*Multiple offender*” means any person who has equaled or exceeded five points for convictions in Iowa Code chapters 481A, 481B, 482, 483A, 484A, 484B, and 716 during a consecutive three-year period as provided in 15.16(3).

“*Revocation*” means the taking or cancellation of an existing license.

“*Suspension*” means to bar or exclude one from applying for or acquiring licenses for future seasons.

15.16(2) Record-keeping procedures. For the purpose of administering this rule, it shall be the responsibility of the clerk of district court for each county to deliver, on a weekly basis, disposition reports of each charge filed under Iowa Code chapters 481A, 481B, 482, 483A, 484A, 484B, and 716 to the department. Dispositions and orders of the court of all cases filed on the chapters listed in this subrule shall be sent to the department regardless of the jurisdiction or the department of the initiating officer.

a. License suspensions. In the event of a license suspension pursuant to Iowa Code section 481A.133, the clerk of court shall immediately notify the department.

b. Entering information. Upon receipt of the disposition information from the clerks of court, the department will, on a monthly basis, enter this information into a computerized system that is directly accessible by the department of public safety communications system for use by the department’s licensing section, and all state and local law enforcement officers. Direct access through the department of public safety communications system will be available as soon as practical and is dependent on the development of appropriate computer linkage by the department of public safety.

c. Disposition report information. Information from the disposition report that will be entered into a computerized system which includes but may not be limited to the following:

County of violation, name of defendant, address of defendant, social security or driver’s license number, date of birth, race, sex, height, weight, date and time of violation, charge and Iowa Code section, officer name/C-number who filed charge, and date of conviction.

15.16(3) Point values assigned to convictions. For the purposes of defining a multiple offender, the person shall be classified as a multiple offender when the person equals or exceeds a total of five points during a consecutive three-year period using the values attached to the following offenses. Multiple citations and convictions of the same offense will be added as separate convictions:

a. Convictions of the following offenses shall have a point value of three attached to them:

- (1) Illegal sale of birds, game, fish, or bait.
- (2) More than the possession or bag limit for any species of game or fish.
- (3) Hunting, trapping, or fishing during the closed season.
- (4) Hunting by artificial light.
- (5) Hunting from aircraft, snowmobiles, all-terrain vehicles or motor vehicle.
- (6) Any violation involving threatened or endangered species.
- (7) Any violations of Iowa Code chapter 482, except sections 482.6 and 482.14.
- (8) Any violation of nonresident license requirements.
- (9) No fur dealer license (resident or nonresident).
- (10) Illegal taking or possession of protected nongame species.
- (11) The taking of any fish, game, or fur-bearing animal by illegal methods.
- (12) Illegal taking, possession, or transporting of a raptor.
- (13) Hunting, fishing, or trapping while under license suspension or revocation.
- (14) Illegal removal of fish, minnows, frogs, or other aquatic wildlife from a state fish hatchery.
- (15) Any fur dealer violations except failure to submit a timely annual report.
- (16) Any resident or nonresident making false claims to obtain a license.
- (17) Illegal taking or possession of hen pheasant.
- (18) Applying for or acquiring a license while under suspension or revocation.
- (19) For a repeat offense of acquiring a hunting license without hunter safety certification.
- (20) Taking game from the wild—see Iowa Code section 481A.61.
- (21) Violation of Iowa Code section 483A.27(7).
- (22) Any violation of Iowa Code Supplement section 716.8 as amended by 2008 Iowa Acts, House

File 2612, section 21, while hunting deer.

b. Convictions of the following offenses shall have a point value of two attached to them:

- (1) Hunting, fishing, or trapping on a refuge.
- (2) Illegal possession of fur, fish, or game.
- (3) Chasing wildlife from or disturbing dens.
- (4) Trapping within 200 yards of an occupied building or private drive.
- (5) Possession of undersized or oversized fish.
- (6) Snagging of game fish.
- (7) Shooting within 200 yards of occupied building or feedlot.
- (8) No valid resident license relating to deer or turkey.
- (9) Illegal importation of fur, fish, or game.
- (10) Failure to exhibit catch to an officer.
- (11) Trapping or poisoning game birds, or poisoning game animals.
- (12) Violations pertaining to private fish hatcheries and aquaculture.
- (13) Violations of the fur dealers reporting requirements.
- (14) Violation of Iowa Code section 481A.126 pertaining to taxidermy.
- (15) Loaded gun in a vehicle.
- (16) Attempting to take any fish, game, or fur-bearing animals by illegal methods.
- (17) Attempting to take game before or after legal shooting hours.
- (18) Wanton waste of fish, game or fur-bearing animals.
- (19) Illegal discharge of a firearm pursuant to Iowa Code section 481A.54.
- (20) Any violation of Iowa Code section 482.14 pertaining to commercial fishing.
- (21) Failure to tag deer or turkey.
- (22) Applying for or obtaining more than the legal number of licenses allowed for deer or turkey.
- (23) Illegal transportation of game, fish or furbearers.

(24) Violation of Iowa Code section 483A.27, except subsection (7).

c. All other convictions of provisions in Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B shall have a point value of one attached to them.

15.16(4) Length of suspension or revocation.

a. The term of license suspension or revocation shall be determined by the total points accumulated during any consecutive three-year period, according to the following: 5 points through 8 points is one year, 9 points through 12 points is two years, and 13 points or over is three years.

b. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(2) shall have an additional suspension of one year. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(3) shall have an additional suspension of two years. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(4) shall have an additional suspension of three years. The foregoing provisions apply whether or not a person has been found guilty of a simple misdemeanor, serious misdemeanor or aggravated misdemeanor pursuant to Iowa Code subsections 481A.135(2), 481A.135(3) and 481A.135(4). If a magistrate suspends the privilege of a defendant to procure another license and the conviction contributes to the accumulation of a point total that requires the department to initiate a suspension, the term of suspension shall run consecutively up to a maximum of five years. After a five-year suspension, remaining time will be calculated at a concurrent rate.

15.16(5) Points applicable toward suspension or revocation. If a person pleads guilty or is found guilty of an offense for which points have been established by this rule but is given a suspended sentence or deferred sentence by the court as defined in Iowa Code section 907.1, the assigned points will become part of that person's violation record and apply toward a department suspension or revocation.

15.16(6) Notification of intent to suspend and revoke license. If a person reaches a total of five or more points, the department shall provide written notice of intent to revoke and suspend hunting, fishing, or trapping licenses as provided in 571—Chapter 7. If the person requests a hearing, it shall be conducted in accordance with 571—Chapter 7.

15.16(7) Dates of suspension or revocation. The suspension or revocation shall be effective upon failure of the person to request a hearing within 30 days of the notice described in 15.16(6) or upon issuance of an order affirming the department's intent to suspend or revoke the license after the hearing. The person shall immediately surrender all licenses and shall not apply for or obtain new licenses for the full term of the suspension or revocation.

15.16(8) Magistrate authority. This chapter does not limit the magistrate authority as described in Iowa Code section 483A.21.

15.16(9) Suspension for failure to comply with a child support order. The department is required to suspend or deny all licenses of an individual upon receipt of a certificate of noncompliance with child support obligation from the Iowa child support recovery unit pursuant to Iowa Code section 252J.8(4).

a. The receipt by the department of the certificate of noncompliance shall be conclusive evidence. Pursuant to Iowa Code section 252J.8(4), the person does not have a right to a hearing before the department to contest the denial or suspension action taken due to the department's receipt of a certificate of noncompliance with a child support obligation but may seek a hearing in district court in accordance with Iowa Code section 252J.9.

b. Suspensions for noncompliance with a child support obligation shall continue until the department receives a withdrawal of the certificate of noncompliance from the Iowa child support recovery unit.

c. After the department receives a withdrawal of the certificate of noncompliance, an individual may obtain a new license upon application and the payment of all applicable fees.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.17(456A) Wildlife violator compact. The department has entered into the wildlife violator compact (the compact) with other states for the uniform enforcement of license suspensions. The

compact, a copy of which may be obtained by contacting the department's law enforcement bureau, is adopted herein by reference. The procedures set forth in this rule shall apply to license suspensions pursuant to the wildlife violator compact.

