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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(4); an effective date delay imposed by the ARRC pursuant to section 17A.4(5) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(6); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index 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.

Editor's telephone (515) 281-3355 or (515) 281-8157

Soil Conservation Division[27]

Replace Chapter 12

Iowa Finance Authority[265]

Replace Analysis
Replace Chapter 9
Replace Chapter 12
Replace Chapter 19

Elder Affairs Department[321]

Replace Chapter 9

Human Services Department[441]

Replace Analysis
Replace Chapter 41
Replace Chapter 58
Replace Chapter 75
Replace Chapter 76
Replace Chapter 81
Replace Chapter 88
Replace Chapter 92

Inspections and Appeals Department[481]

Replace Chapter 57
Replace Chapter 58
Replace Chapter 63

Environmental Protection Commission[567]

Replace Chapter 135

Natural Resource Commission[571]

Replace Analysis
Replace Chapter 40

Public Health Department[641]

Replace Analysis
Replace Reserved Chapters 47 to 54 with Reserved Chapters 47 to 49
Insert Chapter 50

Insert Chapter 51
Insert Reserved Chapters 52 to 54
Replace Reserved Chapters 57 to 67 with Reserved Chapters 57 to 66
Insert Chapter 67
Replace Chapter 109
Remove Reserved Chapters 114 to 120
Insert Chapter 114
Insert Reserved Chapters 115 to 120
Replace Chapter 127
Remove Chapter 128
Replace Reserved Chapter 129 with Reserved Chapters 128 and 129
Remove Reserved Chapters 153 and 154
Insert Chapter 153
Insert Reserved Chapter 154
Replace Chapter 175

Public Safety Department[661]

Replace Analysis
Replace Chapter 6
Replace Chapter 11
Replace Chapter 121
Replace Chapter 275
Replace Chapter 322
Remove Reserved Chapters 323 to 349
Insert Chapter 323
Insert Reserved Chapters 324 to 349
Replace Chapter 372

Secretary of State[721]

Replace Analysis
Replace Chapter 21

Veterans Affairs, Iowa Department of[801]

Replace Analysis
Replace Chapter 14
Insert Chapter 16

Index

Replace “C”

CHAPTER 12
WATER PROTECTION PRACTICES—WATER PROTECTION FUND

27—12.1 to **12.9** Reserved.

PART 1

27—12.10(161C) Authority and scope. This chapter establishes procedures and standards to be followed by soil and water conservation districts and the division of soil conservation of the Iowa department of agriculture and land stewardship, in accordance with the policies of the state soil conservation committee in implementing water protection practices through the water protection fund created in Iowa Code section 161C.4, unnumbered paragraph 1, and subsection 2. This account shall be used to establish water protection practices with individual landowners including, but not limited to, woodland establishment and protection, establishment of native grasses and forbs, sinkhole management, agricultural drainage well management, streambank stabilization, grass waterway establishment, stream buffer strip establishment, and erosion control structure construction. Twenty-five percent of funds appropriated to the water protection practices account plus any additional appropriations for reforestation shall be used for woodland establishment and protection and establishment of native grasses and forbs.

27—12.11(161C) Rules are severable. If any provision of a rule or subrule or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rule or subrule which can be given effect without invalid provision or application, and to this end the provisions of these rules or subrules are severable.

27—12.12 to **12.19** Reserved.

PART 2

27—12.20(161C) Definition of terms. In addition to the term defined herein, definitions in rule 27—10.20(161A) shall apply.

"Agricultural production" means the commercial production of food or fiber.

27—12.21 to **12.29** Reserved.

PART 3

27—12.30(161C) Compliance, refund, reviews and appeals. Rule 27—10.30(161A) shall apply.

27—12.31 to **12.39** Reserved.

PART 4

27—12.40(161C) Appropriations. Resource enhancement and protection program, soil and water enhancement account funds are allocated to the water protection fund. Each year's allocation of water protection funds is divided equally between the water quality protection account and the water protection practices account until the water quality protection account has received $1 million. The balance of funds is deposited in the water protection practices account.

27—12.41 to **12.49** Reserved.

PART 5

27—12.50(161C) Water protection practices account. This part defines procedures for allocation, recall and reallocation of water protection practices funds to soil and water conservation districts and to the division's reserve fund. These funds shall not be used alone or in combination with other public funds to provide a financial incentive payment greater than 75 percent of the approved cost for practices listed in 12.84(161C), or 50 percent in 12.77(1), 12.77(2) and 12.77(3).

27—12.51(161C) Allocation to soil and water conservation districts.

12.51(1) *Original allocation.* July 1 of each year, funds appropriated to the water protection practices account will be allocated to districts. Seventy-three and one-half percent of the funds will be divided equally among 100 soil and water conservation districts. Twenty-five percent of the funds plus any additional appropriations for reforestation will be kept in a separate account for woodland establishment and protection, and establishment of native grasses and forbs. One and one-half percent will be held in a reserve fund.

12.51(2) *Recall of funds.* Any funds allocated to the districts that have not been obligated by June 30 and any funds that were obligated for projects for which construction has not been started during that time period may be recalled by the division.

12.51(3) *Supplemental allocations.* The districts shall identify valid applications and cost estimates, if any, for supplemental allocations to the division by October 15. The allocation to any district will be the lesser amount of:

a. The sum of cost estimates (for pending applications) in each district, divided by the total cost estimates (for pending applications) for all 100 districts, multiplied by the remaining available program funds; or

b. Three times the original allocation to the district.

12.51(4) *Reallocation of recalled funds.* Rescinded IAB 7/18/07, effective 6/27/07.

12.51(5) *Woodland, native grass and forbs fund.* Twenty-five percent of the funds and any additional appropriations for reforestation will be allocated to districts.

a. *Original allocation.* Seventy-five percent of the funds distributed to this program will be allocated equally to districts at the beginning of each fiscal year.

b. *Supplemental allocation.* The districts shall identify valid applications and cost estimates, if any, for supplemental allocations to the division by October 15. The allocation to any district will be the lesser amount of:

(1) The sum of cost estimates (for pending applications) in each district, divided by the total cost estimates (for pending applications) for all 100 districts, multiplied by the remaining available program funds; or

(2) Three times the original allocation to the district.

c. *Eligibility of soil and water conservation districts for supplemental allocation.* For a district to qualify for a supplemental allocation, the district must meet the following requirement: ninety percent of the woodland, native grass and forbs funds shall be obligated to landowners.

12.51(6) *Reserve funds.* The division may administer a reserve fund for the program consisting of not more than 1.5 percent of each year's appropriated funds.

a. Purpose and use of the reserve fund. The reserve fund will be set aside and used only to fund contingencies that occur in the application of practices in the districts.

b. On June 30 each year the division will transfer the unspent reserve fund balance into the water protection practices account to be allocated to districts under subrule 12.51(1).

27—12.52 to **12.59** Reserved.

PART 6

27—12.60(161C) Applications and agreements. The purpose of this part is to identify and define procedures to be followed in applying for and entering agreements for receiving water protection practices funds.

27—12.61(161C) Applications submitted to soil and water conservation district. Landowners or farm operators desiring to be considered for water protection practices funds shall complete necessary applications as specified by the district. All application forms and agreements for water protection practices funds are available from and shall be submitted to the district office located in the county where such practices are proposed. If an applicant's land is in more than one district, the respective district commissioners will review the application and agree to obligate all funds from one district or prorate the funding between districts.

27—12.62(161C) Application sign-up.

12.62(1) *Signatures by landowner and qualified applicant.* All applications and agreements shall be signed by the landowner and applicant. For an applicant to qualify for payment, both landowner and applicant must sign the application.

12.62(2) *Land being bought under contract.* All applications and agreements concerning land being purchased under contract shall be signed by both the contract seller and the contract buyer. If the operator is applying, the contract buyer, the contract seller, and the operator must sign.

12.62(3) *Power of attorney.* Applications and agreements may be signed by any person designated to represent the landowner or farm operator, provided the appropriate power of attorney has been filed with the district office. The power of attorney requirement can be met by submitting a notarized full power of attorney statement to the district office. In the case of estates and trusts, court documents designating the responsible person or administrator may be submitted to the district in lieu of the power of attorney.

27—12.63(161C) Eligibility for financial incentives.

12.63(1) *District cooperator.* Rescinded IAB 7/18/07, effective 6/27/07.

12.63(2) *Practices installed on adjoining public lands.* Where water protection practices which benefit adjoining private lands are installed on public lands and costs of the installation are to be shared by the parties, state water protection practices funds may be used to cost-share only the landowner cost of the water protection practice.

12.63(3) *Ineligible lands.*

a. Water protection practices funds shall not be used to reimburse other units of government for implementing soil and water conservation practices.

b. Privately owned land not used for agricultural production shall not qualify for water protection practices funds. Windbreaks and stormwater quality best management practices established on privately owned land are eligible whether or not the land is in agricultural production.

12.63(4) *District priorities.* Each application for water protection practices shall be evaluated under the priority system adopted by the district for disbursement of allocated funds. Soil and water conservation district commissioners shall give priority to applications for practices that implement their soil and water resource conservation plan. The priority system adopted by the district shall be made available for review at the district office.

27—12.64 to **12.69** Reserved.

PART 7

27—12.70(161C) Water protection practices. The purpose of this part is to establish the general conditions, eligible practices, specifications, and cost-share rates for the installation of water protection practices authorized in Iowa Code chapter 161C.

27—12.71(161C) General conditions. The following general conditions shall be met.

12.71(1) *Technician certification.* The designated water protection practices shall not be funded unless the technician has inspected the site and has determined that such practice(s) is needed to protect water quality.

12.71(2) *Limitation of reimbursable cost of practices.* Overbuilding or other practice modifications which exceed the minimum requirements of the specification shall be permitted, if approved by the technician. Any additional costs resulting from such overbuilding or exceeding of the minimum specifications shall not be cost shared by the state.

12.71(3) *Materials.* Projects funded with water protection funds will utilize only new materials or used materials that meet or exceed design standards and have a life expectancy of 20 years.

12.71(4) *Repair or maintenance.* Repair or maintenance of existing practices is not eligible for funding.

27—12.72(161C) Eligible practices. Practices listed in this rule are eligible for water protection practices fund reimbursement.

12.72(1) *Critical area planting.* Establishment of vegetative planting to control sediment movement from severely eroding areas by stabilizing the soil. These plantings would include vegetation such as trees, shrubs, vines, grasses or legumes.

12.72(2) *Strip-cropping (wind).* A strip of tall growing perennial vegetation within or adjacent to a field to reduce sediment damage and soil depletion caused by wind.

12.72(3) *Field border.* A strip of perennial vegetation established at the edge of a field, to be used as a turn area in lieu of end-rows up and down hill to control erosion and provide wildlife food and cover.

12.72(4) *Filter strips.* A strip or area of vegetation for removing sediment, organic matter and other pollutants from runoff.

12.72(5) *Strip-cropping, contour.* Growing crops in a systematic arrangement of strips or bands on the contour to reduce water and wind erosion. The crops are arranged so that a strip of grass or close-growing crop is alternated with a strip of clean-tilled crop or fallow or a strip of grass is alternated with a close-growing crop.

12.72(6) *Pasture and hayland planting.* The establishment of long-term stands of adapted species of perennial forage plants, to control excessive water erosion, by converting land from row crop production to permanent vegetative cover.

12.72(7) *Restored or constructed wetlands in buffer systems.* An area where hydric (wetland) vegetation and hydrology are established within or adjacent to a buffer system that filters pollutants from runoff or underground tile lines, or both. (Land enrolled in the Conservation Reserve Program, or other similar programs, is eligible, if this practice is not an allowable practice under that program.)

12.72(8) *Bioengineering for stabilization of banks along waterways.* A system designed to emphasize the use of live vegetation, natural materials, and structural practices to produce living, functioning systems to stabilize stream banks, reduce sedimentation, provide habitat, and filter pollutants. Bioengineering uses combinations of stream-side plantings or trees, other vegetation, structural practices such as modification of slopes, and installation of reinforcing materials and in-stream structures. (Land enrolled in the Conservation Reserve Program, or other similar programs, is eligible, if this practice is not an allowable practice under that program.)

27—12.73(161C) Eligible practices for priority water resource protection. Practices listed in this rule are eligible for water protection practice fund reimbursement only in those areas or instances approved in rule 27—12.75(161C).

12.73(1) *Grassed waterway.* A natural or constructed waterway or outlet, shaped and graded, on which suitable vegetation is established to conduct excess surface runoff water from terraces, diversions or natural watershed basins.

12.73(2) *Grade stabilization structure.* An earthen dam or embankment with a mechanical outlet (pipe conduit, drop spillway or chute outlet, etc.) to stabilize the flowline grade or control head cutting in a natural or constructed channel.

12.73(3) *Terrace.* An earthen barrier or embankment constructed across the field slope using a combination of a ridge and channel to reduce field erosion and trap sediment. Types of terraces commonly referred to as broad based, narrow based, grassed backslope, basin, level, gradient and parallel are eligible for water protection practice fund reimbursement.

12.73(4) *Water and sediment control basin.* A short earthen embankment with an underground outlet, constructed across the slope in minor water courses to reduce erosion and trap sediment.

12.73(5) *Diversion.* A channel with a supporting ridge on the lower side constructed across the slope to conduct excess runoff water to a suitable outlet.

12.73(6) *Animal waste management system.* A planned system to correct existing animal waste management problems in which all necessary components are installed for managing liquid and solid waste, including runoff from concentrated waste areas from an existing animal feeding operation, in a manner that does not degrade soil or water resources.

Cost-sharing under this practice is not authorized for:

a. Portable pumps and pumping equipment.

b. Waste disposal equipment.

c. Building, modification of a building, that portion of the animal waste structure that serves as part of the building, or its foundation.

d. That portion of the cost of animal waste control structures attributed to expansion of an animal waste management system.

12.73(7) *Stormwater quality best management practices (BMPs).* A technique, measure, or structural control that is used for a given set of conditions to manage the quantity and improve the quality of stormwater runoff in the most cost-effective manner. BMPs can be either:

a. Nonstructural BMPs, which include a range of pollution prevention, education, or institutional management and development practices designed to limit the conversion of rainfall to runoff and to prevent pollutants from entering runoff at the source of runoff generation; or

b. Structural BMPs, which are engineered and constructed systems that are used to treat the stormwater at either the point of generation or the point of discharge to either the storm sewer system or to receiving waters (e.g., detention ponds or constructed wetlands).

27—12.74(161C) Agricultural drainage well closure. Practices listed in this rule are eligible for water protection practice fund reimbursement where installation of the practice is consistent with current drainage law of the state of Iowa. This practice is intended to assist in the voluntary closure of agricultural drainage wells registered with the department of natural resources prior to September 30, 1988. It is not intended to be a substitute for future agricultural drainage well assistance programs authorized in Iowa Code section 159.29 that will be developed in conjunction with the Iowa department of agriculture and land stewardship's agricultural drainage well research and demonstration project.

12.74(1) *Eligible practices.*

a. Agricultural drainage well plugging and cistern removal.

b. Tile outlet from plugged agricultural drainage well to a suitable, legal outlet.

12.74(2) *Implementation of practice.* This practice shall not be used to provide outlet(s) for previously undrained wetland(s) as defined and classified under state or federal law.

12.74(3) *Outlets with excess capacity.* Tile outlets which exceed the minimum capacity required to provide one-half inch drainage coefficient to the area originally served by the drainage well shall be permitted, if approved by the technician. Any additional cost resulting from providing such excess capacity shall not be cost-shared by the state.

27—12.75(161C) Priority watersheds and water quality problems. Practices listed in rule 27—12.73(161C) will be eligible for landowner reimbursement from water protection practices funds only for watersheds and water quality problems designated by soil and water conservation district commissioners and approved by the state soil conservation committee.

12.75(1) *District designation.* Districts shall submit to the division the description of high priority watershed(s) or water quality problems within their district to be designated as eligible for practices listed in rule 27—12.73(161C).

12.75(2) *State soil conservation committee evaluation.* The state soil conservation committee shall examine the district submission under 12.75(1) with respect to the following criteria.

a. The public value and current use of the water resource to be protected.

b. The nature, extent and severity of the water quality problem to be addressed.

c. The degree to which the district designation focuses practice application in a manner that will achieve a water quality benefit from the funds available.

12.75(3) *Review time limit.* The state soil conservation committee shall approve or disapprove the district designation within 90 days of receipt by the division.

12.75(4) *Disapproval of designation.* In the event of disapproval of district designation, the state soil conservation committee shall inform the district of the reason for disapproval.

27—12.76(161C) Practice standards and specifications. In addition to specifications defined herein, rule 27—10.84(161A) specifications shall apply.

12.76(1) *Agricultural drainage well closure.* 567 IAC Chapter 39, Requirements for Properly Plugging Abandoned Wells.

12.76(2) *Agricultural drainage well plugging and cistern removal.* 567 IAC Chapter 39, Requirements for Properly Plugging Abandoned Wells.

12.76(3) *Stormwater quality best management practices.* Iowa Stormwater Management Manual, Chapter 2, Sections D-L.

27—12.77(161C) Cost-share rates. The following cost-share rates shall apply for eligible practices designated in rules 12.72(161C) to 12.74(161C).

12.77(1) *Cost-share rates.* Cost-share rates for practices designated in rule 12.72(161C) shall be 50 percent of the eligible or estimated cost of installation, whichever is less, except for strip-cropping contour and field borders. Cost-share rates for 12.72(3), field borders, and 12.72(5), strip-cropping contour, shall be a one-time payment of 50 percent of the cost up to $25 per acre.

12.77(2) *Cost-share rates for water protection practices.* Cost-share rates for practices designated in rule 12.73(161C) shall be 50 percent of the eligible or estimated cost, whichever is less.

12.77(3) *Cost-share rates for agricultural drainage well closure.* Cost-share rates for practices designated in rule 12.74(161C) shall be the following:

a. 50 percent of the eligible or estimated cost, whichever is less, of agricultural drainage well plugging and cistern removal, not to exceed $500.

b. 50 percent of the eligible or estimated cost, whichever is less, of establishing a tile outlet from the plugged agricultural drainage well to a suitable, legal outlet, not to exceed $2000.

27—12.78 and **12.79** Reserved.

PART 8

27—12.80(161C) Water protection practices—woodlands, native grasses and forbs. The purpose of this part is to establish the general conditions, eligible practices, specifications and cost-share rates for the installation of woodlands, native grasses and forbs as authorized in Iowa Code chapter 161C.

27—12.81(161C) General conditions. The following general conditions shall be met.

12.81(1) *Practice need.* The designated practices shall not be funded unless the certifying technician has inspected the site and has determined that such practice(s) is needed.

12.81(2) *Forest management plan required.* A forest management plan approved by the forestry bureau of the department of natural resources is required for the practices of timber stand improvement, tree planting, site preparation for natural regeneration, and rescue treatments.

12.81(3) *Eligibility of practices.* Planting or management of trees for nut orchards or Christmas tree production is only eligible as intermediate products in stands being established for other approved purposes. Planting or management of trees for ornamental purposes or fruit orchards is not eligible.

27—12.82(161C) Eligible practices. Land enrolled in the Conservation Reserve Program is only eligible for woodland establishment, management and protection practices. All practices listed in this part are available to all other eligible landowners within Iowa soil and water conservation districts. All practices listed below are permanent.

12.82(1) *Windbreaks.* A belt of trees or shrubs established or restored next to an occupied structure.

12.82(2) *Field windbreak.* A belt of trees or shrubs established or restored, within or adjacent to a field.

12.82(3) *Timber stand improvement.* To increase the growth and quality of forest stands and improve wildlife habitat. Minimum eligible area is five acres.

12.82(4) *Tree planting.* To establish a stand of trees for timber production and environmental improvement. Minimum eligible area is three acres.

12.82(5) *Site preparation for natural regeneration.* To establish a stand of forest trees through natural regeneration for timber production and environmental improvement. Minimum eligible area is three acres.

12.82(6) *Riparian forest buffer.* To establish an area of trees or shrubs, or both, located adjacent to and up-gradient from water bodies.

12.82(7) *Rescue treatments.* To rescue plantations from conditions that would threaten the adequate survival or quality of the plantation if not controlled. Minimum eligible area is three acres.

12.82(8) *Prescribed grazing.* The controlled harvest of vegetation with grazing or browsing animals that is managed with the intent to achieve a specified objective.

12.82(9) *Conservation cover.* Establishing and maintaining perennial vegetative cover on land.

27—12.83(161C) Practice standards and specifications. Soil and water conservation practices shall meet Natural Resources Conservation Service conservation standards and specifications where applicable. These standards may be accessed through the electronic field office technical guide at http://efotg.nrcs.usda.gov/efotg_locator.aspx?map=IA.

Tree planting, timber stand improvement, site preparation for natural regeneration and rescue treatment standards may be accessed through the department of natural resource's forestry technical guide found at http://www.iowadnr.com/forestry/pdf/techguide.pdf.

Standards and specifications are also available in hard copy in the district office where the practice will be implemented. These specifications and the general conditions, rule 27—10.81(161A), shall be met in all cases. To the extent of any inconsistency between the general conditions and the specifications, the general conditions shall control.

27—12.84(161C) Cost-share rates. The following cost-share rates shall apply for eligible practices designated in rule 12.82(161C). The use of state cost-share funds alone or in combination with other public funds shall not exceed the limits established by these rules.

12.84(1) *Windbreaks.* 75 percent of the actual cost, not to exceed $1500 for the total cost of the establishment or restoration of the windbreak.

12.84(2) *Field windbreaks.* 75 percent of the actual cost, not to exceed $450 per acre.

12.84(3) *Timber stand improvement.* 75 percent of the actual cost, not to exceed $120 per acre for prescribed woodland burning, thinning, pruning crop trees, or releasing seedlings or young trees.

12.84(4) *Tree planting.*

a. 75 percent of the actual cost, not to exceed $450 per acre, for tree planting including the following:

(1) Establishing ground cover,

(2) Trees and tree-planting operations,

(3) Weed and pest control,

(4) Mowing, disking, and spraying.

b. 75 percent of the actual cost, not to exceed $150 per acre for woody plant competition control.

12.84(5) *Site preparation for natural regeneration.* 75 percent of the actual cost, not to exceed $120 per acre of site preparation.

12.84(6) *Riparian forest buffer.* 75 percent of the actual cost or estimated cost, whichever is less.

12.84(7) *Rescue treatment.*

a. 75 percent of the actual cost, not to exceed $60 per acre to establish alternate cover for competition control.

b. A one-time payment of 75 percent of the actual cost, not to exceed $15 per acre to control damaging rodent populations.

c. 75 percent of the actual cost, not to exceed $450 per acre, for plantation replanting including the following:

(1) Establishing ground cover,

(2) Trees and tree planting,

(3) Weed control.

12.84(8) *Planned grazing systems.* 75 percent of the actual cost or estimated cost, whichever is less. Does not include boundary fences or road fences. Development of a water source is not eligible.

12.84(9) *Conservation cover.* 75 percent of the actual cost or estimated cost, whichever is less.

12.84(10) *Fencing systems.* Fencing systems used to implement or protect a conservation practice described in rule 27—12.82(161C) are eligible for the lesser of 75 percent of the actual cost or the estimated cost. The fencing costs cannot exceed $14 per rod for permanent fencing or $5 per rod for temporary electric fencing. Fences along roads or land boundaries are not eligible.

27—12.85(161C) Special practice and cost-share procedures eligibility. Districts may submit requests to establish eligible practices, develop cost-share procedures, experiment with new conservation practices and explore new technologies with approval of the state soil conservation committee.

12.85(1) *District designation.* Districts shall submit to the SSCC the description of their intentions which could include:

a. Type of practice.

b. Cost-share rate.

c. Resource to be protected.

d. Estimated cost.

e. Landowner interest.

f. Technology to be addressed.

12.85(2) *State soil conservation committee evaluation.* The state soil conservation committee shall examine the district submission under 12.85(1) with respect to the following criteria.

a. The public and current use of the resource to be protected.

b. The nature, extent, and severity of the problem to be addressed.

c. The degree to which the request focuses practice or technology application in a manner that will achieve a soil erosion or water quality benefit from the funds available.

d. Whether a specification can be developed by NRCS or DNR for the new technology or practice.

12.85(3) *Review time limit.* The state soil conservation committee shall approve or disapprove the district designation within 90 days of receipt by the division.

12.85(4) *Disapproval of designation.* In the event of disapproval of district requests, the state soil conservation committee shall inform the district of the reason for disapproval.

This rule is intended to implement Iowa Code chapters 161A and 161C.

27—12.86 to **12.89** Reserved.

PART 9

27—12.90(161C,312) Reporting and accounting. Reports will be prepared in the same manner as provided in rule 27—10.91(161A).

These rules are intended to implement Iowa Code chapters 161A and 161C, Iowa Code section 99E.34 and 1989 Iowa Acts, chapter 236.