15.17(1) Definitions. For purposes of this rule, the following definitions shall apply:

"Compliance" with respect to a citation means the act of answering a citation through an appearance in a court or through the payment of all fines, costs, and surcharges, if any.

"Department" means the Iowa department of natural resources.

"Home state" means the state of primary residence of a person.

"Issuing state" means a participating state that issues a fish or wildlife citation to a person.

"License" means any license, permit, or other public document which conveys to the person to whom it was issued the privilege of pursuing, possessing, or taking any fish or wildlife regulated by statute, law, regulation, ordinance, or administrative rule of a participating state.

"Participating state" means any state which enacts legislation to become a member of the wildlife violator compact. Iowa is a participating state pursuant to Iowa Code section 456A.24(14).

15.17(2) Suspension of licenses for noncompliance. Upon the receipt of a valid notice of failure to comply, as defined in the compact, the department shall issue a notice of suspension to the Iowa resident. The notice of suspension shall:

a. Indicate that all department-issued hunting (including furbearer) or fishing licenses shall be suspended, effective 30 days from the receipt of the notice, unless the department receives proof of compliance.

b. Inform the violator of the facts behind the suspension with special emphasis on the procedures to be followed in resolving the matter with the court in the issuing state. Accurate information in regard to the court (name, address, telephone number) must be provided in the notice of suspension.

c. Notify the license holder of the right to appeal the notice of suspension within 30 days of receipt. Said appeal shall be conducted pursuant to 571—Chapter 7 but shall be limited to the issues of whether the person so notified has a pending charge in the issuing state, whether the person has previously received notice of the violation from the issuing state, and whether the pending charge is subject to a license suspension for failure to comply pursuant to the terms of the compact.

d. Notify the license holder that, prior to the effective date of suspension, a person may avoid suspension through an appearance in the court with jurisdiction over the underlying violations or through the payment of all fines, costs, and surcharges associated with the violations.

e. Indicate that, once a suspension has become effective, the suspension may only be lifted upon the final resolution of the underlying violations.

15.17(3) Reinstatement of licenses. Any license suspended pursuant to this rule may be reinstated upon the receipt of an acknowledgement of compliance from the issuing state, a copy of a court judgment, or a certificate from the court with jurisdiction over the underlying violations and the payment of applicable Iowa license fees.

15.17(4) Issuance of notice of failure to comply. When a nonresident is issued a citation by the state of Iowa for violations of any provisions under the jurisdiction of the natural resource commission which is covered by the suspension procedures of the compact and fails to timely resolve said citation by payment of applicable fines or by properly contesting the citation through the courts, the department shall issue a notice of failure to comply.

a. The notice of failure to comply shall be delivered to the violator by certified mail, return receipt requested, or by personal service.

b. The notice of failure to comply shall provide the violator with 14 days to comply with the terms of the citation. The violator may avoid the imposition of the suspension by answering a citation through an appearance in a court or through the payment of all fines, costs, and surcharges, if any.

c. If the violator fails to achieve compliance, as defined in this rule, within 14 days of receipt of the notice of failure to comply, the department shall forward a copy of the notice of failure to comply to the home state of the violator.

15.17(5) Issuance of acknowledgement of compliance. When a person who has previously been issued a notice of failure to comply achieves compliance, as defined in this rule, the department shall issue an acknowledgement of compliance to the person who was issued the notice of failure to comply.

15.17(6) Reciprocal recognition of suspensions. Upon receipt of notification from a state that is a member of the wildlife violator compact that the state has suspended or revoked any person's hunting or fishing license privileges, the department shall:

- a. Enter the person's identifying information into the records of the department.
- b. Deny all applications for licenses to the person for the term of the suspension or until the department is notified by the suspending state that the suspension has been lifted.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.18 to 15.20 Reserved.

DIVISION III
SPECIAL LICENSES

571—15.21(483A) Fishing license exemption for patients of substance abuse facilities.

15.21(1) Definition. For the purpose of this rule, the definition of "substance abuse facility" is identical to the definition of "facility" in Iowa Code subsection 125.2(9).

15.21(2) Procedure. Each substance abuse facility may apply to the department of natural resources for a license exempting patients from the fishing license requirement while fishing as a supervised group as follows:

- a. Application shall be made on a form provided by the department and shall include the name, address and telephone number of the substance abuse facility including the name of the contact person. A general description of the type of services or care offered by the facility must be included as well as the expected number of participants in the fishing program and the water bodies to be fished.
- b. A license will be issued to qualifying substance abuse facilities and will be valid for all patients under the care of that facility.
- c. Patients of the substance abuse facility must be supervised by an employee of the facility while fishing without a license pursuant to this rule. An employee of the substance abuse facility must have the license in possession while supervising the fishing activity of patients.
- d. Notwithstanding the provisions of this rule, each employee of the substance abuse facility must possess a valid fishing license while participating in fishing.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.22(481A) Authorization to use a crossbow for deer and turkey hunting during the bow season by handicapped individuals.

15.22(1) Definitions. For the purpose of this rule:

"Bow and arrow" means a compound, recurve, or longbow.

"Crossbow" means a weapon consisting of a bow mounted transversely on a stock or frame and designed to fire a bolt, arrow, or quarrel by the release of the bow string, which is controlled by a mechanical or electric trigger and a working safety.

"Handicapped" means a person possessing a physical impairment of the upper extremities that makes a person physically incapable of shooting a bow and arrow. This includes difficulty in lifting and reaching with arms as well as difficulty in handling and fingering.

15.22(2) Application for authorization card. An individual requesting use of a crossbow for hunting deer or turkey must submit an application for an authorization card on forms provided by the department. The application must include a statement signed by the applicant's physician declaring that the individual is not physically capable of shooting a bow and arrow. A first-time applicant must submit the authorization card application no later than ten days before the last day of the license application period for the season the person intends to hunt.

15.22(3) Authorization card—issuance and use. Approved applicants will be issued a card authorizing the individual to hunt deer and turkey with a crossbow. The authorization card must be

carried with the license and on the person while hunting deer and turkey and must be exhibited to a conservation officer upon request.

15.22(4) *Validity and forfeiture of authorization card.* A card authorizing the use of a crossbow for hunting deer and turkey will be valid for as long as the person is incapable of shooting a bow and arrow. If a conservation officer has probable cause to believe the person's handicapped status has improved, making it possible for the person to shoot a bow and arrow, the department may, upon the officer's request, require the person to obtain in writing a current physician's statement.

If the person is unable to obtain a current physician's statement confirming that the person is incapable of shooting a bow and arrow, the department may initiate action to revoke the authorization card pursuant to 571—Chapter 7.

15.22(5) *Restrictions.* Crossbows equipped with pistol grips and designed to be fired with one hand are illegal for taking or attempting to take deer or turkey. All projectiles used in conjunction with a crossbow for deer hunting must be equipped with a broadhead with at least three blades.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.23(483A) Free hunting and fishing license for low-income persons 65 years of age and older or low-income persons who are permanently disabled.

15.23(1) *Purpose.* Pursuant to Iowa Code subsection 483A.24(15), the department of natural resources will issue a free annual combination hunting and fishing license to low-income persons who meet the age status or permanently disabled status as defined.

15.23(2) *Definitions.*

"Age status" means a person who has achieved the sixty-fifth birthday.

"Low-income person" means a person who is a recipient of a program administered by the state department of human services for persons who meet low-income guidelines.

"Permanently disabled" means a person who meets the definition in Iowa Code section 483A.4.

15.23(3) *Procedure.* Each person shall apply to the department of natural resources for a license as follows:

a. Application shall be made on a form provided by the department and shall include the name, address, height, weight, color of eyes and hair, date of birth, and gender of the applicant. In addition, applicants shall include a copy of an official document such as a birth certificate if claiming age status, or a copy of an award letter from the Social Security Administration or private pension plan if claiming permanent disabled status. The application shall include an authorization allowing the department of human services to verify the applicant's household income if proof of income is provided through the department of human services.

b. The free annual hunting and fishing combination license will be issued by the department upon verification of program eligibility. The license issued under this rule will be valid until January 10 of the subsequent year. Proof of eligibility must be submitted each year in order to obtain a free license.

c. A person whose income falls below the federal poverty guidelines may apply for this license by providing either of the following:

(1) A current Notice of Decision letter. For purposes of this rule, a "current Notice of Decision letter" shall mean a letter from the department of human services dated in the month the application is received or dated in the five months immediately preceding the month the application is received that describes the applicant's monthly or annual household income.

(2) If a person does not have a Notice of Decision letter as described in subparagraph (1), a document shall be provided that states that the applicant's annual income does not exceed the federal poverty limit for the current year and lists income from all sources, including but not limited to any wages or compensation, social security, retirement income, dividends and interest, cash gifts, rents and royalties, or other cash income. In addition, the applicant shall provide documentation of such income by submitting a copy of the applicant's most recently filed state or federal income tax return to the department. In the event an applicant does not have a tax return that was filed within the last year because the applicant's income level does not require the filing of a tax return, the applicant shall so notify the department, shall provide to the department bank statements, social security statements or

other relevant income documentation identified by the department, and shall meet with the department to verify income eligibility under this rule.

Federal poverty guidelines are published in February of each year and will be the income standard for applicants from that time until the guidelines are available in the subsequent year. The guidelines will be shown on the application and will be available upon request from the department.

15.23(4) Revocation. Any license issued pursuant to rule 571—15.23(483A) may be revoked, in whole or in part, by written notice, if the director determines that a license holder had provided false information to obtain a license under this chapter or has violated any provision of this chapter and that continuation of the license is not in the public interest. Such revocation shall become effective upon a date specified in the notice. The notice shall state the extent of the revocation and the reasons for the action. Within 30 days following receipt of the notice of a revocation, the license holder may file a notice of appeal, requesting a contested case hearing pursuant to 561—Chapter 7. The notice of appeal shall specify the basis for requesting that the license be reinstated.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.24(483A) Free annual fishing license for persons who have severe physical or mental disabilities.

15.24(1) Purpose. Pursuant to Iowa Code subsection 483A.24(9), the department of natural resources will issue a free annual fishing license to Iowa residents 16 or more years of age who have severe mental or physical disabilities who meet the definition of “severe mental disability” or “severe physical disability” in 15.24(2).

15.24(2) Definitions. For the purposes of this rule, the following definitions apply:

“*Severe mental disability*” means a person who has severe, chronic conditions in all of the following areas which:

1. Are attributable to a mental impairment or combination of mental and physical impairments;
2. Result in substantial functional limitations in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency;
3. Reflect the person’s need for a combination and sequence of services that are individually planned and coordinated; and
4. Requires the full-time assistance of another person to maintain a safe presence in the outdoors.

“*Severe physical disability*” means a disability that limits or impairs the person’s mobility or use of a hand or arm and that requires the full-time assistance of another person or that makes the person dependant on a wheelchair for the person’s normal life routine.

15.24(3) Procedure. Each person shall apply to the department of natural resources for a license as follows:

a. Application shall be made on a form provided by the department and shall include the name, home address, home telephone number, height, weight, eye and hair color, date of birth, and gender of the applicant and other information as required. The license issued under this rule will be issued by the department upon verification of program eligibility and will be valid until January 10 of the subsequent year. Proof of eligibility must be submitted each year in order to obtain the license.

b. The application shall be certified by the applicant’s attending physician with an original signature and, based upon the definition of severe mental disability or severe physical disability as provided for in this rule, declare that the applicant has a severe mental or physical disability. A medical statement from the applicant’s attending physician specifying the applicant’s type of disability shall be on 8½" x 11" stationery of the attending physician or on paper inscribed with the attending physician’s letterhead. For purposes of this rule, the attending physician must be a currently practicing doctor of medicine, doctor of osteopathy, physician’s assistant or nurse practitioner.

15.24(4) Revocation. Any license issued pursuant to 571—15.24(483A) may be revoked, in whole or in part, by written notice, if the director determines that a license holder had provided false information to obtain a license under this chapter or has violated any provision of this chapter and that continuation of the license is not in the public interest. Such revocation shall become effective upon a date specified

in the notice. The notice shall state the extent of the revocation and the reasons for the action. Within 30 days following receipt of the notice of a revocation, the license holder may file a notice of appeal, requesting a contested case hearing pursuant to 561—Chapter 7. The notice of appeal shall specify the basis for requesting that the license be reinstated.

[ARC 7852B, IAB 6/17/09, effective 7/22/09; ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.25(483A) Transportation tags for military personnel on leave from active duty.

15.25(1) *Military transportation tags for deer and turkey.* The military transportation tag shall include the following information: name, birth date, current address of military person; species and sex of animal taken; date of kill; and weapon used. Only conservation officers of the department shall be authorized to issue military transportation tags.

15.25(2) *Annual limit for military transportation tags.* A person receiving a military transportation tag shall be limited to one military deer tag and one military turkey tag annually.

15.25(3) *Regulations apply to military personnel.* With the exception of the license requirement exemption set forth in Iowa Code section 483A.24(6), all hunting and fishing regulations shall apply to active duty military personnel.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.26 to 15.40 Reserved.

DIVISION IV
EDUCATION AND CERTIFICATION PROGRAMS

571—15.41(483A) Hunter safety and ethics education program. This division clarifies the term “hunting license” as used in Iowa Code section 483A.27 in relation to the hunter safety and ethics education course requirement, clarifies the need for exhibiting a hunter safety and ethics education course certificate when applying for a deer or wild turkey license, and explains the requirements for individuals who wish to demonstrate their knowledge of hunter safety and ethics to qualify for purchase of an Iowa hunting license. For the purpose of this division, a hunting license, pursuant to Iowa Code sections 483A.1 and 483A.24, includes:

1. Hunting licenses for legal residents except as otherwise provided. (Iowa Code section 483A.1(1))
2. Hunting licenses for nonresidents. (Iowa Code section 483A.1(2))
3. Hunting preserve license.
4. Free annual hunting and fishing licenses for persons who are disabled or are 65 years of age or older and qualify for low-income status as defined in Iowa Code section 483A.24.
5. Veteran’s lifetime hunting and fishing license as defined in Iowa Code section 483A.24.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.42(483A) Testing procedures.

15.42(1) *General testing procedures.* Upon completion of the required curriculum, each person shall score a minimum of 75 percent on the written or oral test provided by the department and demonstrate safe handling of a firearm. Based on the results of the written or oral test and demonstrated firearm safe handling techniques as prescribed by the department, the volunteer instructor shall determine the persons who shall be issued a certificate of completion.

15.42(2) *Special testing out provisions.* Any person born after January 1, 1972, who does not complete the required ten-hour hunter safety and ethics course (as described in Iowa Code section 483A.27, subsection (1)), must meet the following requirements to be eligible to purchase an Iowa hunting license:

- a. To comply with Iowa Code section 483A.27, subsection (5), an individual must pass a written examination compiled by the department of natural resources under the direct supervision of a state conservation officer or certified hunter safety instructor.
- b. If the applicant does not pass the examination by a score of 95 percent or more, the applicant must then wait seven days to take the examination again.

c. If the applicant does not pass the second examination with a score of 95 percent or more, the applicant must successfully complete the ten-hour safety and ethics course to obtain a certificate of completion (as described in Iowa Code section 483A.27, subsection (2)).