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IOWA FINANCE AUTHORITY[265]

[Prior to 7/26/85, Housing Finance Authority[495]]
[Prior to 4/3/91, Iowa Finance Authority[524]]

CHAPTER 1
GENERAL

1.1(16) Purpose
1.2(16) Mission
1.3(16) Organization, programs and operations
1.4(16) Location where the public may submit requests or obtain information
1.5(16) Forms

CHAPTER 2
LOAN PROGRAMS

GENERAL PROVISIONS

2.1(16) Administrative agents

TERMS AND CONDITIONS

2.2(16) Interest and fees
2.3 Reserved
2.4(16) Loan conditions
2.5(16) Security for loans
2.6(16) Types of loans
2.7(16) Delinquency and foreclosure
2.8(16) Application processing
2.9(16) Mortgage purchase or loans to lenders for existing, newly built single-family or multifamily housing—general information
2.10(16) Assumption of mortgages

CHAPTER 3
MULTIFAMILY HOUSING

DIVISION I
MULTIFAMILY LOAN PROGRAM

3.1(16) Purpose
3.2(16) Available funds
3.3(16) Intent of the authority
3.4(16) Application procedure
3.5(16) Program guidelines
3.6(16) Multifamily loan program for preservation of affordable housing
3.7(16) Multifamily loan program for low-income housing tax credits
3.8(16) Multifamily loan program for substantial rehabilitation of nonrestricted projects
3.9(16) Authority analysis of applications
3.10(16) Discretion of authority board
3.11(16) Closing/advance of funds
3.12 to 3.19 Reserved

DIVISION II
PREDEVELOPMENT LOAN FUND

3.20(16) Purpose
3.21(16) Available funds
3.22(16) Intent of the authority
3.23(16) Application procedure
3.24(16) Fund guidelines

3.25(16) Authority analysis of applications
3.26(16) Discretion of authority board
3.27(16) Closing/advance of funds
3.28 to 3.30 Reserved

DIVISION III
GAP FINANCING FUND

3.31(16) Purpose
3.32(16) Intent of the authority
3.33(16) Application procedure
3.34(16) Fund guidelines
3.35(16) Authority analysis of applications
3.36(16) Discretion of authority board
3.37(16) Closing/advance of funds

CHAPTER 4
GENERAL REVENUE BOND PROCEDURES

4.1(16) Revenue bonds authorized
4.2(16) Participating lenders
4.3(16) Procedures for project sponsors
4.4(16) Authority review
4.5(16) Public hearing and approval
4.6(16) Procedures following bond issuance
4.7(16) Right to audit

CHAPTER 5
SMALL BUSINESS LOAN PROGRAM

PART I
GENERAL

5.1(16) Program description
5.2(16) Waiver
5.3(16) Urban revitalization
5.4 to 5.9 Reserved

PART II
DEFINITIONS

5.10(16) Definitions
5.11 to 5.19 Reserved

PART III
LOAN CRITERIA AND DOCUMENTATION

5.20(16) Application
5.21(16) Public benefit
5.22(16) Loan criteria
5.23(16) Good character

CHAPTER 6
GROUP HOME FACILITIES LOAN PROGRAM

PART I
GENERAL

6.1(16) Program description
6.2(16) Waiver
6.3 to 6.9 Reserved

PART II
DEFINITIONS

6.10(16) Definitions
6.11 to 6.19 Reserved

PART III
LOAN CRITERIA AND DOCUMENTATION

6.20(16) Application
6.21(16) Public benefit
6.22(16) Eligibility

CHAPTER 7
CONTESTED CASES

7.1(17A) Scope and applicability
7.2(17A) Definitions
7.3(17A) Time requirements
7.4(17A) Requests for contested case proceeding
7.5(17A) Notice of hearing
7.6(17A) Presiding officer
7.7(17A) Waiver of procedures
7.8(17A) Telephone or video proceedings
7.9(17A) Disqualification
7.10(17A) Consolidation—severance
7.11(17A) Pleadings
7.12(17A) Service and filing of pleadings and other papers
7.13(17A) Discovery
7.14(17A) Subpoenas
7.15(17A) Motions
7.16(17A) Prehearing conference
7.17(17A) Continuances
7.18(17A) Withdrawals
7.19(17A) Intervention
7.20(17A) Hearing procedures
7.21(17A) Evidence
7.22(17A) Default
7.23(17A) Ex parte communication
7.24(17A) Recording costs
7.25(17A) Interlocutory appeals
7.26(17A) Posthearing procedures and orders
7.27(17A) Appeals and review
7.28(17A) Applications for rehearing
7.29(17A) Stays of authority actions
7.30(17A) No factual dispute contested cases
7.31(17A) Emergency adjudicative proceedings
7.32(17A,16) Informal procedure prior to hearing

CHAPTER 8
PRIVATE ACTIVITY BOND ALLOCATION

8.1(7C) General
8.2(7C) Forms
8.3(7C) Formula for allocation
8.4(7C) Application for allocation
8.5(7C) Certification of allocation
8.6(7C) State ceiling carryforwards

8.7(7C) Expiration dates
8.8(7C) Resubmission of expired allocations
8.9(7C) Use by political subdivisions
8.10(7C) Application and allocation fees

CHAPTER 9
TITLE GUARANTY DIVISION

9.1(16) Purpose
9.2(16) Mission
9.3(16) Definitions
9.4(16) Organization
9.5(16) Location where public may obtain information
9.6(16) Title guaranty program
9.7(16) Application for waiver of participation requirements
9.8(16) Application for title guaranty certificates
9.9(16) Contracts, forms, manuals, instructions, and guides
9.10(16) Rates
9.11(16) Fees and premiums
9.12(16) Audit procedures
9.13(16) Claims
9.14(16) Rules of construction
9.15(16) Implementation
9.16(16) Forms, endorsements, and manuals
9.17(16) Application for waiver of participation requirements
9.18(16) Rates
9.19(16) Charges
9.20(16) Mortgage release certificate
9.21(16) Seal
9.22(16) Closing protection letters

CHAPTER 10
MORTGAGE CREDIT CERTIFICATES

10.1(16) General
10.2(16) Participating lenders
10.3(16) Eligible borrowers
10.4(16) MCC procedures

CHAPTER 11
IOWA MAIN STREET LOAN PROGRAM

11.1(16) Program description
11.2(16) Waiver
11.3(16) Main street loan program
11.4(16) Definitions
11.5(16) Application
11.6(16) Public benefit
11.7(16) Loan criteria

CHAPTER 12
LOW-INCOME HOUSING TAX CREDITS

12.1(16) Qualified allocation plan
12.2(16) Location of copies of the plan
12.3(16) Compliance manual
12.4(16) Location of copies of the manual

CHAPTER 13
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

13.1(17A,22) Definitions
13.3(17A,22) Requests for access to records
13.4(17A,22) Access to confidential records
13.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
13.9(17A,22) Availability of records

CHAPTER 14
HOMELESS SHELTER ASSISTANCE PROGRAM

14.1(16) General
14.2(16) Eligible applicants
14.3(16) Eligible activities
14.4(16) Application procedure
14.5(16) Application review criteria
14.6(16) Maximum grant award
14.7(16) Contracts

CHAPTER 15
PURCHASING

15.1(16) Applicability of competitive bidding
15.2(16) Methods of obtaining bids or proposals used by the authority
15.3(16) Items purchased through the department of administrative services
15.4(16) Advertising solicitations
15.5(16) Contract purchases
15.6(16) Blanket purchase agreements
15.7(16) Bids and proposals to conform to specifications
15.8(16) Time of delivery
15.9(16) Cash discounts
15.10(16) Ties
15.11(16) Time of submission
15.12(16) Modification or withdrawal of bids
15.13(16) Financial security
15.14(16) Rejection of bids and proposals
15.15(16) Vendor appeals

CHAPTER 16
DECLARATORY ORDERS

16.1(17A) Petition for declaratory order
16.2(17A) Notice of petition
16.3(17A) Intervention
16.4(17A) Briefs
16.5(17A) Inquiries
16.6(17A) Service and filing of petitions and other papers
16.7(17A) Consideration
16.8(17A) Action on petition
16.9(17A) Refusal to issue order
16.10(17A) Contents of declaratory order—effective date
16.11(17A) Copies of orders
16.12(17A) Effect of a declaratory order

CHAPTER 17
PROCEDURE FOR RULE MAKING

17.1(17A) Applicability
17.2(17A) Advice on possible rules before notice of proposed rule adoption
17.3(17A) Public rule-making docket
17.4(17A) Notice of proposed rule making
17.5(17A) Public participation
17.6(17A) Regulatory analysis
17.7(17A,25B) Fiscal impact statement
17.8(17A) Time and manner of rule adoption
17.9(17A) Variance between adopted rule and published notice of proposed rule adoption
17.10(17A) Exemptions from public rule-making procedures
17.11(17A) Concise statement of reasons
17.12(17A) Contents, style, and form of rule
17.13(17A) Authority rule-making record
17.14(17A) Filing of rules
17.15(17A) Effectiveness of rules prior to publication
17.16(17A) General statements of policy
17.17(17A) Review by authority of rules

CHAPTER 18
WAIVERS AND VARIANCES FROM ADMINISTRATIVE RULES

18.1(17A,16) Definitions
18.2(17A,16) Scope
18.3(17A,16) Applicability of chapter
18.4(17A,16) Criteria for waiver or variance
18.5(17A,16) Filing of petition
18.6(17A,16) Content of petition
18.7(17A,16) Additional information
18.8(17A,16) Notice
18.9(17A,16) Hearing procedures
18.10(17A,16) Ruling
18.11(17A,16) Public availability
18.12(17A,16) Summary reports
18.13(17A,16) Voiding or cancellation
18.14(17A,16) Violations
18.15(17A,16) Defense
18.16(17A,16) Judicial review

CHAPTER 19
STATE HOUSING TRUST FUND

19.1(16) Trust fund allocation plans
19.2(16) Location of copies of the plans

CHAPTER 20
SENIOR LIVING REVOLVING LOAN PROGRAM

20.1(16) Purpose
20.2(16) Priority of loan awards
20.3(16) Application process
20.4(16) Program guidelines
20.5(16) Authority analysis of applications
20.6(16) Discretion of authority board
20.7(16) Closing/advance of funds

CHAPTER 21
HOME AND COMMUNITY-BASED SERVICES REVOLVING LOAN PROGRAM

21.1(16) Purpose
21.2(16) Available funds
21.3(16) Intent of the authority
21.4(16) Application procedure
21.5(16) Program guidelines
21.6(16) Authority analysis of applications
21.7(16) Discretion of authority board
21.8(16) Closing/advance of funds

CHAPTER 22
IOWA AFTERCARE SERVICES RENT SUBSIDY PROGRAM

22.1(16,PL106-169) Purpose
22.2(16,PL106-169) Definitions
22.3(16,PL106-169) Eligibility requirements for direct rent subsidy
22.4(16,PL106-169) Application for direct rent subsidy
22.5(16,PL106-169) Amount of rent subsidy
22.6(16,PL106-169) Redetermination of direct rent subsidy eligibility
22.7(16,PL106-169) Termination of rent subsidy payments
22.8(16,PL106-169) Eligibility requirements for transitional apartment subsidy
22.9(16,PL106-169) Application for transitional apartment subsidy
22.10(16,PL106-169) Amount of transitional apartment subsidy
22.11(16,PL106-169) Redetermination of transitional apartment subsidy eligibility
22.12(16,PL106-169) Termination of transitional apartment subsidy payments
22.13(16,PL106-169) Fraudulent practices relating to the aftercare rent subsidy program
22.14(16,PL106-169) Appeals

CHAPTER 23
TRANSITIONAL HOUSING REVOLVING LOAN PROGRAM

23.1(16) Purpose
23.2(16) Priority of loan awards
23.3(16) Application process
23.4(16) Program guidelines
23.5(16) Authority analysis of applications
23.6(16) Discretion of authority board
23.7(16) Closing/advance of funds

CHAPTER 24
HOME AND COMMUNITY-BASED SERVICES RENT SUBSIDY PROGRAM

24.1(16) Purpose
24.2(16) Definitions
24.3(16) Eligibility requirements
24.4(16) Application
24.5(16) Amount of rent subsidy
24.6(16) Redetermination of eligibility
24.7(16) Termination of rent subsidy payments
24.8(16) Fraudulent practices relating to the rent subsidy program
24.9(16) Appeals

CHAPTER 25
ENTREPRENEURS WITH DISABILITIES PROGRAM

25.1(16) Purpose
25.2(16) Definitions
25.3(16) Eligibility requirements
25.4(16) Application procedure
25.5(16) Award of technical assistance grants
25.6(16) Financial assistance grants
25.7(16) Monitoring

CHAPTER 26
WATER POLLUTION CONTROL WORKS AND
DRINKING WATER FACILITIES FINANCING

26.1(16) Statutory authority
26.2(16) Purpose
26.3(16) Definitions
26.4(16) Project funding
26.5(16) WPCSRF/DWSRF infrastructure construction loans
26.6(16) Planning and design loans
26.7(16) Disadvantaged community status
26.8(16) WPCSRF nonpoint source set-aside loan programs
26.9(16) Termination and rectification of disputes

CHAPTER 27
MILITARY SERVICE MEMBER HOME OWNERSHIP ASSISTANCE PROGRAM

27.1(16) Purpose
27.2(16) Definitions
27.3(16) Application procedure and determination of eligibility
27.4(16) Grant award
27.5(16) Income, purchase price and qualified mortgage

CHAPTER 28
WASTEWATER TREATMENT FINANCIAL ASSISTANCE PROGRAM

28.1(81GA,HF2782) Overview
28.2(81GA,HF2782) Definitions
28.3(81GA,HF2782) Project funding
28.4(81GA,HF2782) Termination; rectification of deficiencies; disputes

CHAPTER 9
TITLE GUARANTY DIVISION

265—9.1(16) Purpose. This chapter describes the mission, organization, programs and operations of the title guaranty division (division) of the Iowa finance authority (authority), including the office where and the means by which interested persons may obtain information and make submissions or requests.

265—9.2(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.

265—9.3(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 a nonpurchase product, and for only such purposes, the "abstract of title" or "abstract" may also mean a title guaranty report of title.

"Certificate" means the title guaranty certificate including any part or schedule and any endorsements.

"Commitment" means the commitment to insure title including any part or schedule and any endorsements.

"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.

"Nonpurchase product," for the purposes of the title guaranty program, means a refinanced or junior mortgage securing an amount not more than $500,000 for a residential property.

"Participant" means a participating attorney and 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, manuals, and guides 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 and who is in full compliance with the attorney's participation agreement, the Code of Iowa, these rules, manuals, and guides 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.

"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 six units.

"Supervision and control," for the purposes of the title guaranty program, means that a participant's shareholders, partners, associates, secretaries, paralegals, and other persons under the participant'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, shall comply with the requirements of the contracts, forms, manuals, instructions, and guides and any other written or oral instructions given by the division. A participant shall be liable to the division for loss or damage suffered by the division resulting from

acts or omissions of the participant's shareholders, partners, associates, secretaries, paralegals, and other persons under the participant'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 as an agent of the division as though the act or omission were that of the participant.

"Title guaranty report of title," for the purposes of the title guaranty program, means a short form of the abstract of title that is in writing or an electronic summary covering:

1. The last deed of a sales transaction for the approximate full value determined from the county records by document stamps, purchase money mortgage or other recorded evidence (not including family transactions, contract vendee deeds, gift deeds, tax deeds, probates, foreclosures, and no value or partial value transfers) provided, however, no search may cover less than two years prior to the certification date;
2. All liens, judgments, taxes and special assessments affecting the property;
3. An update known as the postclosing title report which extends the search through the refinanced or junior mortgage including releases by addendum; and
4. Certifications by the participating abstractor that the search and its extension are complete and accurate.

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

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 and staff.* The powers of the division are vested in and exercised by a board of five members, appointed by the governor and subject to confirmation by the senate. The board membership includes an attorney, an abstractor, a real estate broker, a representative of a mortgage lender, and a representative of the housing development industry. A chair and vice-chair are elected annually by the members, generally at the first meeting following July 1 of each year, which is the beginning of the fiscal year. Division staff consists of a director and additional staff as approved by the executive director of the authority.

9.4(3) *Division director.* The executive director of the authority appoints the director of the division. The division director shall be an attorney licensed to practice law in the state of Iowa and in good standing with the Iowa supreme court at all times while acting as the division director. The appointment of and compensation for the division director are exempt from the merit system provisions of Iowa Code chapter 19A. The division director serves as an ex-officio member of the division board and as secretary to the division board.

9.4(4) *Meetings.* Meetings of the division board are 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 division office and 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 party may attend and observe board meetings except for any portion of a meeting that may be closed pursuant to Iowa Code section 21.5. The minutes of the board meetings are available for viewing at the division's office 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 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.

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) *General.* The division operates a program to offer guaranties of real property titles in the state through the issuance of title guaranty certificates. Title guaranty certificates may be issued by the division, by participating abstractors for the division pursuant to subrule 9.6(3), paragraph *"f,"* herein, or by participating attorneys pursuant to Iowa Code section 16.91(7).

9.6(2) *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 to the division and upon execution and acceptance by the division director of an attorney's participation agreement.

a. 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, manuals, requirements 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, of the division and of other participants, agents, or representatives of the division to transact the business of opining on titles to real estate or issuing commitments or certificates and is further subject to the right of the division to appoint other participants.

b. 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.

c. Errors and omissions insurance. A participating attorney 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.

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. 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.

d. Participation fees. A participating attorney shall pay participation fees in such amounts and at such times as the division board may set from time to time by resolution. Participation fees set by the division board are subject to the approval of the authority board.

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 attorney participation fees at least 30 days prior to the date of the meeting at which the matter will be considered. 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.

e. Training. A participating attorney shall complete division forms and procedures training prior to issuing title guaranty certificates as an agent of the division.

f. Underwriting determinations. A participating attorney shall make all underwriting determinations prior to or at the 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, insuring 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.

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

(1) Generally accepted and prudent title examining methods; and

(2) Procedures implemented by the division and outlined in these rules, manuals, and guides and any other written or oral instructions or requirements given by the division.

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.

g. *Title files.* A participating attorney shall maintain separate title files or maintain client files in such a manner that information pertaining to activities of the participating attorney as an agent and underwriter for the division are readily available to the division. A participating attorney shall maintain title files and the title portion of client files for a period of ten years after the effective date of the certificate or certificates.

h. *Forms.* The division will provide forms to a participating attorney for use in acting as an agent of the division. A participating attorney 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.

A participating attorney who obtains serialized forms from the division must maintain a forms register, in a format approved or supplied by the division, in which the participating attorney shall enter a record of and show the disposition of all serialized forms. In addition, the participating attorney shall:

(1) Return the original of any damaged, spoiled, or otherwise unusable serialized form to the division;

(2) Return the original of any unused serialized form to the division at the request of the division; and

(3) Not transfer or attempt to transfer unissued serialized forms to another participant or other person or entity unless authorized in writing by the division.

If a participating attorney fails to comply with the requirements of this rule, in addition to the division's other rights and remedies, the division may refuse to supply any forms to the participating attorney until the participating attorney complies with the requirements of this rule to the satisfaction of the division.

The participating attorney 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 participating attorney to account for any form supplied by the division, or the failure of the participating attorney to comply with the requirements of this rule.

i. *Certificate amount limitations.* A participating attorney shall obtain the written authorization 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 rule is not obtained through the act or omission of the participating attorney, the participating attorney shall be strictly liable to the division for any loss or damage resulting from issuance of the commitment or certificate.

9.6(3) *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. *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, manuals, requirements and any other written or oral instructions 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, of the division and of 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.

b. 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.

c. Exempt attorneys. Participating attorneys who have 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 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 participating attorney, is not transferable, and terminates at such time as the individual ceases providing abstracting services or upon the death or incapacity of the individual.

d. Errors and omissions insurance. A participating abstractor 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.

The division will inform the Iowa Land Title Association, the Iowa State Bar 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. 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.

e. Participation fees. A participating abstractor shall pay participation fees in such amounts and at such times as the division board may set from time to time by resolution. Participation fees set by the division board are subject to the approval of the authority board.

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

f. Issuing title guaranty. A participating abstractor may be authorized pursuant to a written contract with the division director 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 process a title guaranty commitment or certificate must comply with the Code of Iowa, these rules, manuals, requirements, and any other written or oral instructions 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 of other participants of the division to issue commitments or certificates and are further subject to the right of the division to appoint other participants. A participating abstractor's right to process commitments and certificates is a privilege for the convenience of the division and may be terminated pursuant to the written contract with the division.

g. Training. A participating abstractor authorized to process title guaranty commitments and certificates for division issuance shall complete division forms and procedures training prior to processing title guaranty commitments and certificates for division issuance.

h. Title files. A participating abstractor authorized to process title guaranty commitments and certificates for division issuance shall maintain separate title files or maintain client files in such a manner that information pertaining to the preparation of the commitments and certificates and all underwriting determinations made by the participating attorney as an agent and underwriter for the division are readily

available for review by the division. A participating abstractor shall maintain title files and the title portion of client files for a period of ten years after the effective date of the certificate or certificates.

i. *Forms.* The division may provide forms to a participating abstractor for use in processing commitments and certificates for division issuance. The participating abstractor 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. A participating abstractor who obtains serialized forms from the division must maintain a forms register, in a format approved or supplied by the division, in which the participating abstractor shall enter a record of and show the disposition of all serialized forms. In addition, the participating abstractor shall:

(1) Return the original of any damaged, spoiled, or otherwise unusable serialized form to the division;

(2) Return the original of any unused serialized form to the division at the request of the division;

(3) Not transfer or attempt to transfer unissued serialized forms to another participant or other person or entity unless authorized in writing by the division.

If the participating abstractor fails to comply with the requirements of this rule, in addition to the division's other rights and remedies, the division may refuse to supply any forms to the participating abstractor and, upon written request from the division, the participating abstractor must deliver immediately all division forms and pending title guaranty files to the division.

The participating abstractor 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 participating abstractor to account for any form supplied by the division or by reason of the failure of the participating abstractor to comply with the requirements of this rule.

9.6(4) *Abstract of title.*

a. *Preparation.* An abstract of title shall be brought up to date and certified by a participating abstractor prior to the issuance of a title guaranty certificate.

b. *Compliance.* All abstracts of title shall be prepared and conducted in compliance with division procedures in effect at the time of the updating of the abstract. 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(5) *Attorney title opinion.* All attorney title opinions shall be prepared and issued in compliance with division procedures in effect at the time of issue. A participating attorney shall retain a written or electronic copy of each attorney title opinion and shall provide such copy to the division upon request. Participating attorneys who are issuing agents for the division may issue a commitment as the preliminary attorney title opinion and the title guaranty certificate as the final attorney title opinion in compliance with division procedures in effect at the time of issue.

9.6(6) *Participant's interest in property.* No participant shall prepare an abstract of title or issue attorney title opinions, commitments, or certificates upon property in which the participant has an interest without prior authorization of the division.

265—9.7(16) Application for waiver of participation requirements. The division board shall consider applications for waiver of the requirements of Iowa Code section 16.91(5).

9.7(1) Applications for waiver of participation requirements shall be in writing and directed to the division board. The application shall:

a. State which participation requirements are requested to be waived; and

b. Include adequate supporting information and argument so that the division board may make an informed decision on the request.

9.7(2) The applicant may request to appear before the division board but shall not be required to make a personal appearance.

a. If the applicant appears before the division board regarding the application, the applicant may present additional evidence, including the testimony of witnesses, in support of the application for waiver.

b. If the applicant does not make a personal appearance before the division board regarding the application, the division board may proceed to make a decision based on the application and the supporting information submitted with the application for waiver.

9.7(3) The division will inform participating abstractors and participating attorneys 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. Interested parties may submit evidence or statements in support of or in opposition to the application in writing or by personal appearance before the division board. Notification to interested parties is not a requirement for the division board to consider the waiver, and failure to inform interested parties of an application for waiver shall not void or otherwise nullify any action or decision of the division board.

9.7(4) The division board may grant the waiver if the board finds:

a. That the requirements of Iowa Code section 16.91(5) impose a hardship to the attorney or abstractor; and

b. That the waiver is:

(1) Clearly in the public interest; or

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

9.7(5) The decision of the division board shall be final agency action.

265—9.8(16) Application for title guaranty certificates. The division may authorize entities engaged in the real estate industry to apply directly to the division, to a participating attorney pursuant to Iowa Code section 16.91(7), or to a participating abstractor approved to issue title guaranty pursuant to subrule 9.6(3), paragraph *"f,"* 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 which the division may authorize include, but are not limited to, mortgage lenders as defined in Iowa Code section 16.1(27), and closing and escrow companies.

265—9.9(16) Contracts, forms, manuals, instructions, and guides. The division shall adopt and issue such contracts, forms, manuals, instructions, and guides as the division deems necessary to set out participation standards and requirements, and such other matters that the division deems necessary for implementation and effective administration of the title guaranty program. The provisions of the manuals, instructions, and guides shall be applicable to participants in the title guaranty program.

9.9(1) *Adoption.* The contracts, forms, manuals, instructions, and guides will be adopted or revised or amended on approval of a majority vote of the division board, without publication of notice and without providing an opportunity for public comment. In accordance with Iowa Code section 17A.4(2), the contracts, forms, manuals, instructions, and guides are a classification of rule making for which notice and public participation are impracticable and unnecessary because:

a. Iowa Code section 16.2 vests the powers of the division relating to the issuance of title guaranties in the division board, and Iowa Code section 16.91 authorizes the division board to operate the title guaranty program and adopt contracts and forms and set fees;

b. Such contracts, forms, manuals, instructions, and guides may need to be amended quickly to address title underwriting standards and procedures, to protect the division and its programs, and to ensure the efficient operation of the division; and

c. Participants are agents or quasi agents of the division and the contracts, forms, manuals, instructions, and guides are intra-agency directives.

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 contracts, forms, manuals, instructions, and guides at least 30 days prior to the date of the division board meeting at which the matter will be considered. 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.

9.9(2) *Availability.* The contracts, forms, manuals, instructions, and guides are furnished to participants in the title guaranty program at no charge. They may be reviewed and copied in their entirety from the division's Web site. Copies shall be deposited with the administrative rules coordinator

and at the state law library. Copies of paper editions for nonparticipants are available from the division upon request for a fee. The division will charge a fee to recover the costs of the binder, contents, and mailing for the paper editions. Current price information is available upon request from the division.

265—9.10(16) Rates. The division board shall fix the rate or fee, if any, for the owner's guaranty, the lender's guaranty, the various endorsements, the closing protection letter and any other product or service that will be offered by the division. The division shall set the rates by resolution and may change the rates from time to time in the same manner.

265—9.11(16) Fees and premiums. No participant in the title guaranty program shall charge or receive any portion of the fee for the guaranty or the fee for any other product or service that is paid to the division.

9.11(1) A participant shall calculate the title certificate fees according to the applicable rate schedule in effect on the effective date of the commitment or of the certificate, whichever is earlier. A participant 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.

9.11(2) A participant may charge and collect fees that are customarily charged for services or other products provided as part of a real property transaction.

9.11(3) All fees collected by a participant payable to the division shall be held for the use and benefit of the division until paid to the division. The participant shall remit the fees payable to the division at the time and in the manner directed by the division from time to time, but in no event later than the date of the issuance of the guaranty.

265—9.12(16) Audit procedures.

9.12(1) *Serialized forms audit.* The division will periodically supply to a participant who issues title guaranty certificates a list of all serialized forms that, according to the division's records, are in the custody and control of the participant. The participant shall, within 15 days of receipt of the list of serialized forms, return the list to the division either with a certification that it is correct or with an explanation of any discrepancies between the records of the division and those of the participant.

9.12(2) *Office audits.* The division may, with or without notice to a participating abstractor or participating attorney, audit the participant at the participant's office. This audit may include, but need not be limited to, a review of the participant's commitment and policy issuance procedures, an audit of serialized forms, an audit and test of title plants and tract indices, and verification of the participant's compliance with participation agreements, the Code of Iowa, these rules, manuals, and guides and any other written or oral instructions or requirements of the division.

265—9.13(16) Claims.

9.13(1) *Claim procedures.* In the event of loss or damage or potential loss or damage arising by reason of a matter actually, possibly, or allegedly within the coverage of a commitment or certificate or by reason of any other matter for which the division is actually, possibly, or allegedly liable (referred to herein as a "claim"), the rights and responsibilities of the division and the participating abstractor and participating attorney are as follows:

a. Upon receipt of notice by a participant of a claim, the participant must notify the division in writing, setting forth and including at a minimum:

(1) The name, address, and telephone number of the claimant and the claimant's attorney, if any;

(2) The number assigned to the commitment and certificate and a copy of the commitment and certificate if not previously forwarded to the division; and

(3) A description of the claim and copies of any documents, correspondence, surveys, title searches, or other writings, and other information supplied to or available to the participant relevant to the claim.

Under this rule, the participant shall notify the division within three business days of receipt of information about a claim by the participant and shall mail notification to the division by first-class mail

at the division's address in subrule 9.4(1). In addition to the notice required by the preceding sentence, if the nature of the claim is such that the insured 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 participant shall notify the division by telephone, facsimile transmission, overnight mail or other overnight delivery service, or any combination of these methods.

b. When a participant receives a request from the division for information with respect to a claim, the participant 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 participant and relevant to the claim, even if not specifically requested by the division. The participant's response to the division under this paragraph must be made within three days of the participant's receipt of the request and must be sent by first-class mail to the division employee, agent, or other authorized person who requested the information. In addition to the participant's response as required by the preceding sentence, if the nature of the claim is such that the insured claimant or the division, or both, may suffer loss or damage that might be reduced or avoided by a response quicker than that required by the preceding sentence, or if the division requests a quicker response, the participant shall respond by telephone, facsimile transmission, overnight mail or other overnight delivery service, or any combination of these methods, to the division employee, agent, or other authorized person requesting the information.

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

d. The division may, with or without prior notice to the participant or participants involved, investigate and resolve any claim in any manner that, in the division's sole discretion, the division may deem advisable. Investigation and resolution may include, but are not limited to, determinations of liability, retention of counsel for the division or for the insured claimant, settlement with the insured claimant or other party, and recovery of amounts paid.