15.42(3) Exemptions. The following groups of individuals do not need hunting licenses and therefore do not need to satisfactorily complete a hunter safety and ethics education course:

a. *Landowners and tenants.* Owners or tenants of land and their children when hunting on the land which they own or on which they are tenants.

b. *Residents under 16.* Residents of the state under 16 years of age accompanied by their parent or guardian or in the company of any other competent adult if the adult accompanying said minor possesses a valid hunting license, providing, however, there is one licensed adult accompanying each person under 16 years of age.

15.42(4) Deer and wild turkey license applications. Individuals are not required to exhibit a certificate showing satisfactory completion of a hunter safety and ethics education course only when applying for a deer or wild turkey license.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.43(321G,462A,483A) Volunteer bow and fur harvester education instructors, snowmobile and all-terrain vehicle (ATV) safety instructors, boating safety instructors and hunter education instructors.

15.43(1) Purpose. Pursuant to Iowa Code sections 321G.23(2), 462A.3 and 483A.27(4), the department will certify volunteer instructors to teach bow, fur harvester, snowmobile, ATV, boating and hunter education courses.

15.43(2) Definitions. For the purpose of this rule:

“*Certified instructor*” means a person who has met all criteria in this rule for one or more of the above-named courses.

“*Course*” means the department’s bow, fur harvester, snowmobile, ATV, boating and hunter education and ethics courses.

“*Department*” means the department of natural resources.

“*Instructor applicant*” means a person who has applied to become a certified volunteer instructor for one of the above-named courses.

15.43(3) Minimum qualifications. The following conditions must be satisfied before any person can become a certified instructor. Failure to meet these conditions will result in the denial of the application. An applicant may be disqualified if the applicant has accumulated any habitual offender points pursuant to rule 571—15.16(481A,481B,482,483A,484A,484B), or other license suspension by the court or department. The instructor applicant will be notified of the denial by the recreational safety coordinator. An instructor applicant shall:

a. Submit an application as provided by the department to the local conservation officer or recreational safety officer.

b. Be at least 18 years of age.

c. Have experience in handling equipment, such as firearms, bows and arrows, furbearer traps, snowmobiles, ATVs and various navigational vessels, that is necessary for the various prescribed courses.

d. Have completed the course as defined in subrule 15.43(2).

e. Attend and pass an instructor’s training and certification course administered by the department.

f. Submit to a background check. This check will include, but not be limited to, a criminal history check as provided by the department of public safety. A record of a felony conviction will disqualify the applicant. A record of serious or aggravated misdemeanors may disqualify the applicant based on type of offense and year committed.

g. Successfully complete the apprenticeship as required in subrule 15.43(4).

15.43(4) Instructor applicant apprenticeship. In addition to subrule 15.43(3), the following conditions must be satisfied to complete the instructor applicant apprenticeship:

a. Participate in one course.

b. Apprentice with a certified instructor.

The recreational safety officer may make the determination as to which certified instructor will be supervising the instructor applicant during the apprenticeship.

15.43(5) *Certified education instructor responsibilities.* A certified instructor has the following responsibilities:

- a. To complete all prerequisites to becoming an instructor as provided in subrules 15.43(3) and 15.43(4).
- b. To follow all policies and procedures as set forth in the current "Instructor Procedures Manual."
- c. To assist in the recruitment and training of additional volunteer instructors.
- d. To recruit and train students in the applied-for prescribed course program.
- e. To actively promote the program in the instructor's county and to arrange for publicity for each new class.
- f. To maintain order and discipline in the classroom and outdoor classroom at all times.
- g. To accurately fill out required forms and reports for each class and mail that material to the recreational safety coordinator within 15 days after completion of the course.
- h. To teach the course as prescribed by the department.
- i. To maintain a file on all students that the instructor teaches.
- j. To actively participate in one course every two years. If this requirement is not met, the instructor's certification may be terminated after notification by letter by the recreational safety coordinator. The person may reapply to become a volunteer safety education instructor pursuant to subrule 15.43(3).
- k. To attend a minimum of one continuing education instructor workshop every three years for hunter education as provided by the department.

15.43(6) *Grounds for revocation of instructor certification.* The department may, at any time, seek to revoke the instructor certification of any person who:

- a. Fails to meet the instructor responsibilities as outlined in subrules 15.43(4) and 15.43(5).
- b. Fails to follow the policies and procedures as set forth in the current "Instructor Procedures Manual."
- c. Falsifies any information as may be required by the department.
- d. Handles any equipment in an unsafe manner, or allows any student or other instructor to handle equipment in a reckless or unsafe manner.
- e. Is convicted of or forfeits bond for any fish and game, snowmobile, ATV or navigation violation of this state or any other state.
- f. Uses abusive or foul language while conducting a course.
- g. Participates in a course while under the influence of alcohol or any illegal drug.
- h. Has substantiated complaints filed against the instructor by the public, department personnel or other certified instructor(s).
- i. Fails to meet the requirements in subrule 15.43(5), paragraphs "j" and "k."
- j. Is convicted of a felony or an aggravated or serious misdemeanor as defined in the statutes of this state. This would also include any felonies or comparable misdemeanors of any other state.
- k. Receives compensation directly or indirectly from students for time spent preparing for or participating in a course.

15.43(7) *Termination of certification.* Any certified instructor has the right, at any time, to voluntarily terminate certification. If an instructor voluntarily terminates certification or certification is terminated by the department, the instructor must return to the department the certification card and all materials that were provided.

15.43(8) *Compensation for instructors.* Instructor applicants and certified instructors shall not receive any compensation for their time either directly or indirectly from students while preparing for or participating in a course. However, instructor applicants and certified instructors may require students to pay for actual course-related expenses involving facilities, meals or materials other than those provided by the department.

15.43(9) *Hearing rights.* If the department seeks to revoke an instructor certification pursuant to subrule 15.43(6), the department shall provide written notice of intent to revoke the certification as

provided in 571—Chapter 7. If the certified instructor requests a hearing, it shall be conducted in accordance with 571—Chapter 7.

[ARC 7852B, IAB 6/17/09, effective 7/22/09]

571—15.44 to 15.50 Reserved.

DIVISION V

LICENSE REVOCATION, SUSPENSION, AND MODIFICATION DUE TO LIABILITIES OWED TO THE STATE

571—15.51(272D) Purpose and use. This rule is intended to help collect liabilities of the state or a state agency. This rule shall apply to all licenses issued, renewed or otherwise authorized by the department.
[ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.52(272D) Definitions. For purposes of this chapter, the following definitions shall apply:

“*Certificate of noncompliance*” means a document provided by the unit certifying the named person has outstanding liability placed with the unit and has not entered into an approved payment plan to pay the liability.

“*Department*” means the department of natural resources.

“*Liability*” means a debt or obligation placed with the unit for collection that is greater than \$1,000. For purposes of this chapter, “liability” does not include child support payments collected pursuant to Iowa Code chapter 252J.

“*License*” means a license, certification, registration, permit, approval, renewal or other similar authorization issued to a person by the department which evidences the admission to, or granting of authority to engage in, a profession, occupation, business, industry, or recreation, including those authorizations set out in Iowa Code chapters 321G, 321I, 455B, 455C, 455D, 456A, 459, 459A, 461A, 462A, 481A, 481B, 481C, 482, 483A, 484B and 484C.

“*Licensee*” means a person to whom a license has been issued by the department or who is seeking the issuance of a license from the department.

“*Notice of intent*” means a notice sent to a licensee indicating the department’s intent to suspend, revoke, or deny renewal or issuance of a license.

“*Obligor*” means a person with a liability placed with the unit.

“*Unit*” means the centralized collection unit of the department of revenue.

“*Withdrawal of a certificate of noncompliance*” means a document provided by the unit certifying that the certificate of noncompliance is withdrawn and that the department may proceed with issuance, reinstatement, or renewal of a person’s license.

[ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.53(272D) Requirements of the department.

15.53(1) Records. The department shall collect and maintain records of its licensees that must include, at a minimum, the following:

- a. The licensee’s first and last names.
- b. The licensee’s current known address.
- c. The licensee’s social security number.

The records shall be made available to the unit so that the unit may match to the records the names of persons with any liabilities placed with the unit for collections. The records must be submitted in an electronic format and updated on a quarterly basis.

15.53(2) Certificate of noncompliance. Upon receipt of a certificate of noncompliance from the unit, the department shall initiate its existing rules and procedures for the suspension, revocation, or denial of issuance or renewal of a person’s license.

15.53(3) Notice of intent. The department shall provide a notice of intent to a person of its intent to suspend, revoke or deny issuance or renewal of a license in accordance with chapter 272D of the Iowa Code. The suspension, revocation, or denial shall be effective no sooner than 30 days following the issuance of the notice of intent to the person. The notice shall include all of the following:

- a.* That the department has received a certificate of noncompliance from the unit and intends to suspend, revoke or deny issuance or renewal of a person's license;
- b.* That the person must contact the unit to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;
- c.* That the department will revoke, suspend or deny the person's license unless a withdrawal of a certificate of noncompliance is received from the unit within 30 days from the date of the notice;
- d.* That, in the event the department's rules and procedures conflict with the additional rules and procedures under this action, the rules and procedures of this action shall apply;
- e.* That mistakes of fact in the amount of the liability owed and the person's identity may not be contested to the department; and
- f.* That the person may request a district court hearing as outlined in rule 701—153.14(272D).

15.53(4) *Withdrawal.* Upon receipt of a withdrawal of a certificate of noncompliance from the unit, the department shall immediately reinstate, renew, or issue a license if the person is otherwise in compliance with the department's requirements.

[ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.54(272D) No administrative appeal of the department's action. Pursuant to Iowa Code section 272D.8, a person does not have a right to a hearing before the department to contest the department's action under this rule but may request a court hearing pursuant to rule 571—15.55(272D). [ARC 8465B, IAB 1/13/10, effective 2/17/10]

571—15.55(272D) District court hearing. A person may seek review of the actions listed in rule 701—153.14(272D) and request a hearing before the district court by filing an application with the district court in the county in which the majority of the liability was incurred. The person must send a copy of the application to the unit by regular mail. The application must be filed no later than 30 days after the department issues its notice of intent.

15.55(1) *Scheduling.* The clerk of the district court shall schedule a hearing and mail a copy of the scheduling order to the person, the unit, and the department.

15.55(2) *Certification.* The unit shall certify a copy of its written decision and certificate of noncompliance, indicating the date of issuance, and the department shall certify a copy of the notice issued pursuant to subrule 15.53(3) to the court prior to the hearing.

15.55(3) *Stay.* Upon receipt from the clerk of court of a copy of a scheduling order and prior to the hearing, the department shall stay any action contemplated on the person's license pursuant to the notice of intent.

15.55(4) *Hearing.* The hearing on the person's application shall be scheduled and held within 30 days of the application being filed. However, if the person fails to appear at the scheduled hearing, the stay shall be lifted and the department shall continue its procedures pursuant to the notice of intent.

15.55(5) *Scope of review.* The district court's review shall be limited to demonstration of the amount of the liability owed or the identity of the person.

15.55(6) *Findings.* If the court finds the unit was in error either in issuing a certificate of noncompliance or in its failure to issue a withdrawal of a certificate of noncompliance, the unit shall issue a withdrawal of a certificate of noncompliance to the department. If the court finds the unit was justified in issuing a certificate of noncompliance or in not issuing a withdrawal of a certificate of noncompliance, a stay imposed under subrule 15.55(3) shall be lifted and the department shall proceed with the action as outlined in its notice of intent.

[ARC 8465B, IAB 1/13/10, effective 2/17/10]

These rules are intended to implement Iowa Code chapters 272D, 321G, 456A, 462A, 481A, 481B, 482, 483A, 484A, and 484B.

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CHAPTER 113
RESTITUTION FOR POLLUTION CAUSING INJURY TO WILD ANIMALS

571—113.1(481A) Applicability. These rules apply to persons who cause, by water pollution, the destruction of or injury to wild animals held in trust by the state for the public. In most cases this would involve the destruction of aquatic life or other wildlife under the ownership of the state, as provided in Iowa Code section 481A.2. These rules relate to the compensation to the state and public for the natural resource damages and are in addition to any other legal recourse for the event or action that caused the destruction or damage. The administration of this chapter shall not result in a duplication of damages collected by the department under Iowa Code section 455B.392, subsection 1, paragraph “c.”

571—113.2(481A) Definitions.

“*AFS*” means the Special Publication 30, “Investigation and Monetary Values of Fish and Freshwater Mussel Kills,” published by the American Fisheries Society.

“*Damages*” means the costs of restoration, rehabilitation, and replacement of resources or acquisition of equivalent resources, as determined in accordance with this chapter; the reasonable and necessary costs of the assessment, to include the cost of performing the assessment and administrative costs and expenses necessary for, and incidental to, the assessment; lost services to the public; and, in the event the damages claim is not resolved within six months after the incident leading to the damages, interest at the current rate published in the Iowa Administrative Bulletin by the department of revenue pursuant to Iowa Code section 421.7. The interest amount shall be computed from the date the amount of the claim is confirmed by a final ruling of the commission in a contested case decision.

“*Surface water resources*” means the waters of the state, including the sediments suspended in water or lying on the bank, bed, or shoreline. This term does not include groundwater or water or sediments in ponds, lakes, or reservoirs designed for waste treatment under applicable laws regulating waste treatment.

“*Wild animals*” means fish, wildlife and other biota belonging to, managed by, held in trust by, appertaining to, or otherwise controlled by the state of Iowa, the United States, or local government. Fish and wildlife include freshwater aquatic and terrestrial species; game, nongame, and commercial species; and threatened and endangered species. Other biota encompass shellfish and other living organisms not otherwise listed in this definition.

[ARC 8464B, IAB 1/13/10, effective 2/17/10]

571—113.3(481A) Liability to the state. Persons who cause by water pollution the destruction of or injury to wild animals of the state shall be liable to the state as provided in Iowa Code section 481A.151. These rules establish the methodologies and criteria for evaluating the extent and value of the destruction or injury and establish the methods of compensation. If the person and the department cannot agree to the proper resolution of a particular case, the issues of liability, damage and compensation will be established through contested case proceedings, as provided by 571—Chapter 7.

[ARC 8464B, IAB 1/13/10, effective 2/17/10]

571—113.4(481A) Assessment. When wild animals are destroyed or injured by an identifiable source of water pollution, the degree and value of the losses shall be assessed by collecting, compiling, and analyzing relevant information, statistics, or data through prescribed methodologies to determine damages, as set forth in this rule.

113.4(1) General. For species other than fish, the professional judgment of fish and wildlife staff and available literature and guidance normally relied on in the fish and wildlife professions may be used to assess the injuries.