9.13(2) *Claim loss recovery from participants.*

a. Amounts paid by the division in the investigation and resolution of a claim, hereinafter referred to as a "claim loss," including, but not limited to, payments to the insured, 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, are recoverable from a participant by the division.

b. In the absence of knowledge by the participant about the title defect or other matter causing the claim loss, the division shall not seek recovery from the participant 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 division's manuals, guides, procedures, and any other written or oral instructions or requirements given by the division that the participant 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 participant 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 participant shall reimburse the division for a claim loss when the division determines, in accordance with 9.13(2)*"d,"* that the participant is liable and when the claim loss arises from one or more of the following:

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

(2) Reliance by the participant 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 participant in examining the title information provided in an abstract of title, survey, affidavit, or other source of title information;

(4) Errors made by the participant 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 participant upon a defective title; or

(6) Failure of the participant to follow these rules, the division's manuals, guides, procedures, or any other written or oral instructions or requirements given by the division with respect to any other matters not included within 9.13(2)*"c."*

d. Unless another rule, the Code of Iowa, a procedure, or a guideline provides for a different standard of liability or other rule for determining whether the participant 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 participant under 9.13(2)*"c"*(1), the division may demand reimbursement from the participant if the participant 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 participant 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 participant.

(2) In the event that a claim loss occurs for which the division may seek recovery from the participant under 9.13(2)*"c"*(2), the division may demand reimbursement from the participant if the participant 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 participant under 9.13(2)*"c"*(3), the division may demand reimbursement from the participant if the participant 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. The division may make full review of local county abstracting standards and bar title rules as a guide to determine whether the participant has failed to meet the standard of skill and competence of an abstractor who prepares an abstract of title or a lawyer who examines titles in the community where the claim arose. The division may also consider whether the participant followed these rules, the division's manuals, guides, procedures, or any other written or oral instructions or requirements given by the division in examining the title. In addition, the division may seek input from other participants 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 a lawyer who examines titles in that community.

(4) In the event that a claim loss occurs for which the division may seek recovery from the participant under 9.13(2)*"c"*(4), the division may demand reimbursement from the participant if the participant 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 participant under 9.13(2)*"c"*(5), the division may demand reimbursement from the participant 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 participant under 9.13(2)*"c"*(6), the division may demand reimbursement from the participant if the participant failed to follow these rules, the division's manuals, guides, procedures, 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 participant, the division shall state the basis of the reimbursement as indicated in 9.13(2)*"c"* and 9.13(2)*"d"*(1) to (6).

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

265—9.14(16) Rules of construction. In the construction of these rules, the following rules shall be observed, unless either the rules of the Iowa Code chapter 4, Construction of Statutes, or the following rules are inconsistent with the manifest intent or the context of the rule:

The word "shall" means mandatory and not permissive and the word "may" means permissive and not mandatory.

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.

Nothing contained in these rules shall be construed to require a participating attorney to disclose privileged information of a client to the division or to any other party.

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 these rules, or otherwise, against the participating abstractor, participating attorney or other person responsible or liable, either separately, concurrently, cumulatively, or in any combination, at the sole discretion of the division.

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

265—9.15(16) Implementation. The provisions for abstracting requirements in the event of refinancing a mortgage or granting a second mortgage set out in subrule 9.6(4), first unnumbered paragraph, shall be implemented upon the issuance of a manual, instruction or guide by the division board.

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.

9.20(1) *Definitions.* As used in this rule, unless the context otherwise requires:

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

"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 the staff of the division are acting within the scope of their office or employment.

"Division" means the title guaranty division in the Iowa finance authority.

"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. For mortgages paid off by the division staff, $20,000,000.
2. For mortgages paid off by a division closer within a division closing, $20,000,000.
3. For all other mortgages, without prior division written approval, $1,000,000.

"Mortgagee" means the grantee of a mortgage. If a mortgage has been assigned of record, the mortgagee is the last person to whom the mortgage is assigned of record.

"Mortgage servicer" means the mortgagee or a person other than the mortgagee to whom a mortgagor or the mortgagor's successor in interest is instructed by the mortgagee to send payments on a loan secured by the mortgage. A person transmitting a payoff statement for a mortgage is the mortgage servicer for purposes of such mortgage.

"Mortgagor" means the grantor of a mortgage.

"Payoff statement" means a written statement furnished by the mortgage servicer which sets forth all of the following:

1. The unpaid balance of the loan secured by a mortgage, including principal, interest, and any other charges properly due under or secured by the mortgage, or the amount required to be paid in order to release or partially release the mortgage.
2. Interest on a per-day basis for an amount set forth pursuant to "1" above.
3. The address where payment is to be sent or other specific instructions for making a payment.
4. If, after payment of the unpaid balance of the loan secured by the mortgage, the mortgage continues to secure any unpaid obligation due the mortgagee or any unfunded commitment by the mortgagor to the mortgagee, the legal description of the property that will be released from the mortgage.

"Person" shall have the same meaning as in Iowa Code chapter 4.

"Prior mortgage" means a mortgage for which an effective release or satisfaction has not been filed of record which was either paid in full by someone other than the real estate lender or closer or was paid by the real estate lender or closer under a previous transaction.

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

9.20(2) *Request for certificate.*

a. A real estate lender or closer may request a certificate from the division by submitting:

(1) A fully and accurately completed request form.

(2) All necessary documents and information to support the certifications made on the request form, if required to be submitted.

(3) Payment, if required by the division, of the filing fee by check or money order made payable to the filing officer of the county in which the certificate is to be recorded in the amount of the filing fee imposed by the filing officer of the county in which the certificate is to be recorded. If duplicate certificates are to be recorded in more than one county, additional checks or money orders payable to the filing officer of such counties shall be submitted.

b. A certificate which is not a full release but is executed and recorded to release part of the security described in a mortgage shall be issued only when the real estate lender or closer has paid the mortgage servicer for the partial release. A certificate shall not be issued for a partial release if the real estate lender or closer is requesting a release pursuant to Iowa Code section 16.92(7).

c. In the event a person requesting a certificate fails to complete any of the steps or include any of the required information described in this rule, the division may reject the request for a certificate and require the person to refile or amend the request so that it conforms to the provisions of the law or this rule.

9.20(3) *Forms.*

a. Requests for mortgage release certificates shall be made on forms developed and provided by the division. The forms may be obtained from the division or from the authority's Internet Web site located at www.iowafinanceauthority.gov. The real estate lender or closer must use the forms developed and provided by the division; however, it is permissible to use reproductions of the forms, including reproductions placed in a word processing program. A reproduced form must substantially conform to the forms provided by the division. A nonconforming form may be rejected by the division.

b. The forms to request a certificate of release shall identify the mortgage to be released and shall contain sufficient information to identify that the requester is a real estate lender or closer; establish that the time requirements have elapsed; establish the party or parties to receive notice of the request; indicate that the debt secured by the mortgage to be released has been paid and the mortgage to be released meets

the definition of "mortgage" set forth in subrule 9.20(1); and, in the case of requests for partial releases, include the legal description of the property that will be released from the mortgage.

c. The forms giving notice of the request shall be directed to the last-known mortgage servicer and shall contain sufficient information to identify the mortgage to be released; inform the mortgage servicer what is required to prevent the filing of a certificate of release; establish a time limit for the mortgage servicer to respond; and, in the case of requests for partial releases, include the legal description of the property that will be released from the mortgage.

d. The certificate of release form shall contain sufficient information to identify the mortgage released; recite the authority for the certificate; recite that the substantive and procedural requirements as to the amount of debt, payment, notice, or other requirements of the division have been met; and, in the case of partial releases, include the legal description of the property that will be released from the mortgage.

e. The notice by publication form shall contain sufficient information to identify the mortgage to be released; inform the mortgage servicer what is required to prevent the filing of a certificate of release; establish a time limit for the mortgage servicer to respond; and, in the case of requests for partial releases, include the legal description of the property that will be released from the mortgage.

f. All forms may require real estate lenders or closers to provide other information as may be required by law or this rule.

9.20(4) *Certification to the division—mortgages paid by real estate lender or closer.* To obtain a certificate for a mortgage which the mortgage lender or closer has paid and an effective release or partial release has not been filed of record, the mortgage lender or closer shall certify to the division in writing on the form provided:

a. That more than 30 days have elapsed since the date the payment was sent.

b. That, as of the date of the request for a certificate, no effective mortgage release or partial release appears of record.

c. That the payoff statement satisfies one of the following:

(1) The statement does not indicate that the mortgage continues to secure an unpaid obligation due the mortgagee or an unfunded commitment by the mortgagor to the mortgagee; or

(2) The statement contains the legal description of the property to be released from the mortgage.

d. That payment was made in accordance with the payoff statement, including a statement as to the date the payment was received by the mortgagee or mortgage servicer, as evidenced by one or more of the following in the records of the real estate lender or closer or its agent:

(1) A bank check, certified check, escrow account check, real estate broker trust account check, or attorney trust account check that was negotiated by the mortgagee or mortgage servicer.

(2) Other documentary evidence satisfactory to the division of payment to the mortgagee or mortgage servicer.

e. That the mortgage to be released meets the definition of "mortgage" set forth in subrule 9.20(1).

f. That the information provided to identify the mortgage to be released includes the name of the mortgagor, the name of the original mortgagee, the mortgage servicer and last-known mailing address, the date of the mortgage, the date of recording, the county of recording, volume and page, or other applicable recording information in the real property records where the mortgage is to be released, and the same information for the last recorded assignment of record.

g. That any documents or other information attached to or included in the form and submitted in support of the request are original documents or are true and accurate reproductions and that the subject matter contained in the documents is true and correct.

h. If the last-known address of the mortgage servicer is unknown and the real estate lender or closer requesting the certificate is unable to locate an address for the last mortgage servicer of record, the real estate lender or closer may attach an affidavit to the request that service by certified mail on the mortgage servicer is not possible because the last-known address of the mortgage servicer is unknown and the real estate lender or closer, after exercising due diligence, is unable to locate an address for the last mortgage servicer of record.

9.20(5) *Certification to the division—prior mortgages.* To obtain a release of a mortgage that has been paid in full by someone other than the real estate lender or closer, or was paid by the real estate lender or closer under a previous transaction, and an effective release has not been filed of record, the mortgage lender or closer shall certify to the division in writing on the form provided:

a. That the mortgage was paid in full in accordance with one of the following:

(1) By someone other than the real estate lender or closer requesting the certificate.

(2) By the real estate lender or closer under a previous transaction.

b. That, as of the date of the request for a certificate, no effective mortgage release appears of record.

c. That the mortgage to be released meets the definition of "mortgage" set forth in subrule 9.20(1).

d. That the information provided to identify the mortgage to be released includes the name of the mortgagor, the name of the original mortgagee, the mortgage servicer and last-known mailing address, the date of the mortgage, the date of recording, the county of recording, volume and page, or other applicable recording information in the real property records where the mortgage is to be released, and the same information for the last recorded assignment of record.

e. That any documents or other information attached to or included in the form and submitted in support of the request are original documents or are true and accurate reproductions and that the subject matter contained in the documents is true and correct.

f. If the last-known address of the mortgage servicer is unknown and the real estate lender or closer requesting the certificate is unable to locate an address for the last mortgage servicer of record, the real estate lender or closer may attach an affidavit to the request that service by certified mail on the mortgage servicer is not possible because the last-known address of the mortgage servicer is unknown and the real estate lender or closer, after exercising due diligence, is unable to locate an address for the last mortgage servicer of record.

9.20(6) *Division determination to give notice—reliance on information submitted.*

a. Upon receipt of a request for issuance of a certificate, the division shall determine that an effective release has not been executed and recorded within 30 days after the date payment was sent or otherwise made in accordance with a payoff statement based upon the information submitted by the person seeking the certificate.

b. The division may use discretion in determining whether an effective release has been executed and recorded and shall rely on the information contained in the request in determining whether further inquiry may be required before giving notice of intent to issue a certificate.

c. The division shall not be required to make a physical search of the real property records in the county or counties where the certificate is to be recorded nor will the division be required to obtain any formal report such as a lien search, abstract opinion, or attorney's opinion. The division may, but is not required to, verify the status of an effective release by contacting the officer responsible for maintaining the real property records of the county in which the certificate is to be recorded; however, if such verification is determined to be necessary, the division may rely on information from the filing officer obtained by telephone, facsimile, electronic mail, or other such means.

d. The division shall not be required to verify or research the accuracy or status of a title to any legal descriptions which are requested to be partially released. The division shall rely on the descriptions certified to the division in the request for a certificate of partial release.

9.20(7) *Contested case proceeding.* In the event a person who is seeking a certificate is aggrieved by the decision of the division not to issue a certificate and wishes to challenge that decision, the person must request a contested case proceeding pursuant to the rules described in 265—Chapter 7. The request for a contested case proceeding must be filed with the division within ten days from the date of the division's decision not to issue a certificate. An aggrieved person must exhaust all administrative remedies before that person may file a proceeding in any court.

9.20(8) *Notice of intent to issue certificate and recording.*

a. Upon determination that an effective release or partial release has not been executed and recorded within 30 days after the date payment was sent or otherwise made in accordance with a payoff statement, the division shall send written notice of intent to execute a certificate by certified mail to the

last-known address of the last mortgage servicer of record. If the real estate lender or closer requesting the certificate has attached an affidavit to the request that service by certified mail on the mortgage servicer is not possible because the last-known address of the mortgage servicer is unknown and the real estate lender or closer is unable to locate an address for the last mortgage servicer of record, the division shall proceed pursuant to paragraph 9.20(8)*"e."*

b. The notice shall be given by certified mail and the 30-day period shall begin on the date the notice is placed in the custody of the United States Postal Service for delivery to the mortgage servicer.

c. The notice shall state that a certificate shall be recorded by the division after 30 days from the date the notice was mailed unless the mortgage servicer notifies the division of any reason the certificate of release should not be executed and recorded.

d. In the event the notice sent by certified mail to the last-known mortgage servicer of record is returned to the division for the reason that the mortgage servicer is no longer at the address or the certificate of receipt is not returned within 30 days of mailing, the division shall proceed pursuant to paragraph 9.20(8)*"e."*

e. In the event the division is unable to serve the mortgage servicer, the division shall prepare a notice for publication and send it to the real estate lender or closer for publication in a newspaper of general circulation in the county in which the mortgage to be released is recorded. Notice by publication shall be once each week for three consecutive weeks and shall provide for a 20-day period following the last publication for the mortgage servicer to respond to the division. A copy of the notice together with a certificate of publication shall be submitted to the division after the last publication date. Upon receipt of the certified notice and expiration of the time to respond, the division shall file the certificate of release provided that the mortgage servicer has not notified the division of any satisfactory reason the certificate of release should not be executed and recorded. The notice shall also be posted to the authority's Web page.

f. If, prior to executing and recording the certificate of release, the division receives written notification setting forth reasons satisfactory to the division why the certificate of release should not be executed and recorded by the division, the division shall not execute and record the certificate of release. The division may use its discretion in determining whether a satisfactory reason not to record the certificate has been given depending upon the facts. A satisfactory reason not to record the certificate includes, but is not limited to:

(1) Evidence of an unpaid balance under the terms of any loan secured by the mortgage.

(2) Evidence that a release or satisfaction of mortgage pursuant to Iowa Code chapter 655 has been placed of record.

(3) Failure to submit any information requested by the division or required by the law or this rule.

g. In the event the division determines that a certificate should not be recorded, the division shall return the check or money order, which was made payable to the county filing officer, to the real estate lender or closer that requested the certificate.

h. If the division does not receive written notification setting forth a reason satisfactory to the division why the certificate of release should not be executed and recorded, the division shall proceed to execute and record the certificate. The certificate shall be delivered, along with proper recording fees, to the filing officer in the county where the subject property is located.

i. If duplicate certificates were requested, the division will also deliver the duplicate certificates to the filing officer of those counties.

j. If duplicate certificates were not requested, the real estate lender or closer may record a certified copy of the certificate in another county with the same effect as the original.

9.20(9) *Certificate—mortgages paid by real estate lender or closer.* Certificates issued on mortgages paid by the real estate lender or closer shall contain substantially the following information:

a. That the division sent the 30-day notice required by Iowa Code section 16.92(2)*"c"* and that more than 30 days have elapsed since the date the notice was sent.

b. That the division did not receive written notification setting forth a reason satisfactory to the division why the certificate of release should not be executed and recorded.

c. A statement indicating one of the following:

(1) That the mortgage servicer provided a payoff statement that was used to make payment, and it does not indicate that the mortgage continues to secure an unpaid obligation due the mortgagee or an unfunded commitment by the mortgagor to the mortgagee.

(2) That the mortgage release certificate is a partial release of the mortgage and contains the legal description of the property that will continue to be subject to the mortgage.

d. That payment was made in accordance with the payoff statement including the date the payment was received by the mortgagee or mortgage servicer as evidenced by a bank check, certified check, escrow account check, real estate broker trust account check, or attorney trust account check that was negotiated by the mortgagee or mortgage servicer or other documentary evidence of payment to the mortgagee or mortgage servicer.

e. That the mortgage to be released meets the definition of "mortgage" set forth in subrule 9.20(1).

f. Information to identify the mortgage to be released includes the name of the mortgagor, the name of the original mortgagee, the mortgage servicer, the date of the mortgage, the date of recording, county of recording, volume and page, or other applicable recording information in the real property records where the mortgage is to be released, and the same information for the last recorded assignment of record.

g. That the person executing the certificate is a duly authorized officer or employee of the division.

9.20(10) *Certificate—prior mortgages.* Certificates issued on mortgages that have been paid in full by someone other than the real estate lender or closer or were paid by the real estate lender or closer under a previous transaction shall contain substantially the following information:

a. That the division sent the 30-day notice required by Iowa Code section 16.92(2)*"c"* and that more than 30 days have elapsed since the date the notice was sent.

b. That the division did not receive written notification setting forth a reason satisfactory to the division why the certificate of release should not be executed and recorded.

c. A statement indicating the mortgage was paid in full in accordance with one of the following:

(1) By someone other than the real estate lender or closer requesting the certificate.

(2) By the real estate lender or closer under a previous transaction.

d. That the mortgage to be released meets the definition of "mortgage" set forth in subrule 9.20(1).

e. Information to identify the mortgage to be released includes the name of the mortgagor, the name of the original mortgagee, the mortgage servicer, the date of the mortgage, the date of recording, county of recording, volume and page, or other applicable recording information in the real property records where the mortgage is to be released, and the same information for the last recorded assignment of record.

f. That the person executing the certificate is a duly authorized officer or employee of the division.

9.20(11) *Authority to sign certificate.* The board of directors of the division may, by resolution, authorize such personnel within the division as the board should determine to execute and record the certificates pursuant to Iowa Code section 16.92 and this rule.

9.20(12) *Records—return to the division.* The certificate of release shall contain instructions to the filing officer(s) to return the document to the division, once file-stamped and entered in the real estate records of the county.

9.20(13) *Photocopy.* The division shall transmit a copy of the recorded certificate to the real estate lender or closer that requested the certificate.

9.20(14) *Effect of filing of the certificate of release.* For purposes of a release or partial release of a mortgage, a certificate of release executed under this rule that contains the information and statements required under Iowa Code section 16.92 and this rule is prima facie evidence of the facts contained in such release or partial release, is entitled to be recorded with the county recorder where the mortgage is recorded, operates as a release or partial release of the mortgage described in the certificate of release, and may be relied upon by any person who owns or subsequently acquires an interest in the property released from the mortgage. The county recorder shall rely upon the certificate of release to release the mortgage.

9.20(15) *Effect of wrongful or erroneous recording of a certificate of release.* A wrongful or erroneous recording of a certificate of release by the division or the authority shall not relieve the

mortgagor, or the mortgagor's successors or assigns on the debt, from personal liability on the loan or on other obligations secured by the mortgage.

9.20(16) *Liability of the division.* In addition to any other remedy provided by law, if the division or the authority through an act of negligence wrongfully or erroneously records a certificate of release pursuant to this rule, the division is liable to the mortgagee and mortgage servicer for actual damages sustained due to the recording of the certificate of release. Prior to any such satisfaction or resolution of a claim for wrongful or erroneous filing of a certificate of release, the division will inform the real estate lender or closer that requested the certificate about the proposed terms and allow it a reasonable opportunity to resolve or satisfy the claim on other terms.

9.20(17) *Subrogation.* Upon payment of a claim relating to the recording of a certificate, the division is subrogated to the rights of the claimant against all persons relating to the claim including, but not limited to, the real estate lender or closer that requested the certificate.

9.20(18) *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 wrongful or erroneous filing of a certificate of release.

9.20(19) *Record keeping.* The original certificate of release document shall remain in the records of the division or the authority for the minimum period of one year after execution. After this time, records may be stored by electronic or other means. Requests and other documents generated or received under this system shall be indexed in such a manner as to allow their retrieval at a future date.

This rule is intended to implement Iowa Code Supplement section 16.92 as amended by 2008 Iowa Acts, House File 2700.

265—9.21(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.

265—9.22(16) Closing protection letters.

9.22(1) *Definitions.* The following words and phrases, when used in this rule and in the program requirements, applications and instructions adopted by the division board pursuant thereto, shall have the meanings set forth below unless inconsistent with the manifest intent or the context of the rules:

"Certificate" means division certificate, 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 division commitment to guarantee title, including any part or schedule thereof and any endorsements thereto.

"Division" means title guaranty division, a division of the Iowa finance authority.

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

"Division closer" means a participating attorney, a participating abstractor, or an independent closer who is currently authorized by the division to close division commitments under 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 loan 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 handling:

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.

"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.

"Independent closer" means a person or entity, other than a participating attorney or participating abstractor, conducting real estate closings and authorized to close transactions under protection of closing protection letters from the division.

9.22(2) *Issuance of closing protection letters.* Division closers may be authorized to receive a closing protection letter when:

a. A division closer has completed division forms and procedures training,

b. The division director has approved the application, and

c. A division commitment is issued.

9.22(3) *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.

9.22(4) *Additional requirements.* The division board may adopt program guidelines and application requirements such as indemnity agreements, criminal background checks, and bonding and insurance requirements.

9.22(5) *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:

a. Needs of the public and existing or potential customers of the applicant to be served by a designation of division closer status.

b. A history of operation and management of the applicant's business.

c. Character, fitness, financial responsibility and experience of the applicant and the applicant's employees.

d. Criminal background checks for felony or misdemeanor convictions of the applicant or the applicant's employees involving moral turpitude.

e. A record of defaulting by the applicant or the applicant's employees in payment of moneys collected for others in this state or other states.

f. A history of discharge of debts by the applicant or the applicant's employees through bankruptcy proceedings.

g. The applicant's credit report, which is to be submitted directly to the division director at the expense of the applicant.

h. Other factors as determined by the division director to be relevant.

9.22(6) *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.

9.22(7) *Revocation.* The division director has discretion to revoke a division closer's status for reasons including but not limited to the following:

a. The financial condition of the division closer deteriorates.

b. The division director determines that the division closer's activities are being conducted unlawfully or in an unsafe or unsound manner.

9.22(8) *Authority of division closer.*

a. 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, manuals, requirements and any other instructions 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.

b. A division closer shall obtain the written authorization 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 rule 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.

9.22(9) *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 such time that the division, in its discretion, deems necessary.

9.22(10) *Division forms.* A division closer shall not change preprinted portions of the division forms without the division's prior written authorization. A division closer shall not 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, and any attempt to do so shall be ineffective.

9.22(11) *Title/closing files.* A division closer shall maintain files in such a manner that information pertaining to closings and issuance of division commitments, certificates, and endorsements is readily available to the division. A division closer shall maintain title files and the title portion of client files for a period of ten years after the effective date of the certificate(s).

9.22(12) *Training.* The division director may require a division closer and the division closer staff to attend training sessions or continuing education seminars as deemed necessary by the division director in order to ensure compliance with division procedures.

9.22(13) *Office audits.*

a. In accordance with subrule 9.12(2), the division may, with or without notice to a division closer, audit the division closer at the division closer's office. This audit may include a review of the division closer's division escrow account(s) and closing procedures, including verification of the division closer's compliance with division rules, participation agreements, manuals, and any other written or oral instructions given by the division.

b. The division may, with or without notice, audit the division closer's division escrow account(s).

c. Procedures for audits shall be conducted pursuant to standards and procedures approved by the division board.

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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◊ Two or more ARCs

CHAPTER 12
LOW-INCOME HOUSING TAX CREDITS

265—12.1(16) Qualified allocation plan. The qualified allocation plan entitled Iowa Finance Authority Low-Income Housing Tax Credit Program 2009 Qualified Allocation Plan shall be the qualified allocation plan for the allocation of 2009 low-income housing tax credits consistent with IRC Section 42 and the applicable Treasury regulations and Iowa Code section 16.52. The qualified allocation plan includes the plan, application, and the application instructions. The qualified allocation plan is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2). The qualified allocation plan does not include any amendments or editions created subsequent to September 3, 2008.

265—12.2(16) Location of copies of the plan. The qualified allocation plan can be reviewed and copied in its entirety on the authority's Web site at http://www.iowafinanceauthority.gov. Copies of the qualified allocation plan, application, and all related attachments and exhibits shall be deposited with the administrative rules coordinator and at the state law library and shall be available on the authority's Web site. The plan incorporates by reference IRC Section 42 and the regulations in effect as of September 3, 2008. Additionally, the plan incorporates by reference Iowa Code section 16.52. These documents are available from the state law library, and information about these statutes, regulations and rules is on the authority's Web site.

265—12.3(16) Compliance manual. The compliance manual for all low-income housing tax credit projects monitored by the authority for compliance with IRC Section 42, effective March 5, 2008, is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2).

265—12.4(16) Location of copies of the manual. The compliance manual can be reviewed and copied in its entirety on the authority's Web site at www.iowafinanceauthority.gov. Copies of the compliance manual shall be deposited with the administrative rules coordinator and at the state law library. The compliance manual incorporates by reference IRC Section 42 and the regulations in effect as of March 5, 2008. Additionally, the compliance manual incorporates by reference Iowa Code section 16.52. These documents are available from the state law library, and links to these statutes, regulations and rules are on the authority's Web site. Copies are available from the authority upon request at no charge.

These rules are intended to implement Iowa Code section 16.52.

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CHAPTER 19
STATE HOUSING TRUST FUND

265—19.1(16) Trust fund allocation plans. The trust fund allocation plan entitled Iowa Finance Authority State Housing Trust Fund Allocation Plan for the Local Housing Trust Fund Program dated May 2008 shall be the allocation plan for the award, pursuant to the local housing trust fund program, of funds held within the state housing trust fund established in Iowa Code section 16.181. The trust fund allocation plan entitled Iowa Finance Authority State Housing Trust Fund 2008 Allocation Plan for the Project-Based Housing Program shall be the allocation plan for the distribution, pursuant to the project-based housing program, of funds held within the state housing trust fund. The trust fund allocation plans for the local housing trust fund program and the project-based housing program include the plans, applications, and application instructions. The trust fund allocation plans for the local housing trust fund program and the project-based housing program are incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2).

265—19.2(16) Location of copies of the plans. The trust fund allocation plans for the local housing trust fund program and the project-based housing program may be reviewed and copied in their entirety on the authority's Web site at www.iowafinanceauthority.gov. Copies of the trust fund allocation plans for the local housing trust fund program and the project-based housing program, the applications, and all related attachments and exhibits, if any, shall be deposited with the administrative rules coordinator and at the state law library. The plans incorporate by reference Iowa Code section 16.181.

These rules are intended to implement Iowa Code Supplement sections 16.5(1)*"r"* and 16.181.