113.4(2) Fish loss. Assessment of damages for fish kills shall be in accordance with the following:

a. Normally investigators will follow the methods prescribed by AFS to determine, by species and size, numbers of fish killed.

b. During periods of ice cover, where local conditions prevent using the methods in “*a*” above, or in other appropriate circumstances, for example, when the resources are known to have been diminished by prior incidents, investigators will utilize the best information available to determine, by species and

size, numbers of fish killed. Information may include existing or prior data on population levels in the affected water body or a nearby water body with similar characteristics, including any historical fish kill data.

c. The monetary valuation of fish shall be the replacement values as published in AFS for all fish lost except the following: channel catfish, flathead catfish, blue catfish, northern pike, muskellunge, northern pike/muskellunge hybrid, rainbow trout, brown trout, brook trout, white bass, yellow bass, white bass/striped bass hybrid, largemouth bass, smallmouth bass, spotted bass, crappie, rock bass, bluegill, redear sunfish, warmouth, pumpkinseed, freshwater drum, yellow perch, walleye, sauger and walleye/sauger hybrid. The value of these fish shall be \$15 each, unless AFS establishes a higher value. Notwithstanding the above, the value of each fish classified by the department as an endangered or threatened species shall be \$1,000.

d. The value of lost services to the public shall be the number of fishing trips lost over the period of the resource loss, as determined through local creel survey information or through interpolation from the most recent statewide creel survey. Each trip shall be valued at \$30.

e. The cost of the investigation shall include:

(1) Salaries plus overhead of staff, including support staff, involved in investigating the fish kill and performing the assessment.

(2) Any meals and lodging of staff while they are in the field conducting the assessment.

(3) Mileage valued at the current rate established pursuant to Iowa Code section 18.117.

(4) Costs borne by the department associated with containment or cleanup operations.

(5) Any other costs directly associated with the investigation and assessment.

[ARC 8464B, IAB 1/13/10, effective 2/17/10]

571—113.5(481A) Compensation. The department will extend to the responsible person the opportunity to reach voluntary agreement as to the amount of damages and the compensation method. The method of compensation shall be solely in the discretion of the department. If the person disputes liability or the damage amount, these issues will be resolved through contested case proceedings.

113.5(1) Direct monetary payment. Compensation shall normally be by direct monetary payment to the department. To the extent reasonable and practical, the money received will be used to replace, restore or rehabilitate the lost or injured animals. Resource enhancement projects, support of educational programs relating to resource protection or enhancement, or resource acquisition of equal or greater value also may be funded. If practical, such alternatives should provide similar services to the public and should be in the vicinity of the loss.

113.5(2) Indirect monetary payment. In appropriate cases, an equal or greater amount of compensation may be made by monetary payment to another government agency or private nonprofit group in the natural resource field for the same purposes as provided in subrule 113.5(1).

113.5(3) Direct funding of projects. With the approval and oversight of the department, the person may be allowed to contract directly for the same purposes as provided in subrule 113.5(1).

These rules are intended to implement Iowa Code sections 456A.23 and 481A.2 and 2002 Iowa Acts, Senate File 2293, section 58.

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CHAPTER 30
CONTINUING EDUCATION FOR PLUMBING AND
MECHANICAL SYSTEMS PROFESSIONALS

641—30.1(105) Definitions. For the purpose of these rules, the following definitions shall apply:

“*Approved program/activity*” means a continuing education program/activity meeting the standard set forth in these rules.

“*Audit*” means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period.

“*Board*” means the plumbing and mechanical systems board as established pursuant to Iowa Code section 105.3.

“*Continuing education*” means planned, organized learning acts acquired during licensure designed to maintain, improve, or expand a licensee’s knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

“*Hour of continuing education*” means at least 50 minutes spent in one sitting by a licensee in actual attendance at and in completion of an approved continuing education activity.

“*License*” means a license to work in a specific discipline covered under Iowa Code chapter 105.

“*Licensee*” means any person licensed to work in a specific discipline covered under Iowa Code chapter 105.

[ARC 8270B, IAB 11/4/09, effective 10/16/09; ARC 8475B, IAB 1/13/10, effective 2/17/10]

641—30.2(105) Continuing education requirements.

30.2(1) The biennial continuing education compliance period shall begin on the license issue date and end two years later on the license expiration date.

30.2(2) Each biennium:

a. A master or journey licensee shall be required to complete a minimum of 8 hours of board-approved continuing education, of which 4 hours shall be in the prescribed practice discipline. A minimum of 2 hours of the 8 hours shall be in the content area of the applicable Iowa plumbing or mechanical codes, and 2 hours of the 8 hours shall be in the content area of the Iowa Occupational Safety and Health Act.

b. A master or journey licensee holding licenses in multiple disciplines shall obtain a minimum of 14 hours of board-approved continuing education, of which 8 hours shall be in any of the prescribed practice disciplines. A minimum of 2 hours of the 14 hours shall be in each of the content areas of the applicable Iowa plumbing code, Iowa mechanical code, or both, and 4 hours of the 14 hours shall be in the content area of the Iowa Occupational Safety and Health Act.

30.2(3) Up to 2 hours of board-approved continuing education required by subrule 30.2(2) each biennium may be obtained through completion of computer-based continuing education programs/activities approved by the board.

30.2(4) It is the responsibility of each licensee to finance the cost of continuing education.

30.2(5) A licensee who is a presenter of a board-approved continuing education program may receive credit once per biennium for the presentation of the program. The licensee may receive the same number of hours granted the attendees.

[ARC 8270B, IAB 11/4/09, effective 10/16/09; ARC 8475B, IAB 1/13/10, effective 2/17/10]

641—30.3(105) Continuing education programs/activities.

30.3(1) *Standards for continuing education programs/activities.* A program/activity is appropriate for continuing education credit if the program/activity meets all of the following criteria:

- a.* Is board-approved;
- b.* Constitutes an organized program of learning that contributes directly to the professional competency of the licensee;
- c.* Pertains to subject matters that integrally relate to the practice of the discipline;

d. Is conducted by individuals who have obtained board approval as required under subrule 30.4(1). This criterion shall not be required for computer-based continuing education programs/activities conducted pursuant to subrule 30.2(3);

e. Fulfills stated program goals, objectives, or both; and

f. Covers product knowledge, methods, and systems of one or more of the following:

- (1) The theory and technique for a specific discipline;
- (2) The current Iowa plumbing code, Iowa mechanical code, or both;
- (3) The standards comprising the current Iowa Occupational Safety and Health Act.

30.3(2) Board approval. Board approval for specific programs/activities under paragraph 30.3(1) “a” shall be valid for one year.

[ARC 8270B, IAB 11/4/09, effective 10/16/09; ARC 8475B, IAB 1/13/10, effective 2/17/10]

641—30.4(105) Course instructor(s).

30.4(1) Standards for instructor approval. An individual is deemed qualified to instruct continuing education programs/activities if the individual meets all of the following criteria:

a. Is board-approved to instruct continuing education programs/activities in one or more of the educational content areas set forth in paragraphs 30.2(2) “a” and “b” (i.e., prescribed practice discipline, plumbing or mechanical code or both, or the Iowa Occupational Safety and Health Act); and

b. Demonstrates appropriate competency to instruct continuing education programs/activities by meeting one or both of the following:

(1) If seeking approval to instruct in the content areas of the plumbing or mechanical code or both or the Iowa Occupational Safety and Health Act, the individual must possess specialized education or training relevant to the subject matter; or

(2) If seeking approval to instruct in the content area of a prescribed practice discipline, the individual must possess specialized education, training, or experience relevant to the subject matter.

30.4(2) Board approval. Board approval for an instructor under paragraph 30.4(1) “a” shall be valid for three years.

[ARC 8270B, IAB 11/4/09, effective 10/16/09; ARC 8475B, IAB 1/13/10, effective 2/17/10]

641—30.5(105) Audit of continuing education requirements. The board may conduct an audit of a licensee’s license renewal application to review compliance with continuing education requirements.

30.5(1) Upon board request, the licensee must submit to the board an individual certificate of completion issued to the licensee or evidence of successful completion of the course from the course sponsor or course instructor. These documents must contain the course title, date(s), contact hours, sponsor’s name, and licensee’s name. In some instances, licensees will be requested to provide to the board additional information including, but not limited to, program content, objectives, presenters, location, and schedule. An inclusive brochure may meet this requirement.

30.5(2) Upon board request, a licensee must submit all information set forth in subrule 30.5(1) within 30 calendar days following the board’s request. The board may grant extensions on an individual basis.

30.5(3) If the submitted materials are incomplete or unsatisfactory and the board determines that the deficiency was the result of good-faith conduct on the part of the licensee, the licensee may be given the opportunity to submit make-up credit to cover the deficit found through the audit. A licensee must complete the continuing education hours and submit documentation establishing completion of the required make-up continuing education hours to the board within 120 calendar days from the date of the board’s finding of good-faith conduct.

30.5(4) A licensee’s failure to provide the board with an accurate mailing address shall not be an excuse for noncompliance with any requirement set forth in this rule.

[ARC 8270B, IAB 11/4/09, effective 10/16/09; ARC 8475B, IAB 1/13/10, effective 2/17/10]

641—30.6(105) Continuing education exemptions.

30.6(1) Automatic exemptions. A licensee shall be exempt from the continuing education requirement during the license biennium when that person:

a. Served honorably on active duty in the military service; or

b. Resided in another state or district having continuing education requirements for the discipline and met all requirements of that state or district for practice therein; or

c. Was a government employee working in the licensee's specialty and assigned to duty outside the United States; or

d. Was absent from the state but engaged in active practice under circumstances which are approved by the board.

30.6(2) Permissive exemptions. The board may, in cases involving exceptional hardship or extenuating circumstances, grant an exemption from some or all of the continuing education requirements.

a. A licensee seeking a permissive exemption shall apply to the board, in such form as the board may prescribe.

b. A licensee seeking a permissive exemption shall be required to provide all such documentary evidence as the board may request to establish the exceptional hardship or extenuating circumstances.

c. In the event of a claimed physical or mental disability or illness, the board may request information from a licensed health care professional who can attest to the existence of any such disability or illness.

d. A licensee who applies for a permissive exemption shall be notified in writing of the board's decision.

e. In granting an exemption, the board may impose any such additional conditions on the exemption including, but not limited to, the requirement that the licensee make up a portion of the continuing education requirements.

f. In lieu of granting a full or partial exemption, the board may grant the licensee an extension of time in which to complete the continuing education requirements.

g. The granting of an exemption shall not prohibit a licensee from seeking, or the board from granting, an exemption in a subsequent biennial continuing education compliance period(s).

h. Permissive exemptions shall only be granted in the most exceptional and extraordinary of circumstances.

[ARC 8270B, IAB 11/4/09, effective 10/16/09; ARC 8475B, IAB 1/13/10, effective 2/17/10]

641—30.7(105) Continuing education extensions. The board may, in individual cases involving hardship or extenuating circumstances, grant an extension of time within which to fulfill the minimum continuing education requirements.

30.7(1) Hardship or extenuating circumstances include documented circumstances beyond the control of the licensee which prevent attendance at required activities.

30.7(2) All requests for extension must be made prior to the license expiration date.

[ARC 8270B, IAB 11/4/09, effective 10/16/09; ARC 8475B, IAB 1/13/10, effective 2/17/10]

641—30.8(105) Continuing education reporting requirements.

30.8(1) Non-computer-based continuing education programs/activities. For non-computer-based continuing education programs/activities, at the conclusion of each continuing education course, the course instructor shall:

a. Inform each attending licensee that a survey of the course and instructor may be completed and submitted by the licensee to the board through either a board-approved written evaluation form or an Internet-based form.

b. Provide a certificate of completion to each licensee who attends the course. The certificate of completion shall include the following information:

- (1) The licensee's full name and board-issued license number;
- (2) The course name or title;
- (3) The board-approved course identification number;
- (4) The date of the course;
- (5) The number of program contact hours;
- (6) The instructor's full name and board-approved identification number; and
- (7) The instructor's signature.

c. Submit to the board a typed or electronic course completion roster within 30 days following the completion of the course. The course completion roster shall contain the following information:

- (1) The full name and board-issued license number of each attending licensee;
- (2) The course name or title;
- (3) The board-approved course identification number;
- (4) The date of the course;
- (5) The location of the course;
- (6) The number of program contact hours;
- (7) The instructor's full name and board-approved identification number; and
- (8) The instructor's signature.

30.8(2) *Computer-based continuing education programs/activities.* For computer-based continuing education programs/activities under subrule 30.2(3), at the conclusion of each computer-based continuing education course, the person authorized to monitor and verify attendance/course completion shall:

a. Provide a certificate of completion to each licensee who completes the course. The certificate of completion shall include the following information:

- (1) The licensee's full name and board-issued license number;
- (2) The course name or title;
- (3) The board-approved course identification number;
- (4) The date the course was completed; and
- (5) The number of program contact hours.

b. Submit to the board a typed or electronic course completion roster within 30 days following a licensee's completion of a computer-based continuing education course. The course completion roster shall contain the following information:

- (1) The full name and board-issued license number of each attending licensee;
- (2) The course name or title;
- (3) The board-approved course identification number;
- (4) The date of the course;
- (5) The location of the course; and
- (6) The number of program contact hours.

[ARC 8270B, IAB 11/4/09, effective 10/16/09; ARC 8475B, IAB 1/13/10, effective 2/17/10]

These rules are intended to implement Iowa Code chapters 105 and 272C.

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CHAPTER 310
SUSTAINABLE DESIGN STANDARDS

661—310.1(103A) Scope and purpose.

310.1(1) Scope. The standards established in this chapter apply to building construction projects in Iowa and are based upon state or federal statutory requirements; administrative rules adopted by state agencies that own, manage, regulate, or finance building construction projects; or federal regulations.

310.1(2) Purpose. The purpose of the standards and requirements included in this chapter is to promote sustainable design in building construction, which is defined as construction that meets current needs while not compromising the needs of future generations. Sustainable design standards are intended to minimize the adverse environmental impacts of construction and the built environment.

[ARC 7773B, IAB 5/20/09, effective 7/1/09]

661—310.2(103A) Definitions. The following definitions apply to rules 661—310.1(103A) through 661—310.6(103A):

“*Commercial*” means a building construction project that is not residential.

“*Commissioner*” means the building code commissioner.

“*Residential*” means a building construction project that involves a building or buildings, each of which is a detached one- or two-family dwelling or which consists of townhouses not more than three stories above grade in height with a separate means of egress to the exterior of the building for each dwelling unit and consisting entirely of dwelling units and their accessory structures.

[ARC 7773B, IAB 5/20/09, effective 7/1/09]

661—310.3(103A) Submission of projects.

310.3(1) Approval of building code commissioner required. Approval of a construction project as sustainably designed pursuant to these rules may be granted only by the building code commissioner. All requests for approval of a project as sustainably designed must be submitted to the Building Code Bureau, Fire Marshal Division, Iowa Department of Public Safety, 215 East 7th Street, Des Moines, Iowa 50319.

310.3(2) Building code approval required. No building construction project shall be approved as a sustainably designed project pursuant to these rules unless construction plans for the project have been approved by the building code commissioner as meeting the state building code or by a local building department as meeting the applicable local building code.

310.3(3) Projects subject to state building code. If approval as a sustainably designed project is requested for a project that is otherwise subject to the state building code, the submission materials required by 661—Chapter 300 shall include a statement that approval for the project as sustainably designed is being requested.

310.3(4) Projects subject to local building codes. If approval from the building code commissioner is sought for a project that is subject to a local building code and code enforcement, construction plans shall be submitted to the building code bureau as provided in 661—Chapter 300, with a cover letter stating that approval of the project as a sustainably designed project is being requested and that the project has been submitted for review to the local building department. Evidence of approval of the construction plans by the local building department shall be submitted to the building code bureau prior to issuance of the commissioner's approval of the project as a sustainably designed project.