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CHAPTER 9
RESIDENT ADVOCATE COMMITTEES

321—9.1(231) Definitions. Words and phrases used in this chapter are as defined in 321 IAC 1 unless the context indicates otherwise. The following definitions also apply to this chapter.

"Commitee" means a resident advocate committee as provided in Iowa Code sections 135C.25 and 231.44.

"Relatives" means any one of the following: father, mother, son, daughter, brother, sister, aunt, uncle, first cousin, nephew, niece, wife, husband, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepparent, stepbrother, stepchild, stepsister, half sister, half brother, grandparent or grandchild.

"Resident's advocate/ombudsman" means the state long-term care resident's advocate as provided in Iowa Code section 231.42.

321—9.2(231) Resident advocate committees established.

9.2(1) *Committee for each licensed facility.* Pursuant to Iowa Code sections 135C.25 and 231.41 through 231.44, a resident advocate committee shall be established for each licensed health care facility as defined in Iowa Code section 135C.1and shall operate within the scope of the Code of Iowa and this chapter.

9.2(2) *Committee membership.* The committee shall consist of a number of members sufficient to meet the needs of the residents. The minimum number of members in facilities licensed to serve fewer than 15 residents is one; the minimum number of members in facilities licensed to serve 15 or more residents is two.

9.2(3) *Committee member residence.* Committee members shall reside within the service area of the facility.

321—9.3(231) Application for committee membership. An interested individual may apply to the department for membership. Individuals, AAAs and other organizations are encouraged to recommend potential volunteers for committee membership to the department pursuant to Iowa Code section 135C.25.

9.3(1) *Application forms.* Application forms may be obtained from the department at the address listed in 321 IAC 2.3(2), from the department Web site or from organizations designated by the department.

9.3(2) *Submission of forms.* Each applicant shall complete and submit an application for membership to the department at the address in 321 IAC 2.3(2).

9.3(3) *Membership restriction.* Applications shall be approved only when written consent is submitted by both the resident's advocate/ombudsman and the administrator of the facility if an applicant:

a. Has an ownership interest in the facility; or

b. Is employed by the facility or a competing facility; or

c. Has been employed by the facility within the past three years; or

d. Is related to an employee, board member, or licensee of the facility; or

e. Is a public employee involved with the sponsoring or placement of residents in the facility; or

f. Is an administrator of a long-term care facility; or

g. Is a professional consultant to the facility.

9.3(4) *Waiver of membership restriction.* When the resident's advocate/ombudsman or the facility administrator does not approve an application, the membership restriction for relatives in paragraph 9.3(3)*"d"* may be waived by the director if sufficient evidence can be presented showing that the membership will not cause a conflict of interest.

321—9.4(231) Appointment to resident advocate committees.

9.4(1) *Notification.* Acceptance of an application shall be confirmed by letter within 15 business days of receipt of the application by the director or designee. Each facility shall be notified of final committee appointments.

9.4(2) *Orientation.* All applicants shall complete the required orientation prior to final appointment and the beginning of volunteer duties.

321—9.5(231) Objection to and termination of appointments to resident advocate committees.

9.5(1) *Filing an objection.* A facility administrator who objects to a particular member's participation on the committee for that facility may file a written objection with the director. The objection shall be investigated as a confidential complaint, and all parties shall be notified of the director's decision.

9.5(2) *Reasons for termination.* A committee member's appointment may be terminated by the director for any of the following reasons:

a. Falsification of information on the application form;

b. Acting as a member prior to appointment;

c. Attending less than one-half of the meetings convened each year by the resident advocate committee chairperson;

d. Conviction of an illegal activity;

e. Breaching confidentiality;

f. Failure to attend approved training for two consecutive years; and

g. Actions which are found by the director to violate these rules or the intent of the state long-term care ombudsman program.

9.5(3) *Notification of termination.* The director shall notify, in writing, the committee chairperson and the facility of the termination of a resident advocate committee member's appointment.

321—9.6(231) Request for reconsideration of appointment or termination of appointment.

9.6(1) *Request.* A request for reconsideration concerning appointment, nonappointment or termination shall be made in writing to the department within 30 days of the written notice of the director's action.

9.6(2) *Decision.* The director shall consider the request within 30 days of receipt and notify all parties of the decision.

321—9.7(231) Resident advocate committee structure and procedures.

9.7(1) *Structure.* Every committee shall have a chairperson and secretary selected by the membership. The chairperson shall coordinate the activities of the committee. The secretary shall record minutes of each meeting and prepare reports as necessary. The chairperson and secretary shall be elected to a term of not more than three years.

9.7(2) *Resident visits.* Committee members shall spend at least three hours each month making visits to observe residents at different times of the day and in differing circumstances and shall document the visits.

9.7(3) *Meetings.* The committee shall meet at least quarterly and on other occasions as required to accomplish its responsibilities. The chairperson shall notify all members of the time and place of each meeting at least two weeks in advance.

a. The administrator and staff of the facility shall not attend committee meetings except upon request of the committee.

b. Confidential information shall not be discussed during meetings if anyone other than committee members is present.

c. Reports of each visit shall be discussed with the committee as appropriate.

d. The secretary shall complete the meeting minutes summary form designated by the department. Copies of the form shall be submitted to the facility administrator and to the office of the resident's advocate/ombudsman within ten business days following the meeting.

e. The forms shall be retained by the facility for a period of at least two years and shall be available to the department of inspections and appeals and the department of elder affairs upon request.

321—9.8(231) Duties of the committee. Committee members shall, at a minimum, participate in one training session approved by the department each calendar year. Committee members shall represent and advocate for the rights of residents of the facility. As a part of this advocacy, committee members shall investigate complaints and grievances according to the procedures established in rule 321—9.11(231).

321—9.9(231) Committee access and assistance.

9.9(1) *Access.* The committee shall have access to facilities, persons and records as provided in the Act, Iowa Code section 231.42 and this chapter.

9.9(2) *Assistance to the committee.* The committee may request information, advice and counsel from the facility administrator or the department. When, in the performance of duties, a committee member contacts anyone on behalf of residents, the committee member shall clearly identify himself or herself and shall clearly state the purpose of and justification for such contact.

321—9.10(231) Confidentiality.

9.10(1) *Access restriction.* Resident advocate committee members shall not have access to the following records unless access is granted by the resident or the resident's responsible party, such as a guardian or conservator, and the resident's advocate/ombudsman:

a. Medical, financial or personal records of residents; or

b. Records of the social services department of the facility.

9.10(2) *Nondisclosure of information.* The committee shall not disclose information concerning residents or the operation of a facility in a manner that will identify individuals or the facility, except to the state long-term care ombudsman program or as requested by the department of inspections and appeals in the investigation of a facility.

321—9.11(231) Committee response to complaints and grievances. Throughout the investigation of all complaints and grievances, the committee shall maintain objectivity and act as advocates for residents without being adversaries of the facility.

9.11(1) In all investigations, the committee shall:

a. Maintain the dignity and privacy of residents, as shall all other persons involved in a complaint or grievance investigation.

b. Using the procedures appropriate to the source of the complaint, receive and investigate complaints or grievances from an individual or the department regarding the rights and welfare of residents.

c. Seek to resolve the complaint or grievance and, if feasible, prevent unnecessary regulatory action against a facility. However, the committee shall not prevent or dissuade regulatory action when necessary to protect or achieve the rights of residents.

d. Solicit input from the complainant and the resident regarding the choices for action to be pursued by the committee.

9.11(2) Action upon receipt of a complaint or grievance. The committee may contact the facility administrator to discuss the allegations only if doing so does not violate confidentiality.

a. Information that identifies the complainant or resident shall be confidential unless the complainant or resident has given permission to the committee to disclose this information. This permission shall be documented in a committee member's notes.

b. The investigating committee member shall make at least one unannounced visit to the facility.

c. The committee shall, to the extent possible, ascertain the facts of the situation through personal observation of conditions and activities in the facility and by talking with all persons who may have knowledge regarding the matter under investigation.

d. If a resolution cannot be reached, the committee may contact the resident's advocate/ombudsman for follow-up action as appropriate.

e. Committee members shall keep the complainant informed of progress in the investigation.

321—9.12(231) Complaints referred from the department of inspections and appeals. The following procedures shall apply to complaints received or initiated by the department of inspections and appeals and referred to the department of elder affairs for investigation by a resident advocate committee.

9.12(1) *Confidentiality.* Information that may identify the complainant or resident shall be confidential.

9.12(2) *Notification.* Depending on the circumstances in each instance, the state long-term care ombudsman program shall provide adequate verbal information within three days to a member of the appropriate resident advocate committee so that an investigation may proceed. Written notification shall be provided within seven days.

9.12(3) *Investigation.* Investigation of the complaint or grievance shall be conducted in accordance with rule 321—9.11(231).

321—9.13(231) Accountability measures.

9.13(1) The committee shall use a standardized form developed by the department, to be completed by the secretary, to specify issues and concerns identified by residents, the facility's response, and whether the matter has been resolved.

9.13(2) An issue or concern shall be designated as resolved when the committee and the facility agree it has been resolved. If there are unresolved issues and the facility disagrees with the committee's determination regarding the resolution of an issue or concern, the facility may request a review by the resident's advocate/ombudsman by submitting a written request within 20 calendar days of receipt of the form described in this rule.

9.13(3) Upon receipt of a request for review, the resident's advocate/ombudsman shall contact the facility administrator and the chairperson of the resident advocate committee to discuss the request. The resident's advocate/ombudsman has the discretion to:

a. Uphold the committee's determination,

b. Designate the issue or concern as resolved, or

c. Redefine the issue or concern as a means to negotiate a compromise.

9.13(4) The decision of the resident's advocate/ombudsman shall be made within 20 calendar days of the receipt of a request for review. Additional time may be allotted by agreement of the resident advocate committee and the facility administrator.

9.13(5) An aggrieved party has 30 calendar days from the receipt of written notice of the decision of the resident's advocate/ombudsman to request a hearing pursuant to 321 IAC 13.

9.13(6) All appeals and judicial review shall be conducted pursuant to 321 IAC 13.

321—9.14(231) Reporting statistics. The office of the resident's advocate/ombudsman shall record the number of issues and concerns listed on the forms submitted by the committees and the number resolved. Each year, the office of the resident's advocate/ombudsman shall calculate the percentage of issues and concerns that are resolved, based on the total number of issues and concerns identified between January 1 and December 31 of the preceding year. Prior to May 1 of each year, the office of the resident's advocate/ombudsman shall report the resolution rate of each facility to the department of human services.

321—9.15(231) Severability. Should any rule, subrule, paragraph, phrase, sentence or clause of this chapter be declared invalid of unconstituional for any reason, the remainder of this chapter shall not be affected.

These rules are intended to implement Iowa Code section 231.44.

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HUMAN SERVICES DEPARTMENT[441]

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

TITLE I
GENERAL DEPARTMENTAL PROCEDURES

CHAPTER 1
DEPARTMENTAL ORGANIZATION AND PROCEDURES

1.1(17A)	Director
1.2(17A)	Council
1.3(17A)	Organization at state level
1.4(17A)	Field operations structure
1.5	Reserved
1.6(17A)	Mental health and developmental disabilities commission
1.7(17A)	Governor's developmental disabilities council (governor's DD council)
1.8(17A,217)	Waivers of administrative rules (hereinafter referred to as exceptions to policy)
1.9	Reserved
1.10(17A,514I)	HAWK-I board

CHAPTER 2
CONTRACTING OUT DEPARTMENT OF HUMAN SERVICES EMPLOYEES AND PROPERTY

2.1(23A,225C)	Definitions
2.2(23A,225C)	Contracts for use of the services of department employees
2.3(23A,225C)	Contract provisions
2.4(23A,225C)	Leasing of space at state institutions
2.5(23A,225C)	Requirements prior to leasing

CHAPTER 3
DEPARTMENT PROCEDURE FOR RULE MAKING

3.1(17A)	Applicability
3.2(17A)	Advice on possible rules before notice of proposed rule adoption
3.3(17A)	Public rule-making docket
3.4(17A)	Notice of proposed rule making
3.5(17A)	Public participation
3.6(17A)	Regulatory analysis
3.7(17A,25B)	Fiscal impact statement
3.8(17A)	Time and manner of rule adoption
3.9(17A)	Variance between adopted rule and published notice of proposed rule adoption
3.10(17A)	Exemptions from public rule-making procedures
3.11(17A)	Concise statement of reasons
3.12(17A)	Contents, style, and form of rule
3.13(17A)	Department rule-making record
3.14(17A)	Filing of rules
3.15(17A)	Effectiveness of rules prior to publication
3.16(17A)	Review by department of rules

CHAPTER 4
PETITIONS FOR RULE MAKING

4.1(17A)	Petition for rule making
4.2(17A)	Briefs

4.3(17A) Inquiries
4.4(17A) Agency consideration

CHAPTER 5
DECLARATORY ORDERS

5.1(17A) Petition for declaratory order
5.2(17A) Notice of petition
5.3(17A) Intervention
5.4(17A) Briefs
5.5(17A) Inquiries
5.6(17A) Service and filing of petitions and other papers
5.7(17A) Consideration
5.8(17A) Action on petition
5.9(17A) Refusal to issue order
5.10(17A) Contents of declaratory order—effective date
5.11(17A) Copies of orders
5.12(17A) Effect of a declaratory order

CHAPTER 6
Reserved

CHAPTER 7
APPEALS AND HEARINGS

7.1(17A) Definitions
7.2(17A) Application of rules
7.3(17A) Presiding officer
7.4(17A) Notification of hearing procedures
7.5(17A) The right to appeal
7.6(17A) Informing persons of their rights
7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance
7.8(17A) Opportunity for hearing
7.9(17A) Continuation of assistance pending a final decision on appeal
7.10(17A) Procedural considerations
7.11(17A) Information and referral for legal services
7.12(17A) Subpoenas
7.13(17A) Rights of appellants during hearings
7.14(17A) Limitation of persons attending
7.15(17A) Medical examination
7.16(17A) The appeal decision
7.17(17A) Exhausting administrative remedies
7.18(17A) Ex parte communication
7.19(17A) Accessibility of hearing decisions
7.20(17A) Right of judicial review and stays of agency action
7.21(17A) Food stamp hearings and appeals
7.22 Reserved
7.23(17A) Contested cases with no factual dispute
7.24(17A) Emergency adjudicative proceedings

CHAPTER 8
PAYMENT OF SMALL CLAIMS

8.1(217) Authorization to reimburse

CHAPTER 9
PUBLIC RECORDS AND FAIR
INFORMATION PRACTICES

9.1(17A,22) Definitions
9.2(17A,22) Statement of policy
9.3(17A,22) Requests for access to records
9.4(17A,22) Access to confidential records
9.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examinations
9.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
9.7(17A,22,228) Consent to disclosure by the subject of a confidential record
9.8(17A,22) Notice to suppliers of information
9.9(17A,22) Release to subject
9.10(17A,22) Use and disclosure without consent of the subject
9.11(22) Availability of records
9.12(22,252G) Personally identifiable information
9.13(217) Distribution of informational materials
9.14(17A,22) Special policies and procedures for protected health information
9.15(17A,22) Person who may exercise rights of the subject

CHAPTER 10
INDIVIDUAL DEVELOPMENT ACCOUNTS

10.1(541A) Definitions
10.2(541A) Establishment of individual development accounts
10.3(541A) Reserve pool
10.4(541A) Eligibility, savings refunds and state tax provisions
10.5(541A) Administration of the initial period
10.6(541A) Requests for proposals—operation of IDAs
10.7(541A) Authorized withdrawals of principal and income
10.8(541A) Notice of nonapproved withdrawals and closure of the account
10.9(541A) Transfers of assets of an account holder's individual development account

CHAPTER 11
COLLECTION OF PUBLIC ASSISTANCE DEBTS

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

CHAPTER 12
VOLUNTEER SERVICES

12.1(234) Definition
12.2(234) Allocation of block grant funds
12.3(234) Requirements for volunteers

12.4(234) Volunteer service programs
12.5(234) Services and benefits available to volunteers

CHAPTER 13
PROGRAM EVALUATION

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

CHAPTER 14
OFFSET OF COUNTY DEBTS OWED DEPARTMENT

14.1(217,234) Definitions
14.2(217,234) Identifying counties with liabilities
14.3(217,234) List of counties with amounts owed
14.4(217,234) Notification to county regarding offset
14.5(217,234) Implementing the final decision
14.6(217,234) Offset completed

CHAPTER 15
RESOLUTION OF LEGAL SETTLEMENT DISPUTES

15.1(225C) Definitions
15.2(225C) Assertion of legal settlement dispute
15.3(225C) Response to dispute notification
15.4(225C) Contested case hearing
15.5(225C) Change in determination

TITLE II
Reserved

CHAPTERS 16 to 21
Reserved

TITLE III
MENTAL HEALTH

CHAPTER 22
STANDARDS FOR SERVICES TO PERSONS WITH MENTAL ILLNESS, CHRONIC MENTAL ILLNESS, MENTAL RETARDATION, DEVELOPMENTAL DISABILITIES, OR BRAIN INJURY

22.1(225C) Definitions
22.2(225C) Principles
22.3(225C) General guidelines for service delivery
22.4(225C) Services
22.5(225C) Compliance hearing

CHAPTER 23
Reserved

CHAPTER 24
ACCREDITATION OF PROVIDERS OF SERVICES TO PERSONS WITH MENTAL ILLNESS, MENTAL RETARDATION, AND DEVELOPMENTAL DISABILITIES

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

CHAPTER 25
DISABILITY SERVICES MANAGEMENT

DIVISION I
DETERMINATION OF STATE PAYMENT AMOUNT

25.1 to 25.10 Reserved

DIVISION II
COUNTY MANAGEMENT PLAN

25.11(331) Definitions
25.12(331) County management plan—general criteria
25.13(331) Policies and procedures manual
25.14(331) Policies and procedures manual review
25.15(331) Amendments
25.16(331) Reconsideration
25.17(331) Management plan annual review
25.18(331) Strategic plan
25.19(331) Technical assistance
25.20(331) Consumer financial eligibility and payment responsibility
25.21 to 25.40 Reserved

DIVISION III
MINIMUM DATA SET

25.41(331) Minimum data set
25.42 to 25.50 Reserved

DIVISION IV
INCENTIVE AND EFFICIENCY POOL FUNDING

25.51(77GA,HF2545) Desired results areas
25.52(77GA,HF2545) Methodology for applying for incentive funding
25.53(77GA,HF2545) Methodology for awarding incentive funding
25.54(77GA,HF2545) Subsequent year performance factors
25.55(77GA,HF2545) Phase-in provisions
25.56 to 25.60 Reserved

DIVISION V
RISK POOL FUNDING

25.61(426B) Definitions
25.62(426B) Risk pool board
25.63(426B) Application process
25.64(426B) Methodology for awarding risk pool funding
25.65(426B) Repayment provisions
25.66(426B) Appeals
25.67 to 25.70 Reserved

DIVISION VI
TOBACCO SETTLEMENT FUND RISK POOL FUNDING

25.71(78GA,ch1221) Definitions
25.72(78GA,ch1221) Risk pool board
25.73(78GA,ch1221) Rate-setting process
25.74(78GA,ch1221) Application process
25.75(78GA,ch1221) Methodology for awarding tobacco settlement fund risk pool funding
25.76(78GA,ch1221) Repayment provisions
25.77(78GA,ch1221) Appeals
25.78 to 25.80 Reserved

DIVISION VII
COMMUNITY MENTAL HEALTH CENTER WAIVER REQUEST

25.81(225C) Waiver request

CHAPTERS 26 and 27
Reserved

CHAPTER 28
POLICIES FOR ALL INSTITUTIONS

28.1(218) Definitions
28.2(218) Voluntary admissions to mental health institute
28.3(218) Admission to hospital-schools
28.4(229) Patients' rights for the mentally ill
28.5(218) Photographing and recording of patients and use of cameras
28.6(218) Interviews and statements
28.7(218) Use of grounds, facilities, or equipment
28.8(218) Tours of institution
28.9(218) Donations
28.10(218) Residents' rights for the mentally retarded
28.11(218) Catchment areas
28.12(217) Release of confidential information
28.13(218) Applying county institutional credit balances

CHAPTER 29
MENTAL HEALTH INSTITUTES

29.1(218) Visiting
29.2(230) Direct medical services
29.3(230) Liability for support
29.4(230) Certification of settlement

CHAPTER 30
STATE RESOURCE CENTERS

30.1(218) Visiting
30.2(222) Liability for support
30.3(222) Certification of settlement

CHAPTERS 31 to 33
Reserved

CHAPTER 34
ALTERNATIVE DIAGNOSTIC FACILITIES

34.1(225C) Definitions
34.2(225C) Function
34.3(225C) Standards

CHAPTER 35
Reserved

CHAPTER 36
FACILITY ASSESSMENTS

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

36.1(249A) Assessment of fee
36.2(249A) Determination and payment of fee for facilities certified to participate in the Medicaid program
36.3(249A) Determination and payment of fee for facilities not certified to participate in the Medicaid program
36.4(249A) Termination of fee assessment

CHAPTER 37
Reserved

CHAPTER 38
DEVELOPMENTAL DISABILITIES BASIC STATE GRANT

38.1(225C,217) Definitions
38.2(225C,217) Program eligibility
38.3(225C,217) Application under competitive process
38.4(225C,217) Competitive project awards
38.5(225C,217) Sole source or emergency selection project awards
38.6(225C,217) Field-initiated proposals
38.7(225C,217) Notification
38.8(225C,217) Request for reconsideration
38.9(225C,217) Contracts
38.10 Reserved
38.11(225C,217) Reallocation of funds
38.12(225C,217) Conflict of interest policy

CHAPTER 39
Reserved

TITLE IV
FAMILY INVESTMENT PROGRAM

CHAPTER 40
APPLICATION FOR AID

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

40.1 to 40.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

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

CHAPTER 41
GRANTING ASSISTANCE

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

41.1 to 41.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

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

CHAPTER 42
Reserved

CHAPTER 43
ALTERNATE PAYEES

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

43.1 to 43.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

43.21(239B) Conservatorship or guardianship
43.22 and 43.23 Reserved
43.24(239B) Emergency payee

CHAPTER 44
Reserved

CHAPTER 45
PAYMENT

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

45.1 to 45.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

45.21(239B) Address
45.22(239B) Return
45.23(239B) Held warrants
45.24(239B) Underpayment
45.25(239B) Deceased payees
45.26(239B) Limitation on payment
45.27(239B) Rounding of need standard and payment amount

CHAPTER 46
OVERPAYMENT RECOVERY

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

46.1 to 46.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

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

CHAPTER 47
DIVERSION INITIATIVES

47.1(239B) Definitions
47.2(239B) Availability of program
47.3(239B) General provisions
47.4(239B) Assistance available
47.5(239B) Relationship to the family investment program and TANF
47.6 Reserved
47.7(239B) Notification and appeals
47.8(239B) Funding and method of payment
47.9 Reserved
47.10(239B) Records and reports
47.11 to 47.20 Reserved
47.21(239B) Definitions
47.22(239B) Availability of the family self-sufficiency grants program
47.23(239B) General criteria
47.24(239B) Assistance available in family self-sufficiency grants
47.25(239B) Application, notification, and appeals
47.26(239B) Approved local plans for family self-sufficiency grants

CHAPTERS 48 and 49
Reserved

TITLE V
STATE SUPPLEMENTARY ASSISTANCE

CHAPTER 50
APPLICATION FOR ASSISTANCE

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

CHAPTER 51
ELIGIBILITY

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

CHAPTER 52
PAYMENT

52.1(249) Assistance standards

CHAPTER 53
RENT SUBSIDY PROGRAM

53.1(79GA,HF732) Definitions
53.2(79GA,HF732) Eligibility requirements
53.3(79GA,HF732) Application
53.4(79GA,HF732) Amount of rent subsidy
53.5(79GA,HF732) Redetermination of eligibility
53.6(79GA,HF732) Termination of rent subsidy payments
53.7(79GA,HF732) Fraudulent practices relating to the rent subsidy program
53.8(79GA,HF732) Appeals

CHAPTER 54
FACILITY PARTICIPATION

54.1(249) Application and contract agreement
54.2(249) Maintenance of case records
54.3(249) Financial and statistical report
54.4(249) Goods and services provided
54.5(249) Personal needs account
54.6(249) Case activity report
54.7(249) Billing procedures
54.8(249) Audits

TITLE VI
GENERAL PUBLIC ASSISTANCE PROVISIONS

CHAPTERS 55 and 56
Reserved

CHAPTER 57
INTERIM ASSISTANCE REIMBURSEMENT

57.1(249) Definitions
57.2(249) Requirements for reimbursement
57.3(249) Audits by the department of human services
57.4(249) Independent audits
57.5(249) Withholding of funds
57.6(249) Notice of interim assistance reimbursement eligibility and accountability
57.7(249) Certificate of authority

CHAPTER 58
EMERGENCY ASSISTANCE

DIVISION I
DISASTER REIMBURSEMENT GRANT PROGRAM

58.1(29C) Definitions
58.2(29C) Program implementation
58.3(29C) Application for assistance
58.4(29C) Eligibility criteria
58.5(29C) Eligible categories of assistance
58.6(29C) Eligibility determination and payment
58.7(29C) Contested cases
58.8(29C) Discontinuance of program
58.9 to 58.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—EMERGENCY ASSISTANCE

58.21(234) Definitions
58.22(234) General provisions
58.23(234) Application procedures
58.24(234) Eligibility requirements
58.25(234) Determination of need
58.26(234) Income
58.27(234) Resources
58.28(234) Payment
58.29(234) Notification and appeals
58.30(234) Discontinuance of the emergency assistance program
58.31(234) Special information received from emergency assistance clients
58.32 to 58.40 Reserved

DIVISION III
TEMPORARY MEASURES RELATED TO DISASTERS

58.41(217) Purpose
58.42(234,237A,239B,249,249A,249J,514I) Extension of scheduled reporting and review requirements
58.43(237A) Need for child care services
58.44(249A,249J,514I) Premium payments
58.45(249A) Citizenship and identity

CHAPTER 59
Reserved

CHAPTER 60
REFUGEE CASH ASSISTANCE

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

60.12(217) Application
60.13(217) Continuing eligibility
60.14(217) Alternate payees
60.15(217) Payment
60.16(217) Overpayment recovery

CHAPTER 61
REFUGEE SERVICES PROGRAM

61.1(217) Definitions
61.2(217) Authority
61.3(217) Eligibility for refugee services
61.4(217) Planning and coordinating the placement of refugees in advance of their arrival
61.5(217) Services of the department available for refugees
61.6(217) Provision of services
61.7(217) Application for services
61.8(217) Adverse service actions
61.9(217) Client appeals
61.10(217) Refugee sponsors
61.11(217) Adverse actions regarding sponsor applications
61.12(217) Administrative review of denial of sponsorship application
61.13(217) Refugee resettlement moneys
61.14(217) Unaccompanied refugee minors program
61.15(217,622A) Interpreters and translators for legal proceedings
61.16(217) Pilot recredentialing services
61.17(217) Targeted assistance grants
61.18(217) Iowa refugee services foundation

CHAPTERS 62 to 64
Reserved

TITLE VII
FOOD PROGRAMS

CHAPTER 65
FOOD ASSISTANCE PROGRAM ADMINISTRATION

DIVISION I

65.1(234) Definitions
65.2(234) Application
65.3(234) Administration of program
65.4(234) Issuance
65.5(234) Simplified reporting
65.6(234) Delays in certification
65.7 Reserved
65.8(234) Deductions
65.9(234) Treatment centers and group living arrangements
65.10(234) Reporting changes
65.11(234) Discrimination complaint
65.12(234) Appeals
65.13(234) Joint processing
65.14 Reserved
65.15(234) Proration of benefits
65.16(234) Complaint system
65.17(234) Involvement in a strike

65.18	Reserved
65.19(234)	Monthly reporting/retrospective budgeting
65.20(234)	Notice of expiration issuance
65.21(234)	Claims
65.22(234)	Verification
65.23(234)	Prospective budgeting
65.24(234)	Inclusion of foster children in household
65.25(234)	Effective date of change
65.26(234)	Eligible students
65.27(234)	Voluntary quit or reduction in hours of work
65.28(234)	Work requirements
65.29(234)	Income
65.30(234)	Resources
65.31(234)	Homeless meal providers
65.32	Reserved
65.33(234)	Maximum monthly dependent care deduction
65.34 to 65.36	Reserved
65.37(234)	Eligibility of noncitizens
65.38(234)	Income deductions
65.39(234)	Categorical eligibility
65.40	Reserved
65.41(234)	Actions on changes increasing benefits
65.42 and 65.43	Reserved
65.44(234)	Reinstatement
65.45	Reserved
65.46(234)	Disqualifications
65.47 to 65.49	Reserved
65.50(234)	No increase in benefits
65.51(234)	State income and eligibility verification system
65.52(234)	Systematic alien verification for entitlements (SAVE) program

CHAPTER 66
EMERGENCY FOOD ASSISTANCE PROGRAM

66.1(234)	Definitions
66.2(234)	Application to be a TEFAP contractor
66.3(234)	Contracts
66.4(234)	Distribution
66.5(234)	Household eligibility
66.6(234)	Reimbursement for allowable costs
66.7(234)	Commodity losses and claims
66.8(234)	State monitoring
66.9(234)	Limits on unrelated activities
66.10(234)	Complaints

CHAPTERS 67 to 74
Reserved

TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 75
CONDITIONS OF ELIGIBILITY

DIVISION I
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

75.1(249A)	Persons covered
75.2(249A)	Medical resources
75.3(249A)	Acceptance of other financial benefits
75.4(249A)	Medical assistance lien
75.5(249A)	Determination of countable income and resources for persons in a medical institution
75.6(249A)	Entrance fee for continuing care retirement community or life care community
75.7(249A)	Furnishing of social security number
75.8(249A)	Medical assistance corrective payments
75.9(249A)	Treatment of Medicaid qualifying trusts
75.10(249A)	Residency requirements
75.11(249A)	Citizenship or alienage requirements
75.12(249A)	Inmates of public institutions
75.13(249A)	Categorical relatedness
75.14(249A)	Establishing paternity and obtaining support
75.15(249A)	Disqualification for long-term care assistance due to substantial home equity
75.16(249A)	Client participation in payment for medical institution care
75.17(249A)	Verification of pregnancy
75.18(249A)	Continuous eligibility for pregnant women
75.19	Reserved
75.20(249A)	Disability requirements for SSI-related Medicaid
75.21(249A)	Health insurance premium payment program
75.22(249A)	AIDS/HIV health insurance premium payment program
75.23(249A)	Disposal of assets for less than fair market value after August 10, 1993
75.24(249A)	Treatment of trusts established after August 10, 1993
75.25(249A)	Definitions
75.26	Reserved
75.27(249A)	AIDS/HIV settlement payments
75.28 to 75.49	Reserved

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

75.50(249A)	Definitions
75.51(249A)	Reinstatement of eligibility
75.52(249A)	Continuing eligibility
75.53(249A)	Iowa residency policies specific to FMAP and FMAP-related coverage groups
75.54(249A)	Eligibility factors specific to child
75.55(249A)	Eligibility factors specific to specified relatives
75.56(249A)	Resources
75.57(249A)	Income
75.58(249A)	Need standards
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
75.60(249A)	Pending SSI approval

CHAPTER 76
APPLICATION AND INVESTIGATION

76.1(249A) Application
76.2(249A) Information and verification procedure
76.3(249A) Time limit for decision
76.4(249A) Notification of decision
76.5(249A) Effective date
76.6(249A) Certification for services
76.7(249A) Reinvestigation
76.8(249A) Investigation by quality control or the department of inspections and appeals
76.9(249A) Member lock-in
76.10(249A) Client responsibilities
76.11(249A) Automatic redetermination
76.12(249A) Recovery
76.13(249A) Health insurance data match program

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

77.1(249A) Physicians
77.2(249A) Retail pharmacies
77.3(249A) Hospitals
77.4(249A) Dentists
77.5(249A) Podiatrists
77.6(249A) Optometrists
77.7(249A) Opticians
77.8(249A) Chiropractors
77.9(249A) Home health agencies
77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies
77.11(249A) Ambulance service
77.12(249A) Remedial services providers
77.13(249A) Hearing aid dispensers
77.14(249A) Audiologists
77.15(249A) Community mental health centers
77.16(249A) Screening centers
77.17(249A) Physical therapists
77.18(249A) Orthopedic shoe dealers and repair shops
77.19(249A) Rehabilitation agencies
77.20(249A) Independent laboratories
77.21(249A) Rural health clinics
77.22(249A) Psychologists
77.23(249A) Maternal health centers
77.24(249A) Ambulatory surgical centers
77.25(249A) Home- and community-based habilitation services
77.26 Reserved
77.27(249A) Birth centers
77.28(249A) Area education agencies
77.29(249A) Case management provider organizations
77.30(249A) HCBS ill and handicapped waiver service providers
77.31 Reserved
77.32(249A) Hospice providers
77.33(249A) HCBS elderly waiver service providers

77.34(249A) HCBS AIDS/HIV waiver service providers
77.35(249A) Federally qualified health centers
77.36(249A) Advanced registered nurse practitioners
77.37(249A) HCBS MR waiver service providers
77.38 Reserved
77.39(249A) HCBS brain injury waiver service providers
77.40(249A) Lead inspection agencies
77.41(249A) HCBS physical disability waiver service providers
77.42 Reserved
77.43(249A) Infant and toddler program providers
77.44(249A) Local education agency services providers
77.45(249A) Indian health service 638 facilities
77.46(249A) HCBS children's mental health waiver service providers

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

78.1(249A) Physicians' services
78.2(249A) Prescribed outpatient drugs
78.3(249A) Inpatient hospital services
78.4(249A) Dentists
78.5(249A) Podiatrists
78.6(249A) Optometrists
78.7(249A) Opticians
78.8(249A) Chiropractors
78.9(249A) Home health agencies
78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies
78.11(249A) Ambulance service
78.12(249A) Remedial services
78.13(249A) Transportation to receive medical care
78.14(249A) Hearing aids
78.15(249A) Orthopedic shoes
78.16(249A) Community mental health centers
78.17(249A) Physical therapists
78.18(249A) Screening centers
78.19(249A) Rehabilitation agencies
78.20(249A) Independent laboratories
78.21(249A) Rural health clinics
78.22(249A) Family planning clinics
78.23(249A) Other clinic services
78.24(249A) Psychologists
78.25(249A) Maternal health centers
78.26(249A) Ambulatory surgical center services
78.27(249A) Home- and community-based habilitation services
78.28(249A) List of medical services and equipment requiring prior approval, preprocedure review or preadmission review
78.29 Reserved
78.30(249A) Birth centers
78.31(249A) Hospital outpatient services
78.32(249A) Area education agencies
78.33(249A) Case management services
78.34(249A) HCBS ill and handicapped waiver services

78.35 Reserved
78.36(249A) Hospice services
78.37(249A) HCBS elderly waiver services
78.38(249A) HCBS AIDS/HIV waiver services
78.39(249A) Federally qualified health centers
78.40(249A) Advanced registered nurse practitioners
78.41(249A) HCBS MR waiver services
78.42 Reserved
78.43(249A) HCBS brain injury waiver services
78.44(249A) Lead inspection services
78.45 Reserved
78.46(249A) Physical disability waiver service
78.47(249A) Pharmaceutical case management services
78.48 Reserved
78.49(249A) Infant and toddler program services
78.50(249A) Local education agency services
78.51(249A) Indian health service 638 facility services
78.52(249A) HCBS children's mental health waiver services

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

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

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT

80.1 Reserved
80.2(249A) Submission of claims
80.3(249A) Amounts paid provider from other sources
80.4(249A) Time limit for submission of claims and claim adjustments
80.5(249A) Authorization process
80.6(249A) Payment to provider—exception

CHAPTER 81
NURSING FACILITIES

DIVISION I
GENERAL POLICIES

81.1(249A)	Definitions
81.2	Reserved
81.3(249A)	Initial approval for nursing facility care
81.4(249A)	Arrangements with residents
81.5(249A)	Discharge and transfer
81.6(249A)	Financial and statistical report and determination of payment rate
81.7(249A)	Continued review
81.8	Reserved
81.9(249A)	Records
81.10(249A)	Payment procedures
81.11(249A)	Billing procedures
81.12(249A)	Closing of facility
81.13(249A)	Conditions of participation for nursing facilities
81.14(249A)	Audits
81.15	Reserved
81.16(249A)	Nurse aide requirements and training and testing programs
81.17	Reserved
81.18(249A)	Sanctions
81.19	Reserved
81.20(249A)	Out-of-state facilities
81.21(249A)	Outpatient services
81.22(249A)	Rates for Medicaid eligibles
81.23(249A)	State-funded personal needs supplement
81.24 to 81.30	Reserved

DIVISION II
ENFORCEMENT OF COMPLIANCE

81.31(249A)	Definitions
81.32(249A)	General provisions
81.33(249A)	Factors to be considered in selecting remedies
81.34(249A)	Available remedies
81.35(249A)	Selection of remedies
81.36(249A)	Action when there is immediate jeopardy
81.37(249A)	Action when there is no immediate jeopardy
81.38(249A)	Action when there is repeated substandard quality of care
81.39(249A)	Temporary management
81.40(249A)	Denial of payment for all new admissions
81.41(249A)	Secretarial authority to deny all payments
81.42(249A)	State monitoring
81.43(249A)	Directed plan of correction
81.44(249A)	Directed in-service training
81.45(249A)	Closure of a facility or transfer of residents, or both
81.46(249A)	Civil money penalties—basis for imposing penalty
81.47(249A)	Civil money penalties—when penalty is collected
81.48(249A)	Civil money penalties—notice of penalty
81.49(249A)	Civil money penalties—waiver of hearing, reduction of penalty amount
81.50(249A)	Civil money penalties—amount of penalty
81.51(249A)	Civil money penalties—effective date and duration of penalty
81.52(249A)	Civil money penalties—due date for payment of penalty

81.53(249A) Civil money penalties—settlement of penalties
81.54(249A) Continuation of payments to a facility with deficiencies
81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy
81.56(249A) Duration of remedies
81.57(249A) Termination of provider agreement

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

82.1(249A) Definition
82.2(249A) Licensing and certification
82.3(249A) Conditions of participation for intermediate care facilities for the mentally retarded
82.4
82.5(249A) Financial and statistical report
82.6(249A) Eligibility for services
82.7(249A) Initial approval for ICF/MR care
82.8(249A) Determination of need for continued stay
82.9(249A) Arrangements with residents
82.10(249A) Discharge and transfer
82.11(249A) Continued stay review
82.12(249A) Quality of care review
82.13(249A) Records
82.14(249A) Payment procedures
82.15(249A) Billing procedures
82.16(249A) Closing of facility
82.17(249A) Audits
82.18(249A) Out-of-state facilities
82.19(249A) State-funded personal needs supplement

CHAPTER 83
MEDICAID WAIVER SERVICES

DIVISION I—HCBS ILL AND HANDICAPPED WAIVER SERVICES

83.1(249A) Definitions
83.2(249A) Eligibility
83.3(249A) Application
83.4(249A) Financial participation
83.5(249A) Redetermination
83.6(249A) Allowable services
83.7(249A) Service plan
83.8(249A) Adverse service actions
83.9(249A) Appeal rights
83.10 to 83.20 Reserved

DIVISION II—HCBS ELDERLY WAIVER SERVICES

83.21(249A) Definitions
83.22(249A) Eligibility
83.23(249A) Application
83.24(249A) Client participation
83.25(249A) Redetermination
83.26(249A) Allowable services
83.27(249A) Service plan
83.28(249A) Adverse service actions
83.29(249A) Appeal rights

83.30(249A) Enhanced services
83.31 to 83.40 Reserved

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

83.41(249A) Definitions
83.42(249A) Eligibility
83.43(249A) Application
83.44(249A) Financial participation
83.45(249A) Redetermination
83.46(249A) Allowable services
83.47(249A) Service plan
83.48(249A) Adverse service actions
83.49(249A) Appeal rights
83.50 to 83.59 Reserved

DIVISION IV—HCBS MR WAIVER SERVICES

83.60(249A) Definitions
83.61(249A) Eligibility
83.62(249A) Application
83.63(249A) Client participation
83.64(249A) Redetermination
83.65 Reserved
83.66(249A) Allowable services
83.67(249A) Service plan
83.68(249A) Adverse service actions
83.69(249A) Appeal rights
83.70(249A) County reimbursement
83.71 Reserved
83.72(249A) Rent subsidy program
83.73 to 83.80 Reserved

DIVISION V—BRAIN INJURY WAIVER SERVICES

83.81(249A) Definitions
83.82(249A) Eligibility
83.83(249A) Application
83.84(249A) Client participation
83.85(249A) Redetermination
83.86(249A) Allowable services
83.87(249A) Service plan
83.88(249A) Adverse service actions
83.89(249A) Appeal rights
83.90(249A) County reimbursement
83.91 to 83.100 Reserved

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

83.101(249A) Definitions
83.102(249A) Eligibility
83.103(249A) Application
83.104(249A) Client participation
83.105(249A) Redetermination
83.106(249A) Allowable services
83.107(249A) Individual service plan
83.108(249A) Adverse service actions
83.109(249A) Appeal rights

83.110 to 83.120 Reserved

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

83.121(249A) Definitions
83.122(249A) Eligibility
83.123(249A) Application
83.124(249A) Financial participation
83.125(249A) Redetermination
83.126(249A) Allowable services
83.127(249A) Service plan
83.128(249A) Adverse service actions
83.129(249A) Appeal rights

CHAPTER 84
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

84.1(249A) Definitions
84.2(249A) Eligibility
84.3(249A) Screening services
84.4(249A) Referral
84.5(249A) Follow up

CHAPTER 85
SERVICES IN PSYCHIATRIC INSTITUTIONS

DIVISION I
PSYCHIATRIC HOSPITALS

85.1(249A) Acute care in psychiatric hospitals
85.2(249A) Out-of-state placement
85.3(249A) Eligibility of persons under the age of 21
85.4(249A) Eligibility of persons aged 65 and over
85.5(249A) Client participation
85.6(249A) Responsibilities of hospitals
85.7(249A) Psychiatric hospital reimbursement
85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64
85.9 to 85.20 Reserved

DIVISION II
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

85.21(249A) Conditions for participation
85.22(249A) Eligibility of persons under the age of 21
85.23(249A) Client participation
85.24(249A) Responsibilities of facilities
85.25(249A) Reimbursement to psychiatric medical institutions for children
85.26(249A) Outpatient day treatment for persons aged 20 or under
85.27 to 85.40 Reserved

DIVISION III
NURSING FACILITIES FOR PERSONS WITH MENTAL ILLNESS

85.41(249A) Conditions of participation
85.42(249A) Out-of-state placement
85.43(249A) Eligibility of persons aged 65 and over
85.44(249A) Client participation
85.45(249A) Responsibilities of nursing facility
85.46(249A) Policies governing reimbursement
85.47(249A) State-funded personal needs supplement

CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

86.1(514I) Definitions
86.2(514I) Eligibility factors
86.3(514I) Application process
86.4(514I) Coordination with Medicaid
86.5(514I) Effective date of coverage
86.6(514I) Selection of a plan
86.7(514I) Disenrollment
86.8(514I) Premiums and copayments
86.9(514I) Annual reviews of eligibility
86.10(514I) Reporting changes
86.11(514I) Notice requirements
86.12(514I) Appeals and fair hearings
86.13(514I) Third-party administrator
86.14(514I) Covered services
86.15(514I) Participating health plans
86.16(514I) Clinical advisory committee
86.17(514I) Use of donations to the HAWK-I program
86.18(505) Health insurance data match program

CHAPTER 87
Reserved

CHAPTER 88
MANAGED HEALTH CARE PROVIDERS

DIVISION I
HEALTH MAINTENANCE ORGANIZATION

88.1(249A) Definitions
88.2(249A) Participation
88.3(249A) Enrollment
88.4(249A) Disenrollment
88.5(249A) Covered services
88.6(249A) Emergency and urgent care services
88.7(249A) Access to service
88.8(249A) Grievance procedures
88.9(249A) Records and reports
88.10(249A) Marketing
88.11(249A) Patient education
88.12(249A) Reimbursement
88.13(249A) Quality assurance
88.14(249A) Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs)
88.15 to 88.20 Reserved

DIVISION II
PREPAID HEALTH PLANS

88.21(249A) Definitions
88.22(249A) Participation
88.23(249A) Enrollment
88.24(249A) Disenrollment
88.25(249A) Covered services
88.26(249A) Emergency services

88.27(249A) Access to service
88.28(249A) Grievance procedures
88.29(249A) Records and reports
88.30(249A) Marketing
88.31(249A) Patient education
88.32(249A) Payment to the PHP
88.33(249A) Quality assurance
88.34 to 88.40 Reserved

DIVISION III
MEDICAID PATIENT MANAGEMENT

88.41(249A) Definitions
88.42(249A) Eligible recipients
88.43(249A) Project area
88.44(249A) Eligible providers
88.45(249A) Contracting for the provision of patient management
88.46(249A) Enrollment and changes in enrollment
88.47(249A) Disenrollment
88.48(249A) Services
88.49(249A) Grievance procedure
88.50(249A) Payment
88.51(249A) Utilization review and quality assessment
88.52(249A) Marketing
88.53 to 88.60 Reserved

DIVISION IV
IOWA PLAN FOR BEHAVIORAL HEALTH

88.61(249A) Definitions
88.62(249A) Participation
88.63(249A) Enrollment
88.64(249A) Disenrollment
88.65(249A) Covered services
88.66(249A) Emergency services
88.67(249A) Access to service
88.68(249A) Review of contractor decisions and actions
88.69(249A) Records and reports
88.70(249A) Marketing
88.71(249A) Enrollee education
88.72(249A) Payment to the contractor
88.73(249A) Claims payment
88.74(249A) Quality assurance
88.75(249A) Iowa Plan advisory committee
88.76 to 88.80 Reserved

DIVISION V
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

88.81(249A) Scope and definitions
88.82(249A) PACE organization application and waiver process
88.83(249A) PACE program agreement
88.84(249A) Enrollment and disenrollment
88.85(249A) Program services
88.86(249A) Access to PACE services
88.87(249A) Program administrative requirements
88.88(249A) Payment

CHAPTER 89
DEBTS DUE FROM TRANSFERS OF ASSETS

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

CHAPTER 90
CASE MANAGEMENT FOR PEOPLE WITH MENTAL RETARDATION, CHRONIC MENTAL ILLNESS, OR DEVELOPMENTAL DISABILITIES

90.1(249A) Definitions
90.2(249A) Eligibility
90.3(249A) Authorization and need for service
90.4(249A) Application
90.5(249A) Services
90.6(249A) Terminating services
90.7(249A) Appeal rights

CHAPTER 91
MEDICARE DRUG SUBSIDY

91.1(249A) Definitions
91.2(249A) Application
91.3(249A) Eligibility determination
91.4(249A) Notice of decision
91.5(249A) Effective date
91.6(249A) Changes in circumstances
91.7(249A) Reinvestigation
91.8(249A) Appeals

CHAPTER 92
IOWACARE

92.1(249A,249J) Definitions
92.2(249A,249J) Eligibility
92.3(249A,249J) Application
92.4(249A,249J) Application processing
92.5(249A,249J) Determining income eligibility
92.6(249A,249J) Effective date
92.7(249A,249J) Financial participation
92.8(249A,249J) Benefits
92.9(249A,249J) Claims
92.10(249A,249J) Reporting changes
92.11(249A,249J) Reapplication
92.12(249A,249J) Terminating eligibility
92.13(249A,249J) Recovery
92.14(249A,249J) Discontinuance of the program
92.15(249A,249J) Right to appeal

TITLE IX
WORK INCENTIVE DEMONSTRATION

CHAPTER 93
PROMISE JOBS PROGRAM

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

93.1 to 93.100	Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

93.101(239B)	Program area
93.102	Reserved
93.103(239B)	Contracts with provider agencies for provision of services
93.104(239B)	Registration and referral requirements
93.105(239B)	Priority of service
93.106(239B)	Orientation for PROMISE JOBS and the FIA
93.107(239B)	Medical examinations
93.108(239B)	Self-initiated training
93.109(239B)	The family investment agreement (FIA)
93.110(239B)	Arranging for services
93.111(239B)	Assessment and assignment to other activities and components
93.112(239B)	Job search options
93.113(239B)	Monitored employment
93.114(239B)	Assignment to vocational classroom training
93.115(239B)	Unpaid community service
93.116(239B)	Parenting skills training
93.117(239B)	Health and safety
93.118(239B)	Family planning
93.119(239B)	PROMISE JOBS family development
93.120	Reserved
93.121(239B)	Assignment to work experience
93.122	Reserved
93.123(239B)	PROMISE JOBS on-the-job training (OJT)
93.124 to 93.130	Reserved
93.131(239B)	Failure to participate in classroom training
93.132(239B)	Participation issues for FIA-responsible persons
93.133(239B)	Problems with participation of a temporary or incidental nature
93.134(239B)	Barriers to participation
93.135(239B)	Required client documentation
93.136	Reserved
93.137(239B)	Written notification
93.138(239B)	Resolution of disputes around the FIA and PROMISE JOBS participation
93.139(239B)	Notice of decision
93.140(239B)	Right of appeal
93.141 and 93.142	Reserved
93.143(239B)	Confidentiality
93.144(239B)	PROMISE JOBS grievance procedure
93.145(239B)	Workers' compensation for PROMISE JOBS work experience participants
93.146(239B)	Safety rules from PROMISE JOBS work sponsors
93.147	Reserved
93.148(239B)	Records maintenance
93.149	Reserved

93.150(239B) Financial
93.151(239B) Recovery of PROMISE JOBS expense allowances

CHAPTER 94
Reserved

TITLE X
SUPPORT RECOVERY

CHAPTER 95
COLLECTIONS

95.1(252B) Definitions
95.2(252B) Child support recovery eligibility and services
95.3(252B) Crediting of current and delinquent support
95.4(252B) Prepayment of support
95.5(252B) Lump sum settlement
95.6(252B) Offset against state income tax refund or rebate
95.7(252B) Offset against federal income tax refund and federal nontax payment
95.8(96) Child support offset of unemployment insurance benefits
95.9 to 95.11 Reserved
95.12(252B) Procedures for providing information to consumer reporting agencies
95.13(17A) Appeals
95.14(252B) Termination of services
95.15(252B) Child support recovery unit attorney
95.16(252B) Handling and use of federal 1099 information
95.17(252B) Effective date of support
95.18(252B) Continued services available to canceled family investment program (FIP) or Medicaid recipients
95.19(252B) Cooperation of public assistance recipients in establishing and obtaining support
95.20(252B) Cooperation of public assistance applicants in establishing and obtaining support
95.21(252B) Cooperation in establishing and obtaining support in nonpublic assistance cases
95.22(252B) Charging pass-through fees
95.23(252B) Reimbursing assistance with collections of assigned support
95.24(252B) Child support account
95.25(252B) Emancipation verification

CHAPTER 96
INFORMATION AND RECORDS

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

CHAPTER 97
COLLECTION SERVICES CENTER

97.1(252B) Definitions
97.2(252B) Transfer of records and payments
97.3(252B) Support payment records
97.4 Reserved
97.5(252B) Method of payment
97.6(252B) Authorization of payment
97.7(252B) Processing misdirected payments

CHAPTER 98
SUPPORT ENFORCEMENT SERVICES

DIVISION I
MEDICAL SUPPORT ENFORCEMENT

98.1(252E)	Definitions
98.2(252E)	Provision of services
98.3(252E)	Establishing medical support
98.4(252E)	Accessibility of the health benefit plan
98.5(252E)	Health benefit plan information
98.6(252E)	Insurer authorization
98.7(252E)	Enforcement
98.8(252E)	Contesting the order
98.9 to 98.20	Reserved

DIVISION II
INCOME WITHHOLDING
PART A
DELINQUENT SUPPORT PAYMENTS

98.21(252D)	When applicable
98.22 and 98.23	Reserved
98.24(252D)	Amount of withholding
98.25 to 98.30	Reserved

PART B
IMMEDIATE INCOME WITHHOLDING

98.31(252D)	Effective date
98.32(252D)	Withholding automatic
98.33	Reserved
98.34(252D)	Approval of request for immediate income withholding
98.35(252D)	Modification or termination of withholding
98.36(252D)	Immediate income withholding amounts
98.37(252D)	Immediate income withholding amounts when current support has ended
98.38	Reserved

PART C
INCOME WITHHOLDING—GENERAL PROVISIONS

98.39(252D,252E)	Provisions for medical support
98.40(252D,252E)	Maximum amounts to be withheld
98.41(252D)	Multiple obligations
98.42(252D)	Notice to employer and obligor
98.43(252D)	Contesting the withholding
98.44(252D)	Termination of order
98.45(252D)	Modification of income withholding
98.46(252D)	Refunds of amounts improperly withheld
98.47(252D)	Additional information about hardship
98.48 to 98.50	Reserved

DIVISION III
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

98.51 to 98.60	Reserved

DIVISION IV
PUBLICATION OF NAMES

98.61(252B)	List for publication
98.62(252B)	Releasing the list
98.63 to 98.70	Reserved

DIVISION V
ADMINISTRATIVE SEEK EMPLOYMENT ORDERS

98.71(252B) Seek employment order
98.72(252B) Effective date of order
98.73(252B) Method and requirements of reporting
98.74(252B) Reasons for noncompliance
98.75(252B) Method of service
98.76(252B) Duration of order
98.77 to 98.80 Reserved

DIVISION VI
DEBTOR OFFSET

98.81(252B) Offset against payment owed to a person by a state agency
98.82 to 98.90 Reserved

DIVISION VII
ADMINISTRATIVE LEVY

98.91(252I) Administrative levy
98.92 Reserved
98.93(252I) Verification of accounts
98.94(252I) Notice to financial institution
98.95(252I) Notice to support obligor
98.96(252I) Responsibilities of financial institution
98.97(252I) Challenging the administrative levy
98.98 to 98.100 Reserved

DIVISION VIII
LICENSE SANCTION

98.101(252J) Referral for license sanction
98.102(252J) Reasons for exemption
98.103(252J) Notice of potential sanction of license
98.104(252J) Conference
98.105(252J) Payment agreement
98.106(252J) Staying the process due to full payment of support
98.107(252J) Duration of license sanction
98.108 to 98.120 Reserved

DIVISION IX
EXTERNAL ENFORCEMENT

98.121(252B) Difficult-to-collect arrearages
98.122(252B) Enforcement services by private attorney entitled to state compensation

CHAPTER 99
SUPPORT ESTABLISHMENT AND ADJUSTMENT SERVICES

DIVISION I
CHILD SUPPORT GUIDELINES

99.1(234,252B,252H) Income considered
99.2(234,252B) Allowable deductions
99.3(234,252B) Determining net income
99.4(234,252B) Applying the guidelines
99.5(234,252B) Deviation from guidelines
99.6 to 99.9 Reserved