310.3(5) Projects not otherwise subject to state or local building codes. If approval as a sustainably designed project is sought for a building construction project that is otherwise not subject to the state building code or a local building code, construction plans for the project shall be submitted to the building code bureau and the project shall be subject to the state building code and to procedures and fees for review of construction plans and inspections as provided in 661—Chapter 300. The cover letter transmitted with the plans shall state that approval as a sustainably designed project is being requested and that the project is not subject to a local building code enforced by a local jurisdiction.

310.3(6) Application form. A completed application form prescribed by the commissioner shall be included with the submission of the construction plans for review of any project for which approval as a sustainably designed project is requested.

[ARC 7773B, IAB 5/20/09, effective 7/1/09]

661—310.4(103A) Sustainable design criteria for residential projects. A residential building construction project shall be approved as sustainably designed if it meets any of the following requirements:

310.4(1) Satisfaction of all of the mandatory criteria of the Iowa green streets criteria described in the publication Iowa Green Streets Criteria, published by the Iowa department of economic development, community development division; or

310.4(2) Compliance with ICC 700-2008, National Green Building Standard, published by the International Code Council, 500 New Jersey Avenue, NW, 6th Floor, Washington, D.C. 20001, at the bronze level; or

310.4(3) Satisfaction of any alternative set of criteria submitted in advance to the commissioner and approved by the commissioner as equivalent to the requirements of either subrule 310.4(1) or 310.4(2).

[ARC 7773B, IAB 5/20/09, effective 7/1/09]

661—310.5(103A) Sustainable design criteria for commercial projects. A commercial building construction project shall be approved as sustainably designed if it meets the following applicable requirements:

310.5(1) If approval as a sustainably designed project is being sought in order to qualify for a tax credit or tax refund, the project shall be approved as sustainably designed if the building receives certification from the United States Green Building Council at the gold level or better in the Leadership in Energy and Environmental Design (LEED) Green Building Rating System, version 3.0; and if the building complies with the requirements of ASHRAE 90.1-2007, Energy Standard for Buildings Except Low-Rise Residential Buildings, published by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, 1791 Tullie Circle, NE, Atlanta, GA 30329.

EXCEPTION: If a good-faith effort has been made to obtain certification at the gold level or above in the LEED Green Building Rating System, version 3.0, and certification at the gold level has not been obtained, but certification at the silver level has been obtained, application may nonetheless be made to the building code commissioner for approval as a sustainably designed project. The commissioner may approve the project as sustainably designed provided that the building is fully in compliance with ASHRAE 90.1-2007, Energy Standard for Buildings Except Low-Rise Residential Buildings, published by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, 1791 Tullie Circle, NE, Atlanta, GA 30329, and demonstration is made to the satisfaction of the building code commissioner that a good-faith effort to achieve certification at the gold level was made and that the project demonstrates an emphasis on energy conservation.

310.5(2) If approval as a sustainably designed project is being sought other than for the purpose of obtaining a tax credit or tax refund, the project shall be approved as sustainably designed if the building receives certification from the United States Green Building Council at the silver level or better in the LEED Green Building Rating System, version 3.0; and if the building complies with the requirements of ASHRAE 90.1-2007, Energy Standard for Buildings Except Low-Rise Residential Buildings, published by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, 1791 Tullie Circle, NE, Atlanta, GA 30329.

EXCEPTION: If a good-faith effort has been made to obtain certification at the silver level or above in the LEED Green Building Rating System, version 3.0, and certification at the silver level or above has not been obtained, but certification has been obtained, application may nonetheless be made to the building code commissioner for approval as a sustainably designed project. The commissioner may approve the project as sustainably designed provided that the building is fully in compliance with ASHRAE 90.1-2007, Energy Standard for Buildings Except Low-Rise Residential Buildings, published by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, 1791 Tullie Circle, NE, Atlanta, GA 30329, and demonstration is made to the satisfaction of the building code commissioner that

a good-faith effort to achieve certification at the silver level was made and that the project demonstrates an emphasis on energy conservation.

310.5(3) If the project includes only the following commercial structures, the project shall be approved as sustainably designed if it satisfies all of the mandatory criteria of the Iowa green streets criteria:

- a. Day care centers.
- b. Vocational rehabilitation centers.
- c. Community centers.
- d. Senior centers.

EXCEPTION: Application may be made to the building code commissioner to accept satisfaction of all of the mandatory criteria of the Iowa green streets criteria, published by the Iowa department of economic development, community development division, as the basis for approval of other commercial projects as sustainably designed. Such submission should be limited to smaller commercial projects, and approval as a sustainably designed project is at the discretion of the building code commissioner, who shall award such approval only if the building code commissioner is convinced that the Iowa green streets criteria are applicable to the project. Written approval for use of the Iowa green streets criteria pursuant to this exception shall be sought and obtained prior to submission of an application for approval as a sustainably designed project.

310.5(4) If a project involves the construction of a building or a portion of a building intended to host a data center or operations of a web portal business, it shall be approved as sustainably designed if the project receives certification from the United States Green Building Council in the Leadership in Energy and Environmental Design (LEED) Green Building Rating System, version 3.0, and complies with the requirements of ASHRAE 90.1-2007, Energy Standard for Buildings Except Low-Rise Residential Buildings, published by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, 1791 Tullie Circle, NE, Atlanta, GA 30329.

EXCEPTION: If a good-faith effort has been made to obtain certification in the LEED Green Building Rating System, version 3.0, and certification has not been obtained, application may nonetheless be made to the building code commissioner for approval as a sustainably designed project. The commissioner may approve the project as sustainably designed provided that:

1. The project is in full compliance with ASHRAE 90.1-2007, Energy Standard for Buildings Except Low-Rise Residential Buildings, published by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, 1791 Tullie Circle, NE, Atlanta, GA 30329, and
2. Demonstration is made to the satisfaction of the building code commissioner that a good-faith effort to achieve certification was made and that the project demonstrates an emphasis on energy conservation.

310.5(5) The building satisfies any alternative set of criteria submitted in advance to the commissioner and approved by the commissioner as equivalent to the requirements set forth in subrule 310.5(1) or 310.5(2), as applicable.

[ARC 7773B, IAB 5/20/09, effective 7/1/09; ARC 8441B, IAB 1/13/10, effective 1/1/10]

661—310.6(103A) Fees.

310.6(1) *Projects subject to the state building code.* For any project for which approval as a sustainably designed project is requested from the commissioner and which is otherwise subject to the state building code, the additional fee for review for compliance with sustainable design standards shall be \$100, which shall be paid prior to review of the application.

310.6(2) *Projects subject to local building codes and code enforcement.* For any project approved by a local building department as compliant with the local building code and for which approval as a sustainably designed project is requested, a fee of \$250 shall apply and shall be paid prior to the commissioner's review of the application for approval as a sustainably designed project.

310.6(3) *Projects not otherwise subject to a building code.* For any project for which approval as a sustainably designed project is requested and which is not otherwise subject to a building code, the plan review fee shall be the same as the plan review fee for the project established in 661—subrule 300.4(2).

An additional fee of \$100 for review for compliance with the requirements set forth in this chapter shall apply and shall be paid prior to review of the plan.

[ARC 7773B, IAB 5/20/09, effective 7/1/09]

These rules are intended to implement Iowa Code section 103A.8B.

[Filed ARC 7773B (Notice ARC 7657B, IAB 3/25/09), IAB 5/20/09, effective 7/1/09]

[Filed Emergency ARC 8441B, IAB 1/13/10, effective 1/1/10]

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See *INDUSTRY*

FACTORY-BUILT STRUCTURES

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FAIRGROUNDS, STATE

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