DIVISION II
PATERNITY ESTABLISHMENT
Part A

99.10(252A)	Temporary support
99.11 to 99.20	Reserved

Part B

99.21(252F)	When paternity may be established administratively
99.22(252F)	Mother's certified statement
99.23(252F)	Notice of alleged paternity and support debt
99.24(252F)	Conference to discuss paternity and support issues
99.25(252F)	Amount of support obligation
99.26(252F)	Court hearing
99.27(252F)	Paternity contested
99.28(252F)	Paternity test results challenge
99.29(252F)	Agreement to entry of paternity and support order
99.30(252F)	Entry of order establishing paternity only
99.31(252F)	Exception to time limit
99.32(252F)	Genetic test costs assessed
99.33 to 99.35	Reserved

Part C

99.36(598,600B)	Definitions
99.37(598,600B)	Communication between parents
99.38(598,600B)	Continuation of enforcement
99.39(598,600B)	Satisfaction of accrued support
99.40	Reserved

DIVISION III
ADMINISTRATIVE ESTABLISHMENT OF SUPPORT

99.41(252C)	Establishment of an administrative order
99.42 to 99.60	Reserved

DIVISION IV
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

99.61(252B,252H)	Definitions
99.62(252B,252H)	Review of permanent child support obligations
99.63(252B,252H)	Notice requirements
99.64(252B,252H)	Financial information
99.65(252B,252H)	Review and adjustment of a child support obligation
99.66(252B,252H)	Medical support
99.67(252B,252H)	Confidentiality of financial information
99.68(252B,252H)	Payment of service fees and other court costs
99.69(252B,252H)	Denying requests
99.70(252B,252H)	Withdrawing requests
99.71(252H)	Effective date of adjustment
99.72 to 99.80	Reserved

DIVISION V
ADMINISTRATIVE MODIFICATION

99.81(252H)	Definitions
99.82(252H)	Availability of service
99.83(252H)	Modification of child support obligations
99.84(252H)	Notice requirements
99.85(252H)	Financial information
99.86(252H)	Challenges to the proposed modification action

99.87(252H) Voluntary reduction of income
99.88(252H) Effective date of modification
99.89(252H) Confidentiality of financial information
99.90(252H) Payment of fees
99.91(252H) Denying requests
99.92(252H) Withdrawing requests
99.93 to 99.100 Reserved

DIVISION VI
SUSPENSION AND REINSTATEMENT OF SUPPORT

99.101(252B) Definitions
99.102(252B) Availability of service
99.103(252B) Basis for suspension of support
99.104(252B) Request for assistance to suspend
99.105(252B) Order suspending support
99.106(252B) Suspension of enforcement of current support
99.107(252B) Request for reinstatement
99.108(252B) Reinstatement
99.109(252B) Reinstatement of enforcement of support
99.110(252B) Temporary suspension becomes final

CHAPTER 100
CHILD SUPPORT PARENTAL OBLIGATION PILOT PROJECTS

100.1(17A,80GA,HF667) Definitions
100.2(17A,80GA,HF667) Incentives
100.3(17A,80GA,HF667) Application to be a funded pilot project
100.4(17A,80GA,HF667) Selection of projects
100.5(17A,80GA,HF667) Termination of pilot projects
100.6(17A,80GA,HF667) Reports and records
100.7(17A,80GA,HF667) Appeals
100.8(17A,80GA,HF667) Continued application of rules and sunset provisions

TITLE XI
CHILDREN'S INSTITUTIONS

CHAPTER 101
IOWA STATE JUVENILE HOME

101.1(218) Definitions
101.2(218) Visiting
101.3(218) Interviews and statements
101.4(218) Mail and packages
101.5(218) Use of buildings and grounds
101.6(218) Incoming telephone calls
101.7(218) Resident employment
101.8(218) Tours
101.9(218) Acceptance
101.10(218) Admission procedures
101.11(218) Program assignment
101.12(218) Individual care plan
101.13(218) Special staffing
101.14 Reserved
101.15(218) Grievance procedure
101.16(218) Alleged child abuse
101.17(218) Temporary home visits

101.18(218) Prerelease staffing
101.19(218) Attorney contacts
101.20(244) Standards

CHAPTER 102
Reserved

CHAPTER 103
ELDORA TRAINING SCHOOL

DIVISION I
GENERAL POLICIES AND PROCEDURES

103.1(218) Definitions
103.2(218) Visiting
103.3(218) Interviews and statements
103.4(218) Mail and packages
103.5(218) Use of buildings and grounds
103.6(218) Incoming telephone calls
103.7(218) Resident employment
103.8(218) Tours
103.9(218) Acceptance
103.10(218) Admission procedures
103.11(218) Program assignment
103.12(218) Individual care plan
103.13(218) Special staffing
103.14(218) Detention
103.15(218) Grievance procedure
103.16(218) Alleged child abuse
103.17(218) Temporary home visits
103.18(218) Prerelease staffing
103.19(218) Attorney contacts
103.20(218,233A) Standards
103.21(218,233A) Advisory committee
103.22 to 103.30 Reserved

DIVISION II
SEX OFFENDERS

103.31(692A) Definitions
103.32(692A) Department responsibilities
103.33(692A) Juveniles required to register
103.34(692A) Completion of risk assessment
103.35(692A) Affirmative public notification pending the exhaustion of administrative or judicial appeal

CHAPTER 104
Reserved

TITLE XII
LICENSING AND APPROVED STANDARDS

CHAPTER 105
COUNTY AND MULTICOUNTY JUVENILE DETENTION HOMES AND COUNTY AND MULTICOUNTY JUVENILE SHELTER CARE HOMES

105.1(232) Definitions
105.2(232) Buildings and grounds
105.3(232) Personnel policies

105.4(232) Procedures manual
105.5(232) Staff
105.6(232) Intake procedures
105.7(232) Assessments
105.8(232) Program services
105.9(232) Medication management and administration
105.10(232) Control room—juvenile detention home only
105.11(232) Clothing
105.12(232) Staffings
105.13(232) Child abuse
105.14(232) Daily log
105.15(232) Children's rights
105.16(232) Discipline
105.17(232) Case files
105.18(232) Discharge
105.19(232) Approval
105.20(232) Provisional approval
105.21(232) Mechanical restraint—juvenile detention only
105.22(232) Chemical restraint

CHAPTER 106
Reserved

CHAPTER 107
CERTIFICATION OF ADOPTION INVESTIGATORS
107.1(600) Introduction
107.2(600) Definitions
107.3(600) Application
107.4(600) Requirements for certification
107.5(600) Granting, denial, or revocation of certification
107.6(600) Certificate
107.7(600) Renewal of certification
107.8(600) Investigative services
107.9(600) Retention of adoption records
107.10(600) Reporting of violations
107.11(600) Appeals

CHAPTER 108
LICENSING AND REGULATION OF CHILD-PLACING AGENCIES
108.1(238) Definitions
108.2(238) Licensing procedure
108.3(238) Administration and organization
108.4(238) Staff qualifications
108.5(238) Staffing requirements
108.6(238) Personnel administration
108.7(238) Foster care services
108.8(238) Foster home studies
108.9(238) Adoption services
108.10(238) Supervised apartment living placement services

CHAPTER 109
CHILD CARE CENTERS

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

CHAPTER 110
CHILD DEVELOPMENT HOMES

110.1(237A)	Definitions
110.2(237A)	Application for registration
110.3(237A)	Renewal
110.4(237A)	Number of children
110.5(237A)	Standards
110.6(237A)	Compliance checks
110.7(234)	Registration decision
110.8(237A)	Additional requirements for child development home category A
110.9(237A)	Additional requirements for child development home category B
110.10(237A)	Additional requirements for child development home category C
110.11(237A)	Complaints
110.12(237A)	Registration actions for nonpayment of child support
110.13(237A)	Transition exception
110.14(237A)	Prohibition from involvement with child care

CHAPTER 111
FAMILY-LIFE HOMES

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

CHAPTER 112
LICENSING AND REGULATION OF CHILD FOSTER CARE FACILITIES

112.1(237) Applicability
112.2(237) Definitions
112.3(237) Application for license
112.4(237) License
112.5(237) Denial
112.6(237) Revocation
112.7(237) Provisional license
112.8(237) Adverse actions
112.9(237) Suspension
112.10(232) Mandatory reporting of child abuse

CHAPTER 113
LICENSING AND REGULATION OF FOSTER FAMILY HOMES

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

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

114.1(237) Applicability
114.2(237) Definitions
114.3(237) Physical standards
114.4(237) Sanitation, water, and waste disposal
114.5(237) Safety
114.6(237) Organization and administration
114.7(237) Policies and record-keeping requirements
114.8(237) Staff
114.9(237) Intake procedures
114.10(237) Program services
114.11(237) Case files
114.12(237) Drug utilization and control
114.13(237) Children's rights

114.14(237) Personal possessions
114.15(237) Religion—culture
114.16(237) Work or vocational experiences
114.17(237) Family involvement
114.18(237) Children's money
114.19(237) Child abuse
114.20(237) Discipline
114.21(237) Illness, accident, death, or absence from the facility
114.22(237) Records
114.23(237) Unannounced visits
114.24(237) Standards for private juvenile shelter care and detention homes

CHAPTER 115
LICENSING AND REGULATION OF
COMPREHENSIVE RESIDENTIAL FACILITIES FOR CHILDREN

115.1(237) Applicability
115.2(237) Definitions
115.3(237) Information upon admission
115.4(237) Staff
115.5(237) Program services
115.6(237) Restraints
115.7(237) Control room
115.8(237) Locked cottages
115.9(237) Mechanical restraint
115.10(237) Chemical restraint

CHAPTER 116
LICENSING AND REGULATION OF RESIDENTIAL FACILITIES
FOR MENTALLY RETARDED CHILDREN

116.1(237) Applicability
116.2(237) Definitions
116.3(237) Qualifications of staff
116.4(237) Staff to client ratio
116.5(237) Program components
116.6(237) Restraint

CHAPTER 117
FOSTER PARENT TRAINING

117.1(237) Required preservice training
117.2(237) Required preplacement orientation
117.3(237) Application materials
117.4(237) Application process
117.5(237) Application decisions
117.6(237) Application conference available
117.7(237) Required in-service training

CHAPTER 118
CHILD CARE QUALITY RATING SYSTEM

118.1(237A) Definitions
118.2(237A) Application for quality rating
118.3(237A) Rating standards for child care centers and preschools
118.4(237A) Rating criteria for child development homes

118.5(237A) Award of quality rating
118.6(237A) Adverse actions

CHAPTER 119
RECORD CHECK EVALUATIONS FOR HEALTH CARE PROGRAMS

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

CHAPTERS 120 to 129
Reserved

TITLE XIII
SERVICE ADMINISTRATION

CHAPTER 130
GENERAL PROVISIONS

130.1(234) Definitions
130.2(234) Application
130.3(234) Eligibility
130.4(234) Fees
130.5(234) Adverse service actions
130.6(234) Social casework
130.7(234) Case plan
130.8 Reserved
130.9(234) Entitlement

CHAPTER 131
SOCIAL CASEWORK

131.1(234) Definitions
131.2(234) Eligibility
131.3(234) Service provision
131.4 Reserved
131.5(234) Adverse actions

CHAPTER 132
Reserved

CHAPTER 133
IV-A EMERGENCY ASSISTANCE PROGRAM

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

CHAPTERS 134 to 141
Reserved

CHAPTER 142
INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

142.1(238) Compact agreement
142.2(238) Compact administrator
142.3(238) Article II(d)
142.4(238) Article III(a)
142.5(238) Article III(a) procedures
142.6(238) Article III(c)
142.7(238) Article VIII(a)
142.8(238) Applicability

CHAPTER 143
INTERSTATE COMPACT ON JUVENILES

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

CHAPTERS 144 to 149
Reserved

TITLE XIV
GRANT/CONTRACT/PAYMENT ADMINISTRATION

CHAPTER 150
PURCHASE OF SERVICE

DIVISION I
CATEGORIES OF CONTRACTS, 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 PROVIDER ADVISORY COMMITTEE AND PUBLIC ACCESS TO CONTRACTS

150.1(234) Definitions
150.2(234) Categories of contracts
150.3(234) Iowa purchase of social services agency contract
150.4(234) Iowa purchase of social services contract—individual providers
150.5(234) Iowa purchase of administrative support
150.6 Reserved
150.7(234) Iowa donation of funds contract
150.8(234) Provider advisory committee
150.9(234) Public access to contracts

CHAPTER 151
JUVENILE COURT SERVICES DIRECTED PROGRAMS

DIVISION I
GENERAL PROVISIONS

151.1(232) Definitions
151.2(232) Administration of funds for court-ordered services and graduated sanction services
151.3(232) Administration of juvenile court services programs within each judicial district
151.4(232) Billing and payment
151.5(232) Appeals
151.6(232) District program reviews and audits
151.7 to 151.19 Reserved

DIVISION II
COURT-ORDERED SERVICES

151.20(232) Juvenile court services responsibilities
151.21(232) Certification process
151.22(232) Expenses
151.23 to 151.29 Reserved

DIVISION III
GRADUATED SANCTION SERVICES

151.30(232) Life skills
151.31(232) School-based supervision
151.32(232) Supervised community treatment
151.33(232) Tracking, monitoring, and outreach
151.34(232) Administration of graduated sanction services
151.35(232) Contract development for graduated sanction services

CHAPTER 152
CONTRACTING

DIVISION I
GENERAL PROVISIONS

152.1(234) Definitions
152.2(234) Conditions of participation relevant to all contracts
152.3(234) Appeals of departmental actions
152.4(234) Review of financial and statistical reports
152.5(234) Copyright and patents
152.6(234) Drug-free workplace
152.7(234) Restriction of use of funds
152.8(234) Term of contract
152.9 to 152.20 Reserved

DIVISION II
PURCHASE OF REHABILITATIVE TREATMENT AND
SUPPORTIVE SERVICES CONTRACT

152.21(234) Contract
152.22(234) Initiation of contract proposal
152.23(234) Contract administration
152.24(234) Client eligibility and referral
152.25(234) Amount, scope, and duration of services
152.26(234) Client fees

CHAPTER 153
FUNDING FOR LOCAL SERVICES

DIVISION I
SOCIAL SERVICES BLOCK GRANT

153.1(234) Definitions
153.2(234) Development of preexpenditure report
153.3(234) Amendment to preexpenditure report
153.4(234) Service availability
153.5(234) Allocation of block grant funds
153.6 to 153.10 Reserved

DIVISION II
DECATEGORIZATION OF CHILD WELFARE AND JUVENILE JUSTICE FUNDING

153.11(232) Definitions
153.12(232) Implementation requirements
153.13(232) Role and responsibilities of decategorization project governance boards

153.14(232) Realignment of decategorization project boundaries
153.15(232) Decategorization services funding pool
153.16(232) Relationship of decategorization funding pool to other department child welfare funding
153.17(232) Relationship of decategorization funding pool to juvenile court services funding streams
153.18(232) Requirements for annual services plan
153.19(232) Requirements for annual progress report
153.20 to 153.30 Reserved

DIVISION III
MENTAL ILLNESS, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES—LOCAL SERVICES

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

153.51(331) Definitions
153.52(331) Eligibility requirements
153.53(331) Application procedure
153.54(331) Eligibility determination
153.55(331) Eligible services
153.56(331) Program administration
153.57(331) Reduction, denial, or termination of benefits
153.58(331) Appeals

CHAPTER 154
Reserved

CHAPTER 155
CHILD ABUSE PREVENTION PROGRAM

155.1(235A) Definitions
155.2(235A) Child abuse prevention program administration
155.3(235A) Project eligibility
155.4(235A) Proposals
155.5(235A) Selection of project proposals
155.6(235A) Project contracts
155.7(235A) Project records
155.8(235A) Quarterly project progress reports
155.9(235A) Evaluation
155.10(235A) Termination
155.11(235A) Advisory council

CHAPTER 156
PAYMENTS FOR FOSTER CARE
AND FOSTER PARENT TRAINING

156.1(234) Definitions
156.2(234) Foster care recovery
156.3 to 156.5 Reserved
156.6(234) Rate of maintenance payment for foster family care
156.7(234) Purchase of family foster care services
156.8(234) Special needs
156.9(234) Rate of payment for foster group care
156.10(234) Payment for reserve bed days

156.11(234) Emergency care
156.12(234) Supervised apartment living
156.13 Reserved
156.14(234,252C) Voluntary placements
156.15(234) Child's earnings
156.16(234) Trust funds and investments
156.17(234) Adoptive homes
156.18(237) Foster parent training expenses
156.19(237) Rate of payment for care in a residential care facility
156.20(234) Eligibility for foster care payment

CHAPTER 157
PURCHASE OF ADOPTION SERVICES
157.1(600) Definitions
157.2(600) Eligibility
157.3(600) Components of adoption service
157.4(600) Contract requirements and management
157.5(600) Case permanency plan requirements
157.6(600) Progress reports

CHAPTER 158
FOSTER HOME INSURANCE FUND
158.1(237) Payments from the foster home insurance fund
158.2(237) Payment limits
158.3(237) Claim procedures
158.4(237) Time frames for filing claims
158.5(237) Appeals

CHAPTER 159
CHILD CARE RESOURCE AND REFERRAL GRANTS PROGRAM
159.1(237A) Definitions
159.2(237A) Availability of grants
159.3(237A) Project eligibility
159.4(237A) Request for proposals for project grants
159.5(237A) Selection of proposals
159.6(237A) Project contracts
159.7(237A) Records
159.8(237A) Evaluation
159.9(237A) Termination of contract
159.10(237A) Appeals

CHAPTER 160
ADOPTION OPPORTUNITY GRANT PROGRAM
160.1(234) Definitions
160.2(234) Availability of grant funds
160.3(234) Project eligibility
160.4(234) Request for proposals for project grants
160.5(234) Selection of proposals
160.6(234) Project contracts
160.7(234) Records
160.8(234) Evaluation of projects
160.9(234) Termination
160.10(234) Appeals

CHAPTER 161
IOWA SENIOR LIVING TRUST FUND

161.1(249H) Definitions
161.2(249H) Funding and operation of trust fund
161.3(249H) Allocations from the senior living trust fund
161.4(249H) Participation by government-owned nursing facilities

CHAPTER 162
NURSING FACILITY CONVERSION
AND LONG-TERM CARE SERVICES
DEVELOPMENT GRANTS

162.1(249H) Definitions
162.2(249H) Availability of grants
162.3(249H) Grant eligibility
162.4(249H) Grant application process
162.5(249H) Grant dispersal stages
162.6(249H) Project contracts
162.7(249H) Grantee responsibilities
162.8(249H) Offset
162.9(249H) Appeals

CHAPTER 163
ADOLESCENT PREGNANCY PREVENTION AND SERVICES
TO PREGNANT AND PARENTING ADOLESCENTS
PROGRAMS

163.1(234) Definitions
163.2(234) Availability of grants for projects
163.3(234) Project eligibility
163.4(234) Request for proposals for pilot project grants
163.5(234) Selection of proposals
163.6(234) Project contracts
163.7(234) Records
163.8(234) Evaluation
163.9(234) Termination of contract
163.10(234) Appeals

CHAPTER 164
IOWA HOSPITAL TRUST FUND

164.1(249I) Definitions
164.2(249I) Funding and operation of trust fund
164.3(249I) Allocations from the hospital trust fund
164.4(249I) Participation by public hospitals

CHAPTER 165
FAMILY DEVELOPMENT AND SELF-SUFFICIENCY PROGRAM

165.1(217) Definitions
165.2(217) Council
165.3(217) Funding of grants
165.4(217) Families at risk
165.5(217) Grant application process
165.6(217) Selection of grantees
165.7(217) Contract with grantee
165.8(217) Grantee responsibilities

165.9(217) Evaluation
165.10(217) Contract revision and termination
165.11(217) Reconsideration

CHAPTER 166
Reserved

CHAPTER 167
JUVENILE DETENTION REIMBURSEMENT

DIVISION I
ANNUAL REIMBURSEMENT PROGRAM

167.1(232) Definitions
167.2(232) Availability of funds
167.3(232) Eligible facilities
167.4(232) Available reimbursement
167.5(232) Submission of voucher
167.6(232) Reimbursement by the department

CHAPTER 168
CHILD CARE EXPANSION PROGRAMS

168.1(234) Definitions
168.2(234) Availability of funds
168.3(234) Eligibility requirements
168.4(234) Request for proposals
168.5(234) Selection of proposals
168.6(234) Appeals
168.7(234) Contracts
168.8(234) Reporting requirements
168.9(234) Termination of contract

CHAPTER 169
FUNDING FOR EMPOWERMENT AREAS

169.1(7I) Definitions
169.2(7I) Use of funds
169.3(7I) Eligibility for funding
169.4(7I) Funding availability
169.5(7I) Community empowerment areas' responsibilities
169.6(7I) Iowa empowerment board's responsibilities
169.7(7I) Department of human services' responsibilities
169.8(7I) Revocation of funding
169.9(7I) Appeals

TITLE XV
INDIVIDUAL AND FAMILY SUPPORT
AND PROTECTIVE SERVICES

CHAPTER 170
CHILD CARE SERVICES

170.1(237A) Definitions
170.2(237A,239B) Eligibility requirements
170.3(237A,239B) Application and determination of eligibility
170.4(237A) Elements of service provision
170.5(237A) Adverse actions
170.6(237A) Appeals

170.7(237A) Provider fraud
170.8 Reserved
170.9(237A) Child care assistance overpayments

CHAPTER 171
Reserved

CHAPTER 172
FAMILY-CENTERED CHILD WELFARE SERVICES

DIVISION I
GENERAL PROVISIONS

172.1(234) Definitions
172.2(234) Purpose and scope
172.3(234) Authorization
172.4(234) Reimbursement
172.5(234) Client appeals
172.6(234) Reviews and audits
172.7 to 172.9 Reserved

DIVISION II
SAFETY PLAN SERVICES

172.10(234) Service requirements
172.11(234) Provider selection
172.12(234) Service eligibility
172.13(234) Service components
172.14(234) Monitoring of service delivery
172.15(234) Billing and payment
172.16 to 172.19 Reserved

DIVISION III
FAMILY SAFETY, RISK, AND PERMANENCY SERVICES

172.20(234) Service requirements
172.21(234) Provider selection
172.22(234) Service eligibility
172.23(234) Service components
172.24(234) Monitoring of service delivery
172.25(234) Billing and payment
172.26 to 172.29 Reserved

DIVISION IV
FAMILY-CENTERED SUPPORTIVE SERVICES

172.30(234) Service components
172.31(234) Provider selection
172.32(234) Service eligibility
172.33(234) Monitoring of service delivery
172.34(234) Billing and payment

CHAPTERS 173 and 174
Reserved

CHAPTER 175
ABUSE OF CHILDREN

DIVISION I
CHILD ABUSE

175.1 to 175.20 Reserved

DIVISION II
CHILD ABUSE ASSESSMENT

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

CHAPTER 176
DEPENDENT ADULT ABUSE

176.1(235B) Definitions
176.2(235B) Denial of critical care
176.3(235B) Appropriate evaluation
176.4(235B) Reporters
176.5(235B) Reporting procedure
176.6(235B) Duties of the department upon receipt of report
176.7(235B) Appropriate evaluation or assessment
176.8(235B) Immunity from liability for reporters
176.9(235B) Registry records
176.10(235B) Adult abuse information disseminated
176.11(235B) Person conducting research
176.12(235B) Examination of information
176.13(235B) Dependent adult abuse information registry
176.14 Reserved
176.15(235B) Multidisciplinary teams
176.16(235B) Medical and mental health examinations
176.17(235B) Request for correction or expungement

CHAPTER 177
IN-HOME HEALTH RELATED CARE

177.1(249) In-home health related care
177.2(249) Own home
177.3(249) Service criteria
177.4(249) Eligibility
177.5(249) Providers of health care services

177.6(249) Health care plan
177.7(249) Client participation
177.8(249) Determination of reasonable charges
177.9(249) Written agreements
177.10(249) Emergency services
177.11(249) Termination

CHAPTERS 178 to 181
Reserved

CHAPTER 182
FAMILY-CENTERED SERVICES

182.1(234) Definitions
182.2(234) Available services
182.3(234) Eligibility for services
182.4(234) Approval and referral for services
182.5(234) Service provider qualifications
182.6(234) Requirements for service delivery
182.7(234) Provider service record requirements
182.8(234) Unit of service and service unit rates
182.9(234) Termination and adverse service actions
182.10(234) Appeals

CHAPTER 183
ADULT SUPPORT PROGRAM

183.1(234) Definitions
183.2(234) Eligibility
183.3(234) Application
183.4(234) Method of provision
183.5(234) Social casework responsibilities
183.6(234) Unit of service
183.7(234) Location of service delivery
183.8(234) Adverse service actions
183.9(234) Appeals

CHAPTER 184
INDIVIDUAL AND FAMILY DIRECT SUPPORT

DIVISION I
FAMILY SUPPORT SUBSIDY PROGRAM

184.1(225C) Definitions
184.2(225C) Eligibility requirements
184.3(225C) Application process
184.4(225C) Family support services plan
184.5 Reserved
184.6(225C) Amount of subsidy payment
184.7(225C) Redetermination of eligibility
184.8(225C) Termination of subsidy payments
184.9(225C) Appeals
184.10 to 184.20 Reserved

DIVISION II
COMPREHENSIVE FAMILY SUPPORT PROGRAM

184.21(225C) Definitions
184.22(225C) Eligibility

184.23(225C) Application
184.24(225C) Contractor selection and duties
184.25(225C) Direct assistance
184.26(225C) Appeals
184.27(225C) Parent advisory council

CHAPTER 185
REHABILITATIVE TREATMENT SERVICES

DIVISION I
GENERAL PROVISIONS

185.1(234) Definitions
185.2 to 185.9 Reserved
185.10(234) Provider certification standards
185.11 Reserved
185.12(234) Sanctions against providers of rehabilitative treatment and supportive services
185.13(234) Provider audits
185.14 to 185.20 Reserved

DIVISION II
FAMILY-CENTERED PROGRAM
Rescinded IAB 4/11/07, effective 7/1/07

185.21 to 185.40 Reserved

DIVISION III
FAMILY PRESERVATION PROGRAM
Rescinded IAB 4/11/07, effective 7/1/07

185.41 to 185.60 Reserved

DIVISION IV
FAMILY FOSTER CARE TREATMENT SERVICES
Rescinded IAB 11/8/06, effective 11/1/06

185.61 to 185.80 Reserved

DIVISION V
GROUP TREATMENT
Rescinded IAB 4/11/07, effective 7/1/07

185.81 to 185.100 Reserved

DIVISION VI
ESTABLISHMENT OF RATES

185.101(234) Definitions
185.102(234) Financial and statistical report
185.103(234) Submission of reports
185.104(234) Expenses not allowed
185.105(234) Costs subject to limits
185.106(234) Establishment of reimbursement rates
185.107(234) Payment of new rates
185.108 Reserved
185.109(234) Fiscal years 1997 and 1998 determination of rates
185.110(234) Providers under an exception to policy for establishing rates
185.111(234) Data
185.112(234) Determination of rates
185.113 to 185.120 Reserved

DIVISION VII
BILLING AND PAYMENT PROCEDURES

185.121(234) Billing procedures
185.122(234) Recoupment procedures
185.123 to 185.125 Reserved

DIVISION VIII
OVERPAYMENT PROVISIONS

185.126(234) Calculation of overpayments

CHAPTER 186
COMMUNITY CARE

186.1(234) Definitions
186.2(234) Eligibility
186.3(234) Services provided
186.4(234) Appeals

CHAPTER 187
AFTERCARE SERVICES AND SUPPORTS

DIVISION I
AFTERCARE SERVICES

187.1(234) Purpose
187.2(234) Eligibility
187.3(234) Services and supports provided
187.4(234) Termination
187.5(234) Waiting list
187.6(234) Administration
187.7 to 187.9 Reserved

DIVISION II
PREPARATION FOR ADULT LIVING (PAL) PROGRAM

187.10(234) Purpose
187.11(234) Eligibility
187.12(234) Payment
187.13(234) Termination of stipend
187.14(234) Waiting list
187.15(234) Administration

CHAPTERS 188 to 199
Reserved

TITLE XVI
ALTERNATIVE LIVING

CHAPTER 200
ADOPTION SERVICES

200.1(600) Definitions
200.2(600) Release of custody services
200.3(600) Application
200.4(600) Components of adoption services
200.5(600) Termination of parental rights
200.6(600) Service provision
200.7(600) Department fees
200.8(600) Interstate placements
200.9(600) International adoptions
200.10(600) Requests for home studies
200.11(600) Reasons for denial
200.12(600) Removal of child from preadoptive family
200.13(600) Consents
200.14(600) Requests for access to information for research or treatment

200.15(600) Requests for information for other than research or treatment
200.16(600) Appeals

CHAPTER 201
SUBSIDIZED ADOPTIONS

201.1(600) Administration
201.2(600) Definitions
201.3(600) Conditions of eligibility or ineligibility
201.4(600) Application
201.5(600) Negotiation of amount of presubsidy or subsidy
201.6(600) Types of subsidy
201.7(600) Termination of subsidy
201.8(600) Reinstatement of subsidy
201.9(600) New application
201.10(600) Medical assistance based on residency
201.11(600) Presubsidy recovery

CHAPTER 202
FOSTER CARE SERVICES

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

CHAPTER 203
IOWA ADOPTION EXCHANGE

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

CHAPTER 204
SUBSIDIZED GUARDIANSHIP PROGRAM

PREAMBLE
204.1(234) Definitions
204.2(234) Eligibility
204.3(234) Application
204.4(234) Negotiation of amount of subsidy
204.5(234) Parental liability

204.6(234) Termination of subsidy
204.7(234) Reinstatement of subsidy
204.8(234) Appeals
204.9(234) Medical assistance

CHAPTER 41
GRANTING ASSISTANCE

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

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

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

441—41.1 to **41.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

[Prior to 10/13/93, Human Services(441—41.1 to 41.9)]

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

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

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

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

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

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

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

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

41.21(5) *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

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

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

41.22(1) Reserved.

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

41.22(3) *Specified relationship.*

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

Father—adoptive father.

Mother—adoptive mother.

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

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

Great-grandfather—great-great-grandfather.

Great-grandmother—great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

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

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

Uncle—aunt, of whole or half blood.

Uncle-in-law—aunt-in-law.

Great uncle—great-great-uncle.

Great aunt—great-great-aunt.

First cousins—nephews—nieces.

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

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

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

d. The presence of an able-bodied stepparent in the home shall not disqualify a child for assistance, provided that other eligibility factors are met.

41.22(4) *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.

a. When necessary to establish eligibility, the local office 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 investment program 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 local office shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

41.22(5) *Referral to child support recovery unit.* The county office 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 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.

"Prompt notice" means within two working days of the date assistance is approved.

41.22(6) *Cooperation in obtaining support.* Each applicant for or recipient of the family investment program shall cooperate with the department in establishing paternity and securing support for persons whose needs are included in the assistance grant, except when good cause as defined in 41.22(8) for refusal to cooperate is established.

a. The applicant or recipient shall cooperate in the following areas:

(1) Identifying and locating the parent of the child for whom aid is claimed.

(2) Establishing the paternity of a child born out of wedlock for whom aid is claimed.

(3) Obtaining support payments for the applicant or recipient and for a child for whom aid is claimed.

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

b. Cooperation is defined as including the following actions by the applicant or recipient:

(1) Appearing at the local office or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the applicant or recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

(4) Paying to the department any cash support payments for a member of the eligible group, except as described at 41.27(7)*"p"* and *"q,"* received by a recipient after the date of decision as defined in 441—subrule 40.24(4).

(5) Providing the name of the absent parent and additional necessary information.

c. The applicant or recipient shall cooperate with the local office in supplying information with respect to the absent parent, the receipt of support, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. The applicant or recipient 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 or enforce a support obligation or establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. In the circumstance as described at paragraph *"b,"* subparagraph (4), the income maintenance unit in the county office shall make the determination of whether or not the client has cooperated. In all other instances, the child support recovery unit (CSRU) shall make the determination of whether the client has cooperated. CSRU delegates the income maintenance unit in the county office to make this determination for applicants.

f. Failure to cooperate shall result in a sanction to the family. The sanction shall be a deduction of 25 percent from the net cash assistance grant amount payable to the family before any deduction for recoupment of a prior overpayment.

(1) When the income maintenance unit determines noncooperation, the sanction shall be implemented after the noncooperation has occurred. The sanction shall remain in effect until the client has expressed willingness to cooperate. However, any action to remove the sanction shall be delayed until cooperation has occurred.

(2) When the child support recovery unit (CSRU) makes the determination, the sanction shall be implemented upon notification from CSRU to the income maintenance unit that the client has failed to cooperate. The sanction shall remain in effect until the client has expressed to either income maintenance or CSRU staff willingness to cooperate. However, any action to remove the sanction shall be delayed until income maintenance is notified by CSRU that the client has cooperated.

41.22(7) *Assignment of support payments.* Each applicant for or recipient of assistance shall assign to the department any rights to support from any other person as the applicant or recipient may have. This shall include rights to support in the applicant's or recipient's own behalf or in behalf of any other family member for whom the applicant or recipient is applying or receiving assistance and which have accrued at the time the assignment is executed. An assignment is effective the same date the county office enters all eligibility information into the department's computer system and is effective for the entire period for which assistance is paid.

a. Rescinded IAB 11/8/06, effective 1/1/07.

b. Rescinded IAB 7/1/98, effective 7/1/98.

c. and *d.* Reserved.

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

41.22(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 local office shall determine that cooperation is against the child's best interest when the applicant's or recipient's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical harm to the child for whom support is to be sought; or

(2) Emotional harm to the child for whom support is to be sought; or

(3) Physical harm to the parent or caretaker relative with whom the child is living which reduces the person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or caretaker relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The local office shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the local office believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

(1) The child for whom support is sought was conceived as a result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm 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 caretaker 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Corroborate the good cause circumstances.

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

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

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

(1) Be in writing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

h. The local office shall:

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

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

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

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 caretaker relative.

(4) Medical records which indicate emotional health history and present emotional health status of the caretaker relative or the child for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the caretaker relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the local office wishes to request additional corroborative evidence which is needed to permit a good cause determination, the local office shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the local office shall:

(1) Advise the applicant or recipient how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The local office will 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 will be found when the claimant's statement and investigation which is conducted satisfies the office that the applicant or recipient has good cause for refusing to cooperate.

(3) A determination that good cause exists will be reviewed and approved or disapproved by the worker's immediate supervisor and the findings will be recorded in the case record.

e. The local office may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the local office determines that it is necessary, it 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 local office will:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

41.22(12) *Enforcement without caretaker's cooperation.* When the local office makes a determination that good cause exists, it shall also make a determination of whether or not child support

enforcement can proceed without risk of harm to the child or caretaker relative when the enforcement or collection activities do not involve their participation.

a. Prior to making the determination, the child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the local office shall consider any recommendation from the unit.

b. The determination shall be in writing, contain the local office's findings and basis for determination, and be entered into the family investment program case record.

c. When the local office excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, it will notify the applicant or recipient to enable the individual to withdraw the application for assistance or have the case closed.

41.22(13) *Furnishing of social security number.* As a condition of eligibility each applicant for or recipient of and all members of the eligible group must furnish a social security account number or proof of application for a number if it has not been issued or is not known and provide the number upon its receipt. The requirement shall not apply to a payee who is not a member of the eligible group.

a. Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicant or recipient has complied with the requirements of 41.22(13).

b. When the mother of the newborn child is a current recipient, the mother shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

c. When the applicant is a battered alien, as described at 41.23(4), the applicant shall have until the month following the month the person receives employment authorization from the Immigration and Naturalization Service to apply for a social security account number.

41.22(14) *Department of workforce development registration and referral.* Rescinded IAB 11/1/00, effective 1/1/01.

41.22(15) *Requiring minor parents to live with parent or legal guardian.* A minor parent and the dependent child in the minor parent's care must live in the home of a parent or legal guardian of the minor parent in order to receive family investment program benefits unless good cause for not living with the parent or legal guardian is established. "Living in the home" includes living in the same apartment, same half of a duplex, same condominium or same row house as the adult parent or legal guardian. It also includes living in an apartment which is located in the home of the adult parent or legal guardian.

For applicants, determination of whether the minor parent and child are living with a parent or legal guardian or have good cause must be made as of the date of the first application interview as described at 441—subrule 40.24(2). If, as of the date of this interview, the minor parent and child are living with a parent or legal guardian or are determined to have good cause, the FIP application for the minor parent and child shall be approved as early as seven days from receipt of the application provided they are otherwise eligible. For pending applications that have already had the first interview before this subrule is implemented, the department shall determine eligibility in accordance with 441—subrule 40.24(4). If, as of the date of this interview, the minor parent and child are not living with a parent or legal guardian and do not have good cause, the FIP application for the minor parent and child shall be denied. For recipients, when changes occur, continuing eligibility shall be redetermined according to 441—subrules 40.27(4) and 40.27(5).

A minor parent determined to have good cause for not living with a parent or legal guardian must attend FaDSS or other family development as required in 441—subrule 93.109(2).

41.22(16) *Good cause for not living in the home of a parent or legal guardian.* Good cause shall exist when at least one of the following conditions applies:

a. The parents or legal guardian of the minor parent is deceased, missing or living in another state.

b. The physical or emotional health or safety of the minor parent or child would be jeopardized if the minor parent is required to live with the parent or legal guardian.

(1) Physical or emotional harm shall be of a serious nature in order to justify a finding of good cause.

(2) Physical or emotional harm shall include situations of documented abuse or incest.

(3) When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the minor parent or child, the following 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.

c. The minor parent is in a foster care supervised apartment living arrangement.

d. The minor parent is participating in the job corps solo parent program.

e. The parents or legal guardian refuses to allow the minor parent and child to return home and the minor parent is living with a specified relative, aged 21 or over, on the day of interview, and the caretaker is the applicant or payee.

f. The minor parent and child live in a maternity home or other licensed adult-supervised supportive living arrangement as defined by the department of human services.

g. Other circumstances exist which indicate that living with the parents or legal guardian will defeat the goals of self-sufficiency and responsible parenting. Situations which appear to meet this good cause reason must be referred to the administrator of the division of economic assistance, or the administrator's designee, for determination of good cause.

41.22(17) *Claiming good cause for not living in the home of a parent or legal guardian.* Each applicant or recipient who is not living with a parent or legal guardian shall have the opportunity to claim good cause for not living with a parent or legal guardian.

41.22(18) *Determination of good cause for not living in the home of a parent or legal guardian.* The county office shall determine whether good cause exists for each applicant or recipient who claims good cause.

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

(1) Be in writing.

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

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

b. When the county office determines that good cause does not exist:

(1) The applicant or recipient shall be so notified.

(2) The application shall be denied or family investment program assistance canceled.

(3) Rescinded IAB 8/31/05, effective 11/1/05.

c. The county office shall:

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

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements.

41.22(19) *Proof of good cause for not living in the home of a parent or legal guardian.* The applicant or recipient who claims good cause shall provide corroborative evidence to prove the good cause claim within the time frames described at 441—subrule 40.24(1) and paragraph 40.27(4)*"c."*

a. A good cause claim may be corroborated by one or more of the following types of evidence:

(1) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the parent or legal guardian might inflict physical or emotional harm on the minor parent or child.

(2) Medical records that indicate the emotional health history and present emotional health status of the minor parent or child; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the minor parent or child.

(3) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim. Written statements from the client's friends or relatives are not sufficient alone to grant good cause based on physical or emotional harm, but may be used to support other evidence.

(4) Notarized statements from the parents or legal guardian or other reliable evidence to verify that the parents or legal guardian refuse to allow the minor parent and child to return home.

(5) Court, criminal, child protective services, social services or other records which verify that the parents or legal guardian of the minor parent is deceased, missing or living in another state, or that the minor parent is in a foster care supervised apartment living arrangement, the job corps solo parent program, maternity home or other licensed adult-supervised supportive living arrangement.

b. When after examining the corroborative evidence submitted by the applicant or recipient, the county office wishes to request additional corroborative evidence which is needed to permit a good cause determination, the county office shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed.

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the county office shall:

(1) Advise the applicant or recipient how to obtain the necessary documents.

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

This rule is intended to implement Iowa Code chapter 239B.

441—41.23(239B) Home, residence, citizenship, and alienage.

41.23(1) *Iowa residence.*

a. A resident of Iowa is one:

(1) Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence 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

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the caretaker is a resident.

b. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of residence.

41.23(2) *Suitability of home.* The home 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.

41.23(3) *Absence from the home.*

a. An individual who is absent from the home shall not be included in the assistance unit, 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, notwithstanding the provisions of subrule 41.22(5). "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group, if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year will result in the individual's needs being removed from the grant.

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

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and the payee intends that the individual will return to the home within three months. Failure to return within three months will result in the individual's needs being removed from the grant.

41.23(4) *Battered aliens.* A person who meets the conditions of eligibility under Iowa Code section 239B.2 and who meets either of the following requirements shall be eligible for participation in the family investment program:

a. The person is a conditional resident alien who was battered or subjected to extreme cruelty, or whose child was battered or subjected to extreme cruelty, perpetrated by the person's spouse who is a United States citizen or lawful permanent resident, as described in 8 CFR Section 216.5(a)(3).

b. The person was battered or subjected to extreme cruelty, or the person's child was battered or subjected to extreme cruelty, perpetrated by the person's spouse who is a United States citizen or lawful permanent resident, and the person's petition has been approved or a petition is pending that sets forth a prima facie case that the person has noncitizen status under any of the following categories:

(1) Status as a spouse or child of a United States citizen or lawful permanent resident under the federal Immigration and Nationality Act, Section 204(a)(1)(A).

(2) Status as a spouse or child who was battered or subjected to extreme cruelty by a United States citizen or lawful permanent resident under the federal Immigration and Nationality Act, Section 204(a)(iii), as codified in 8 United States Code Section 1154(a)(1)(A)(iii).

(3) Classification as a person lawfully admitted for permanent residence under the federal Immigration and Nationality Act.

(4) Suspension of deportation and adjustment of status under the federal Immigration and Nationality Act, Section 244(a), as in effect before the date of enactment of the federal Illegal Immigration Reform and Immigrant Responsibility Act of 1996.

(5) Cancellation of removal or adjustment of status under the federal Immigration and Nationality Act, Section 240A, as codified in 8 United States Code Section 1229b.

(6) Status as an asylee, if asylum is pending, under the federal Immigration and Nationality Act, Section 208, as codified in 8 United States Code Section 1158.

41.23(5) *Citizenship and alienage.*

a. A family investment program assistance grant may include the needs of a citizen or national of the United States, or a qualified alien as defined at 8 United States Code Section 1641.

(1) A person who is a qualified alien as defined at 8 United States Code Section 1641 is not eligible for family investment program assistance for five years. The five-year period of ineligibility begins on the date of the person's entry into the United States with a qualified alien status as defined at 8 United States Code Section 1641.

Exceptions: The five-year prohibition from family investment program assistance does not apply to battered aliens as described at 41.23(4), qualified aliens described in 8 United States Code Section 1612, or to qualified aliens as defined at 8 United States Code Section 1641 who entered the United States before August 22, 1996.

(2) A person who is not a United States citizen, a battered alien as described at 41.23(4), or a qualified alien as defined at 8 United States Code Section 1641 is not eligible for the family investment program regardless of the date the person entered the United States.

b. As a condition of eligibility, each applicant shall attest to the applicant's citizenship or alien status by signing Form 470-0462 or 470-0466, Health and Financial Support Application, or Form 470-2549, Statement of Citizenship Status.

(1) The applicant or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant's behalf shall sign the form. When both parents are in the home, both shall sign a form attesting to their citizenship.

(2) An adult shall sign the form for dependent children. Form 470-2881, Review/Recertification Eligibility Document, may be used to attest to the citizenship of dependent children who enter a recipient household.

(3) Failure to sign a form attesting to citizenship when required to do so creates ineligibility for the entire eligibility group.

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

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

41.24(1) *Referral to PROMISE JOBS.*

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

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

c. All applicants shall be referred to PROMISE JOBS as FIA-responsible persons unless the local office determines that the person is exempt or does not meet other FIP eligibility requirements.

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

41.24(2) *Exemptions.* Except as specified at subrule 41.30(3), the following persons are exempt from referral:

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

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

d. A person found eligible for supplemental security income (SSI) benefits based on disability or blindness.

e. A person who is aged 16 to 19, and is not a parent, who attends an elementary, secondary or equivalent level of vocational or technical school full-time. For persons who lose exempt status for not attending school and who are referred to PROMISE JOBS on or after November 1, 2005, once the person has signed a family investment agreement, the person shall remain referred to PROMISE JOBS and subject to the terms of the agreement.

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

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

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

f. A person who is not a United States citizen and is not a qualified alien as defined in 8 United States Code Section 1641 or a battered alien as described at 41.23(4).

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

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

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

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

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

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

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

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

41.24(4) *Method of referral.*

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

b. While the eligibility decision is pending, applicants who must qualify for a hardship exemption before approval of FIP shall be treated in accordance with subrule 41.30(3).

c. Each person required to be referred to PROMISE JOBS as described at subrule 41.24(1) must meet with PROMISE JOBS staff and sign an FIA.

(1) For an applicant filing an application on or after September 1, 2004, the FIA must be signed before FIP approval, as a condition of eligibility. If a parent fails to sign an FIA, the entire family is ineligible for FIP. If a referred person who is not a parent fails to sign an FIA, only that person is ineligible.

(2) When a FIP participant loses exempt status, the FIP participant shall receive a letter which contains information about participant responsibility under PROMISE JOBS and the FIA and instructs the FIP participant to contact PROMISE JOBS within ten calendar days to schedule the PROMISE JOBS orientation.

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

41.24(6) *Volunteers.* Rescinded IAB 7/21/04, effective 9/1/04.

41.24(7) *Referral to vocational rehabilitation.* The department shall make the department of education, division of vocational rehabilitation services, aware of any person who is referred to PROMISE JOBS and who has a medically determined physical or mental disability and a substantial employment limitation resulting from the disability. However, acceptance of vocational rehabilitation services by the client is optional.

41.24(8) *The limited benefit plan (LBP).* When a participant responsible for signing and meeting the terms of a family investment agreement as described at rule 441—93.109(239B) chooses not to sign or fulfill the terms of the agreement, the FIP assistance unit or the individual participant shall enter into a limited benefit plan. A limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to the participant as defined at 441—subrule 7.7(1). Once the limited benefit plan is imposed, FIP eligibility no longer exists as of the first of the month after the month in which timely and adequate notice is given to the participant. Upon the issuance of the notice to impose a limited benefit plan, the person who chose the limited benefit plan can reconsider and end the limited benefit plan, but only as described at paragraph 41.24(8)*"d."* A participant who is exempt from PROMISE JOBS is not subject to the limited benefit plan.

a. A limited benefit plan shall either be a first limited benefit plan or a subsequent limited benefit plan. From the effective date of the limited benefit plan, for a first limited benefit plan, the

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

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

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

(2) When the participant choosing a limited benefit plan is a needy specified relative or a dependent child's stepparent who is in the FIP eligible group because of incapacity, the limited benefit plan shall apply only to the individual participant choosing the plan. EXCEPTION: The limited benefit plan shall apply to the entire FIP eligible group as defined at subrule 41.28(1) when a needy specified relative who assumes the role of parent was responsible for the family investment agreement and chose a limited benefit plan effective October 1, 2005, or earlier.

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

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

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

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

4. When the needy specified relative chooses the limited benefit plan, the requirements of the limited benefit plan shall apply as described at subparagraph 41.24(8)*"b"*(2).

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

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

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

(5) When the FIP eligible group includes parents or needy specified relatives who are exempt from PROMISE JOBS participation and children who are mandatory PROMISE JOBS participants, the children are responsible for completing a family investment agreement. If a child who is a mandatory

PROMISE JOBS participant chooses the limited benefit plan, the limited benefit plan shall be applied in the manner described in subparagraph (4).

(6) When both parents of a FIP child are in the home, a limited benefit plan shall be applied as follows:

1. When only one parent of a child in the eligible group is responsible for a family investment agreement and that parent chooses the limited benefit plan, the limited benefit plan applies to the entire family and cannot be ended by the voluntary participation in a family investment agreement by the exempt parent.

2. When both parents of a child in the eligible group are responsible for a family investment agreement, both are expected to sign the agreement. If either parent chooses the limited benefit plan, the limited benefit plan cannot be ended by the participation of the other parent in a family investment agreement.

3. When the parents from a two-parent family in a limited benefit plan separate, the limited benefit plan shall follow only the parent who chose the limited benefit plan and any children in the home of that parent.

4. A subsequent limited benefit plan applies when either parent in a two-parent family previously chose a limited benefit plan.

c. A participant shall be considered to have chosen a limited benefit plan under any of the following circumstances:

(1) A participant who does not establish an orientation appointment with the PROMISE JOBS program as described at 441—subrule 93.105(2) or who fails to keep or reschedule an orientation appointment shall receive one reminder letter which informs the participant that those who do not attend orientation have elected to choose the limited benefit plan. A participant who does not establish an orientation appointment within ten calendar days from the mailing date of the reminder letter or who fails to keep or reschedule an orientation appointment shall receive notice establishing the limited benefit plan. Timely and adequate notice provisions as in 441—subrule 7.7(1) apply.

(2) A participant who chooses not to sign the family investment agreement after attending a PROMISE JOBS program orientation shall enter into the limited benefit plan as described in subparagraph (1).

(3) A participant who signs a family investment agreement but does not carry out the family investment agreement responsibilities shall be deemed to have chosen a limited benefit plan as described in subparagraph (1), whether the person signed the agreement as a FIP applicant or as a FIP participant. This includes a participant who fails to respond to the PROMISE JOBS worker's request to renegotiate the family investment agreement when the participant has not attained self-sufficiency by the date established in the family investment agreement. A limited benefit plan shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the family investment agreement.

d. A person who chooses a limited benefit plan may reconsider that choice as follows:

(1) First limited benefit plan. A person who chooses a first limited benefit plan may reconsider at any time from the date timely and adequate notice is issued establishing the limited benefit plan. To reconsider and end the limited benefit plan, the person must communicate the desire to engage in PROMISE JOBS activities to the department or appropriate PROMISE JOBS office and develop and sign the family investment agreement.

Since a first limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition. To end the limited benefit plan, the person must also sign a family investment agreement, even if the person had signed an agreement before choosing the limited benefit plan.

FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later. FIP benefits may be reinstated in accordance with 441—subrule 40.22(5) when the family investment agreement is signed before the effective date of a first limited benefit plan.

(2) Rescinded IAB 4/7/99, effective 5/31/99.

(3) Subsequent limited benefit plan. A person who chooses a subsequent limited benefit plan may reconsider that choice at any time following the required six-month period of ineligibility.

A subsequent limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to establish the limited benefit plan. Therefore, once timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition.

FIP eligibility no longer exists as of the effective date of the limited benefit plan. Eligibility cannot be reestablished until the six-month period of ineligibility has expired. FIP eligibility does not exist for a person who reapplies for FIP after the notice is issued and before the effective date of the limited benefit plan because the person is not eligible to sign a family investment agreement until the six-month period of ineligibility has expired.

To reconsider and end the limited benefit plan, the person must contact the department or the appropriate PROMISE JOBS office to communicate the desire to engage in PROMISE JOBS activities, sign a new or updated family investment agreement, and satisfactorily complete 20 hours of employment or the equivalent in an activity other than work experience or unpaid community service, unless problems or barriers as described at rules 441—93.133(239B) and 93.134(239B) apply. The 20 hours of employment or other activity must be completed within 30 days of the date that the family investment agreement is signed, unless problems or barriers as described at rules 441—93.133(239B) and 93.134(239B) apply.

FIP benefits shall not begin until the person who chose the limited benefit plan completes the previously defined significant actions. FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later, but in no case shall the effective date be within the six-month period of ineligibility.

(4) For a two-parent family when both parents are responsible for a family investment agreement as described at subrule 41.24(1), a first or subsequent limited benefit plan continues until both parents have completed significant contact or action with the PROMISE JOBS program as described in subparagraphs (1) and (3) above.

e. Rescinded IAB 4/3/02, effective 4/1/02.

f. A limited benefit plan imposed in error shall not be considered a limited benefit plan. This includes any instance when participation in PROMISE JOBS should not have been required as defined in the administrative rules. Examples of instances when an error has occurred are:

(1) Rescinded IAB 5/1/02, effective 7/1/02.

(2) It is verified that the person considered to have chosen the limited benefit plan moved out of state prior to the date that PROMISE JOBS determined the limited benefit plan was chosen.

(3) The final appeal decision under 441—Chapter 7 reverses the decision to impose a limited benefit plan.

41.24(9) *Nonparticipation by volunteer participants.* Rescinded IAB 7/21/04, effective 9/1/04.

41.24(10) *Notification of services.*

a. The department shall inform all applicants for and recipients of FIP of the advantages of employment under FIP.

b. The department shall provide a full explanation of the family rights, responsibilities, and obligations under PROMISE JOBS and the FIA, with information on the time-limited nature of the agreement.

c. The department shall provide information on the employment, education and training opportunities, and support services to which they are entitled under PROMISE JOBS, as well as the obligations of the department. This information shall include explanations of child care assistance and transitional Medicaid.

d. The department shall inform applicants for and recipients of FIP benefits of the grounds for exemption from FIA responsibility and from participation in the PROMISE JOBS program.

e. The department shall explain the LBP and the process by which FIA-responsible persons and mandatory PROMISE JOBS participants can choose the LBP or individual LBP.

f. The department shall inform all applicants for and recipients of FIP of their responsibility to cooperate in establishing paternity and enforcing child support obligations.

g. The department shall inform applicants for FIP benefits that a family investment agreement must be signed before FIP approval as a condition of eligibility, except as described at subrule 41.24(2).

41.24(11) *Implementation.* A limited benefit plan imposed effective on or after June 1, 1999, shall be imposed according to the revised rules becoming effective on that date. A limited benefit plan imposed effective on or before May 1, 1999, shall be imposed subject to the previous rules for the limited benefit plan. For a person who is in a limited benefit plan on May 1, 1999, the terms of the person's existing limited benefit plan shall continue until that limited benefit plan either ends or is lifted in accordance with previous limited benefit plan rules. A participant who chose a limited benefit plan under the previous policy and who then chooses a limited benefit plan that becomes effective on or after June 1, 1999, shall be subject to a subsequent limited benefit plan under the provisions of the revised rules.

441—41.25(239B) Uncategorized factors of eligibility.

41.25(1) *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.

41.25(2) *Duplication of assistance.* A recipient whose needs are included in a family investment program grant shall not concurrently receive a grant under any other public assistance program administered by the department, including IV-E foster care, or state-funded foster care. A recipient shall not concurrently receive the family investment program and subsidized adoption unless exclusion of the person from the FIP grant will reduce benefits to the family. Neither shall a recipient concurrently receive a grant from a public assistance program in another state. When a recipient leaves the home of a specified relative, no payment for a concurrent period shall be made for the same recipient in the home of another relative.

41.25(3) *Aid from other funds.* Supplemental aid from any other agency or organization shall be limited to aid for items of need not covered by the department's standards and to the amount of the percentage reduction used in determining the payment level. Any duplicated assistance shall be considered unearned income.

41.25(4) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive the family investment program when the other party, obligated to provide the support, is able to fulfill that part of the contract.

41.25(5) *Participation in a strike.*

a. The family of any parent with whom the child(ren) is living shall be ineligible for the family investment program for any month in which the parent is participating in a strike on the last day of the month.

b. Any individual shall be ineligible for the family investment program for any month in which the individual is participating in a strike on the last day of that month.

c. Definitions:

(1) A strike is a concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted slowdown or other concerted interruption of operations by employees.

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

41.25(6) *Graduate students.* The entire assistance unit is ineligible for FIP when a member of the assistance unit is enrolled in an educational program leading to a degree beyond a bachelor's degree.

41.25(7) *Time limit for receiving assistance.* Rescinded IAB 7/11/01, effective 9/1/01.

41.25(8) *School attendance requirements.* Rescinded IAB 7/7/04, effective 7/1/04.

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

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

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

441—41.26(239B) Resources.

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

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

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

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

d. Motor vehicles.

(1) One motor vehicle without regard to its value.

(2) An equity not to exceed a value of $4115 in one motor vehicle for each adult and working teenage child whose resources must be considered as described in 41.26(2). The disregard shall be allowed when the working teenager is temporarily absent from work. The equity value in excess of $4115 of any vehicle shall be counted toward the resource limit in 41.26(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.

The department shall annually increase the motor vehicle equity value to be disregarded by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

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

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

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

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

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

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

j. Settlements for payment of medical expenses.

k. Life estates.

l. 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 computing whether the eligible group's property is within the reserve defined in paragraph *"e."*

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

41.26(2) *Persons considered.*

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

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

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

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

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

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

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

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

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

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

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

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

41.26(6) *Availability.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

441—41.27(239B) Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered in determining initial and continuing eligibility and the amount of the family investment program grant. The determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income, exclusive of the family investment program grant, received by the eligible group and available to meet the current month's needs is no more than 185 percent of the standard of need for the eligible group; (2) the countable net unearned and earned income is less than the standard of need for the eligible group; and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the payment standard

for the eligible group. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the standard of need for the eligible group; and (2) countable net unearned and earned income is less than the payment standard for the eligible group. The amount of the family investment program grant shall be determined by subtracting countable net income from the payment standard for the eligible group. Child support assigned to the department in accordance with subrule 41.22(7) and retained by the department as described in subparagraph 41.27(1)*"h"*(2) shall be considered as exempt income for the purpose of determining continuing eligibility, including child support as specified in paragraph 41.27(7)*"q."* Deductions and diversions shall be allowed when verification is provided. The county office shall return all verification to the applicant or recipient.

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

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

b. Rescinded, effective December 1, 1986.

c. Rescinded, effective September 1, 1980.

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

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

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

g. Every person in the eligible group and any parent living in the home of a child in the eligible group shall take all steps necessary to apply for and, if entitled, accept any financial benefit for which that person may be qualified, even though the benefit may be reduced because of the laws governing a particular benefit. When the person claims a physical or mental disability that is expected to last continuously for 12 months from the time of the claim or to result in death and the person is unable to engage in substantial activity due to the disability, or the person otherwise appears eligible, as the person is aged 65 or older or is blind, the person shall apply for social security benefits and supplemental security income benefits.

(1) Except as described in subparagraph (2), the needs of any person who refuses to take all steps necessary to apply for and, if eligible, to accept other financial benefits shall be removed from the eligible group. The person remains eligible for the work incentive disregard described in paragraph 41.27(2)*"c."*

(2) The entire assistance unit is ineligible for FIP when a person refuses to apply for or, if entitled, to accept social security or supplemental security income. For applicants, this subparagraph applies to those who apply on or after July 1, 2002. For FIP recipients, this subparagraph applies at the time of the next six-month or annual review as described at 441—subrule 40.27(1) or when the recipient reports a change that may qualify a person in the eligible group or a parent living in the home for these benefits, whichever occurs earlier.

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

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

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

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

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

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

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

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

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

c. Work incentive disregard. After deducting the allowable work-related expenses as defined in paragraph 41.27(2)*"a"* and income diversions as defined in subrules 41.27(4) and 41.27(8), the department shall disregard 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered in determining eligibility and the amount of the assistance grant.

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility is determined without the application of the work incentive disregard as described at subparagraphs 41.27(9)*"a"*(2) and (3).

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

e. Rescinded IAB 9/11/96, effective 11/1/96.

f. to *i.* Reserved.

j. 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.

k. The net profit from self-employment income in a nonhome 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.

l. 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 in subrule 41.28(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 in subrule 41.28(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

m. 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.

n. Gross income from providing child care in the applicant's or recipient's own home shall include the total payment(s) received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children. In determining profit from providing child care services in the applicant's or recipient's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the individual requests to have expenses in excess of the 40 percent considered. When the applicant or recipient requests to have actual expenses considered, profit shall be determined in the same manner as specified in 41.27(2)*"o."*

o. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services in the home, 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.

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

q. The applicant or recipient shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—40.21(239B). A self-employed individual shall keep any records necessary to establish eligibility.

41.27(3) *Shared living arrangements.* When a family investment program parent shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the family investment program eligible group, exclusively for their needs, are considered income.

41.27(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs, including special needs, of the ineligible child(ren) of the parent living in the family group who meets the age and school attendance requirements specified in subrule 41.21(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible child(ren) of the parent and a companion in the home only when the income and resources of the companion and the child(ren) are within family investment program standards. The maximum income that shall be diverted to meet the needs of the ineligible child(ren) shall be the difference between the needs of the eligible group if the ineligible child(ren) were included and the needs of the eligible group with the child(ren) excluded, except as specified in 41.27(8)*"a"*(2) and 41.27(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.

41.27(5) *Income of unmarried specified relatives under age 19.* Treatment of the income of an unmarried specified relative under the age of 19 is determined by whether the specified relative lives with a parent who receives FIP assistance, lives with a nonparental relative, lives in an independent living arrangement, or lives with a self-supporting parent, as follows.

a. Living with a parent on FIP, with a nonparental relative, or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the grant of the specified relative's parent 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 grant 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. Living with a self-supporting parent. The income of an unmarried specified relative under the age of 19 who is living in the same home as one or both of the person's self-supporting parents shall be treated in accordance with subparagraphs (1), (2), and (4) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative 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 parent(s) shall be treated in accordance with 41.27(8)*"c."*

(3) Rescinded IAB 4/3/91, effective 3/14/91.

(4) When the unmarried specified relative is age 18, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority.

41.27(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 utilized 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 41.22(3), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

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

t. Any income restricted by law or regulation which is paid to a representative payee, living outside the home, other than a parent who is the applicant or recipient, unless the income is actually made available to the applicant or recipient by the representative payee.

u. The first $50 received and retained by an applicant or recipient 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 a borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, 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 and benefit amount. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. The deposit shall be deducted from nonexempt earned and unearned income that the client receives in the same budget month in which the deposit is made. To allow a deduction, verification of the deposit shall be provided by the end of the report month or the extended filing date, whichever is later. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions in 41.27(2)*"a"* and *"c"* shall be applied to nonexempt earnings from employment or net profit from self-employment that remain after deducting the amount deposited into the account. Allowable deductions 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.

ac. Assigned support collected in a month and retained by child support recovery as described in subparagraph 41.27(1)*"h"*(2).

41.27(7) *Exempt as income.* The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for job-related expenses.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family providing foster care to a child or children when the family is operating a licensed foster home.

e. Rescinded IAB 5/1/91, effective 7/1/91.

f. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

g. Federal or state earned income tax credit.

h. Supplementation from county funds providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the family investment program, or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

i. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

j. A retroactive corrective payment.

k. The training allowance issued by the division of vocational rehabilitation, department of education.

l. Payments from the PROMISE JOBS program.

m. Rescinded, effective July 1, 1989.

n. The training allowance issued by the department for the blind.

o. Payment(s) from a passenger(s) in a car pool.

p. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.

q. Rescinded IAB 11/8/06, effective 1/1/07.

r. Rescinded IAB 11/8/06, effective 1/1/07.

s. Income of a nonparental relative as defined in 41.22(3) except when the relative is included in the eligible group.

t. Rescinded IAB 11/8/06, effective 1/1/07.

u. Rescinded IAB 9/11/96, effective 11/1/96.

v. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

w. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

x. Rescinded, effective July 1, 1986.

y. Earnings of an applicant or recipient aged 19 or younger who is a full-time student as defined in 41.24(2)*"e."* The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

z. Income attributed to an unmarried, underage parent in accordance with 41.27(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns age 18 on the first day of a month, the income of the self-supporting parent(s) becomes exempt as of the first day of that month.

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

ab. Incentive payments received from participation in the adolescent pregnancy prevention programs.

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

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

ae. Interest and dividend income.

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

ag. Rescinded IAB 11/8/06, effective 1/1/07.

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

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

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

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

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

a. Treatment of income in excluded parent cases.

(1) A parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group is eligible for the earned income deduction described at paragraph 41.27(2)*"a,"* the work incentive disregard described at paragraph 41.27(2)*"c,"* and diversions described at subrule 41.27(4).

(2) The excluded parent shall be permitted to retain that part of the parent's income to meet the parent's needs as determined by the difference between the needs of the eligible group with the parent

included and the needs of the eligible group with the parent excluded except as described at subrule 41.27(11).

(3) All remaining income of the excluded 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 is living with the parent in the home of the eligible child(ren), shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) to (10) below.

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

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

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

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

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

(6) The stepparent shall be allowed the work incentive disregard described at paragraph 41.27(2)*"c"* from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions in subparagraphs 41.27(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 41.27(9)*"a"*(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) will first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt nonrecurring lump sum received by a stepparent shall be considered as income in the month received. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent.

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FIP, the income of the parent may be diverted to meet the unmet needs of the child(ren) of the current marriage except as described at 41.27(11).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any child(ren) of the parent living in the home who is not eligible for FIP 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 parent(s), the income of each self-supporting parent shall be considered available

to the eligible group after appropriate deductions. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to 41.27(8)*"b"*(1) to (7). Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with 41.27(8)*"b"*(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to 41.27(8)*"b"*(1) to (7). Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with 41.27(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.

41.27(9) *Budgeting process.* Both initial and ongoing eligibility and benefits shall be determined using a projection of income based on the best estimate of future income.

a. Initial eligibility.

(1) At time of application, all earned and unearned income received and anticipated to be received by the eligible group during the month the decision is made shall be considered to determine eligibility for the family investment program, except income which is exempt. All countable earned and unearned income received by the eligible group during the 30 days before the interview shall be used to project future income. If the applicant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

When income is prorated in accordance with 41.27(9)*"c"*(1) and 41.27(9)*"i,"* the prorated amount is counted as income received in the month of decision. Allowable work expenses during the month of decision shall be deducted from earned income, except when determining eligibility under the 185 percent test defined in 41.27(239B). The determination of eligibility in the month of decision is a three-step process as described in 41.27(239B).

(2) When countable gross nonexempt earned and unearned income in the month of decision, or in any other month after assistance is approved, exceeds 185 percent of the standard of need for the eligible group, the application shall be rejected or the assistance grant canceled. Countable gross income means nonexempt gross income, as defined in rule 441—41.27(239B), without application of any disregards, deductions, or diversions. When the countable gross nonexempt earned and unearned income in the month of decision equals or is less than 185 percent of the standard of need for the eligible group, initial eligibility under the standard of need shall then be determined. Initial eligibility under the standard of need is determined without application of the work incentive disregard as specified in paragraph 41.27(2)*"c."* All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the standard of need for the eligible group. When countable net earned and unearned income in the month of decision equals or exceeds the standard of need for the eligible group, the application shall be denied.

(3) When the countable net income in the month of decision is less than the standard of need for the eligible group, the work incentive disregard described in paragraph 41.27(2)*"c"* shall be applied when there is eligibility for this disregard. When countable net earned and unearned income in the month of decision, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the payment standard for the eligible group, the application shall be denied.

When the countable net income in the month of decision is less than the payment standard for the eligible group, the eligible group meets income requirements. The amount of the family investment program grant shall be determined by subtracting countable net income in the month of decision from the payment standard for the eligible group, except as specified in subparagraph 41.27(9)*"a"*(4).

(4) Eligibility for the family investment program for any month or partial month before the month of decision shall be determined only when there is eligibility in the month of decision. The family composition for any month or partial month before the month of decision shall be considered the same as on the date of decision. In determining eligibility and the amount of the assistance payment for any month or partial month preceding the month of decision, income and all circumstances except family

composition in that month shall be considered in the same manner as in the month of decision. When the applicant is eligible for some, but not all, months of the application period due to the time limit described at subrule 41.30(1), family investment program eligibility shall be determined for the month of decision first, then the immediately preceding month, and so on until the time limit has been reached.

(5) Rescinded IAB 11/8/06, effective 1/1/07.

(6) Rescinded IAB 11/8/06, effective 1/1/07.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

b. Ongoing eligibility.

(1) The local office shall prospectively compute eligibility and benefits when a Public Assistance Eligibility Report, Form 470-0454, 470-0455, or 470-3719(S); a Combined PAER/FAIR, Form 470-4387, 470-4387(M), or 470-4387(S); or a Review/Recertification Eligibility Document, Form 470-2881, 470-2881(M), or 470-4083 (Spanish), or 470-4083(M), is completed as described in 441—40.27(239B). All countable earned and unearned income received by the eligible group during the previous 30 days shall be used to project future income. If the participant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) When a change in eligibility factors occurs, the local office shall prospectively compute eligibility and benefits based on the change, effective no later than the month following the month the change occurred.

(3) Rescinded IAB 11/8/06, effective 1/1/07.

(4) The earned income deduction for each wage earner as defined in paragraph 41.27(2)*"a"* and the work incentive disregard as defined in paragraph 41.27(2)*"c"* shall be allowed.

c. Lump-sum income.

(1) Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be considered as income in the month received. Income received by an individual employed under a contract shall be prorated over the period of the contract. Income received at periodic intervals or intermittently shall be considered as income in the month received, except periodic or intermittent income from self-employment shall be treated as described in 41.27(9)*"i."* When the income that is subject to proration is earned, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income that is subject to proration is prorated when a lump sum is received before the month of decision and is anticipated to recur; or a lump sum is received during the month of decision or at any time during the receipt of assistance.

(2) Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 41.26(4), 41.26(7), 41.27(8)*"b,"* and 41.27(8)*"c,"* shall be treated in accordance with this rule. Nonrecurring lump-sum income shall be considered as income in the month received and counted in computing eligibility and the amount of the grant, unless the income is exempt. Nonrecurring lump-sum unearned income is defined as a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance or workers' compensation. When countable income, exclusive of the family investment program grant but including countable lump-sum income, exceeds the needs of the eligible group, the case shall be canceled or the application rejected. In addition, the eligible group shall be ineligible for the number of full months derived by dividing the income by the standard of need for the eligible group. Any income remaining after this calculation shall be applied as income to the first month following the period of ineligibility and disregarded as income thereafter. The period of ineligibility shall begin with the month the lump sum is received.

When a nonrecurring lump sum is timely reported as required by 441—paragraph 40.27(4)*"f,"* recoupment shall not be made for the month of receipt. When a nonrecurring lump sum is timely reported, but the timely notice as required by rule 441—7.7(17A) requires the action be delayed until the second calendar month following the month of change, recoupment shall not be made for the first calendar month following the month of change. When a nonrecurring lump sum is not timely reported, recoupment shall be made beginning with the month of receipt.

The period of ineligibility shall be shortened when the schedule of living costs as defined in 41.28(2) increases.

The period of ineligibility shall be shortened by the amount that is no longer available to the eligible group due to a loss or a theft or because the person controlling the lump sum no longer resides with the eligible group.

The period of ineligibility shall also be shortened when there is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82 and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 41.26(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified. A dependent is an individual who is claimed or could be claimed by another individual as a dependent for federal income tax purposes.

When countable income, including the lump-sum income, is less than the needs of the eligible group, the lump sum shall be counted as income for the month received. For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of ineligibility. During the period of ineligibility, individuals not in the eligible group when the lump-sum income was received may be eligible for the family investment program as a separate eligible group. Income of this eligible group plus income, excluding the lump-sum income already considered, of the parent or other legally responsible person in the home shall be considered as available in determining eligibility and the amount of the grant.

d. The third digit to the right of the decimal point in any computation of income and hours of employment shall be dropped. This includes the calculation of the amount of a child support sanction as defined in paragraph 41.22(6)*"f."*

e. In any month for which an individual is determined eligible to be added to a currently active family investment program case, the individual's needs shall be included subject to the effective date of grant limitations as prescribed in 441—40.26(239B).

(1) When adding an individual to an existing eligible group, any income of that individual shall be considered prospectively.

(2) The needs of an individual determined to be ineligible to remain a member of the eligible group shall be removed prospectively effective the first of the following month.

f. Rescinded IAB 11/8/06, effective 1/1/07.

g. 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 period being used and dividing the result by the number of instances of income received in that 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.

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

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

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

shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3), (4) and (5) below.

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

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

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

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

j. Special needs.

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

(2) A one-time special need occurs and is considered in determining need for the calendar month in which the special need is entered on the automated benefit calculation system.

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

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

(5) Rescinded IAB 11/8/06, effective 1/1/07.

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

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

41.27(11) *Restriction on diversion of income.* No income may be diverted to meet the needs of a person living in the home who has been sanctioned under subrule 41.24(8) or 41.25(5), or who has been disqualified under subrule 41.25(10) or rule 441—46.28(239B) or 441—46.29(239B), or who is required to be included in the eligible group according to 41.28(1)*"a"* and has failed to cooperate. This restriction applies to 41.27(4)*"a"* and 41.27(8).

This rule is intended to implement Iowa Code section 239B.7.

441—41.28(239B) Need standards.

41.28(1) *Definition of the eligible group.* The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive supplemental security income under Title XVI of the Social Security Act. There shall be at least one child in the eligible group except when the only eligible child is receiving supplemental security income. The unborn child is not considered a member of the eligible group for purposes of establishing the number of people in the eligible group.

a. The following persons 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 payee when the parent is in the home, but is unable to act as payee.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the incapacitated stepparent does not have a child in the eligible group.

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

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be obtained from either an independent physician or psychologist or the state rehabilitation agency. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity. 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. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity.

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

41.28(2) *Schedule of needs.* The schedule of living costs represents 100 percent of basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the standard of need defined in 441—40.21(239B). The 185 percent schedule is included for the determination of eligibility in accordance with 441—41.27(239B). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in and are eligible for a family investment program grant. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the assistance grant, when these needs must be determined in accordance with the payment standard defined in 441—40.21(239B). The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below.

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communi-cations	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transpor-tation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

(1) Shelter: Rental, taxes, upkeep, insurance, amortization.

(2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Includes bus fares and other out-of-pocket costs of operating a privately owned vehicle.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving the family investment program assistance for the relative's own children.

(2) When the unmarried specified relative under age 19 is living in the same home with a parent or parents who receive the family investment program, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parent(s). When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker 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(s) who receives the family investment program 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(s) who does not receive the family investment program, the needs of the specified relative, when eligible, shall be included in the assistance grant with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined in 41.22(3), only the needs of the eligible children shall be included in the assistance grant. 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 is receiving supplemental security income benefits, the person, income, and resources shall not be considered in determining family investment program benefits for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of assistance, the assistance grant shall be computed on the basis of their comprising one eligible group. This rule shall not be construed to require that an application for assistance be made for children who are not the natural or adoptive children of the applicant.

41.28(3) *Special needs.* On the basis of demonstrated need the following special needs shall be allowed, in addition to the basic needs.

a. *School expenses.* Any specific charge, excluding tuition, for a child's education made by the school, or in accordance with school requirements in connection with a course in the curriculum, shall be allowed provided the allowance shall not exceed the reasonable cost required to meet the specifications of the course, and the student is actually participating in the course at the time the expense is claimed. Payment will not be made for ordinary expenses for school supplies.

b. *Guardian/conservator fee.* An amount not to exceed $10 per case per month may be allowed for guardian's/conservator's fees when authorized by appropriate court order. No additional payment is permitted for court costs or attorney's fees.

c. *FIP special needs classroom training.* Rescinded IAB 12/3/97, effective 2/1/98.

d. *Job Training Partnership Act.* Rescinded IAB 12/3/97, effective 2/1/98.

41.28(4) *Period of adjustment.* Rescinded IAB 11/1/00, effective 1/1/01.

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

441—41.29(239B) Composite FIP/SSI cases. When persons in the family investment program household, who would ordinarily be in the eligible group, are receiving supplemental security income benefits, the following rules shall apply.

41.29(1) *Pending SSI approval.* When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the family investment program grant pending approval of supplemental security income.

41.29(2) *Ownership of property.* When property is owned by both the supplemental security income beneficiary and the family investment program recipient, 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.

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

441—41.30(239B) Time limits.

41.30(1) *Sixty-month limit.* Assistance shall not be provided to a FIP applicant or recipient family that includes an adult who has received assistance for 60 calendar months under FIP or any state program in Iowa or in another state that is funded by the Temporary Assistance for Needy Families (TANF) block grant. The 60-month period need not be consecutive.

a. An "adult" is any person who is a parent of the FIP child in the home, the parent's spouse, or included as an optional member under subparagraphs 41.28(1)*"b"*(1), (2) and (3). In two-parent households or households that include a parent and a stepparent, the 60-month limit is determined when either a parent or stepparent has received assistance for 60 months.

b. "Assistance" shall include any month for which the adult receives a FIP grant. Assistance received for a partial month shall count as a full month.

41.30(2) *Determining number of months.*

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

(1) Assistance received even when the parent is excluded from the grant unless the parent, or both parents in a two-parent household, are supplemental security income (SSI) recipients.

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

b. When the parent, or both parents in a two-parent household, have received 60 months of FIP assistance and are subsequently approved for supplemental security income, FIP assistance for the children may be granted, if all other eligibility requirements are met.

c. When a minor parent and child receive FIP on the adult parent's case and the adult parent is no longer eligible due to the 60-month limit on FIP assistance, the minor parent may reapply for FIP as a minor parent living with a self-supporting parent.

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

(1) A month of suspension.

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

(3) Rescinded IAB 1/9/02, effective 3/1/02.

(4) Rescinded IAB 1/9/02, effective 3/1/02.

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

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

41.30(3) *Exception to the 60-month limit.* A family may receive FIP assistance for more than 60 months as defined in subrule 41.30(1) if the family qualifies for a hardship exemption as described in this subrule. "Hardship" is defined as a circumstance that is preventing the family from being self-supporting. However, the family's safety shall take precedence over the goal of self-sufficiency.

Families with an adult as defined in subrule 41.30(1) who is not a U.S. citizen, a battered alien as described at 41.23(4), or a qualified alien under 8 United States Code Section 1641 as described in subrule 41.23(5) are prohibited from receiving more than 60 months of FIP assistance. The family of an adult who is a nonqualified alien cannot meet the requirements of paragraph *"e"* since the department is precluded from using public funds to provide a nonqualified alien with family investment agreement or PROMISE JOBS services by Iowa Code sections 239B.8 and 239B.18 and rule 441—41.24(239B).

Eligibility for the hardship exemption shall be determined on an individual family basis. A hardship exemption shall not begin until the adult in the family has received at least 60 months of FIP assistance.

a. Hardship exemption criteria. Circumstances that may lead to a hardship exemption may include, but are not limited to, the following:

(1) Domestic violence. "Domestic violence" means that the family includes someone who has been battered or subjected to extreme cruelty. It includes:

1. Physical acts that resulted in, or threatened to result in, physical injury to the individual.
2. Sexual abuse.
3. Sexual activity involving a dependent child.
4. Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities.
5. Threats of, or attempts at, physical or sexual abuse.
6. Mental abuse.
7. Neglect or deprivation of medical care.

(2) Lack of employability.

(3) Lack of suitable child care as defined in 441—subrule 93.134(1).

(4) Chronic or recurring medical conditions or mental health issues, or an accident or disease, when verified by a professional. The applicant or recipient shall follow a treatment plan to address the condition or issue.

(5) Housing situations that make it difficult or impossible to work.

(6) Substance abuse issues. A family requesting a hardship exemption due to substance abuse shall be required to obtain clinical assessment and follow an intensive treatment plan.

(7) Having a child whose circumstances require the parent to be in the home. This may include, but is not limited to, a child as defined in rule 441—170.1(234) or a child receiving child welfare, juvenile court or juvenile justice services. The safety of the child shall take precedence over the goal of self-sufficiency.

(8) Rescinded IAB 1/8/03, effective 1/1/03.

(9) Other circumstances which prevent the family from being self-supporting.

b. Eligibility for a hardship exemption.

(1) Families may be eligible for a hardship exemption when circumstances prevent the family from being self-supporting. The hardship condition shall be a result of a past or current experience that is affecting the family's current functioning. Current experience may include fear of an event that is likely to occur in the future. The definition of the hardship barrier relies upon the impact of the circumstances upon the family's ability to leave FIP rather than the type of circumstances.

(2) Families determined eligible for more than 60 months of FIP shall make incremental steps toward overcoming the hardship and participate to their maximum potential in activities reasonably expected to result in self-sufficiency.

(3) Barriers to economic self-sufficiency that were known and existing before the family reached the 60-month limit shall not be considered as meeting eligibility criteria for hardship unless the individual complied with PROMISE JOBS activities offered to overcome that specific barrier.

c. Requesting a hardship exemption.

(1) Families with adults as defined in subrule 41.30(1) who have or are close to having received 60 months of FIP assistance may request a hardship exemption. Requests for the hardship exemption shall be made on Form 470-3826, Request for FIP Beyond 60 Months. In addition, families that have received FIP for 60 months shall complete Form 470-0462 or Form 470-0466 (Spanish), Health and Financial Support Application, as described at rule 441—40.22(239B) as a condition for regaining FIP eligibility. Failure to provide the required application within ten days from the date of the department's request shall result in denial of the hardship request.

(2) In families that request FIP beyond 60 months, all adults as defined in subrule 41.30(1) shall sign the request. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may sign the request.

(3) Requests for a hardship exemption shall not be accepted prior to the first day of the family's fifty-ninth month of FIP assistance. The date of the request shall be the date an identifiable Form 470-3826 is received in any department of human services or PROMISE JOBS office. An identifiable form is one that contains a legible name and address and that has been signed.

(4) To receive more than 60 months of FIP assistance, families must be eligible for a hardship exemption and meet all other FIP eligibility requirements.

(5) When an adult as defined in subrule 41.30(1) who has received FIP for 60 months joins a recipient family that has not received 60 months of FIP assistance, eligibility shall continue only if the recipient family submits Form 470-3826 and is approved for a hardship exemption as described in subrule 41.30(3) and meets all other FIP eligibility requirements.

(6) When an adult as defined in subrule 41.30(1) joins a recipient family that is in an exemption period, the current exemption period shall continue, if the recipient family continues to meet all other eligibility requirements, regardless of whether the joining adult has received FIP for 60 months.

(7) When two parents who are in a hardship exemption period separate, the remainder of the exemption period, if there is a need, shall follow the parent who retains the current FIP case.

d. Determination of hardship exemption.

(1) A determination on the request shall be made as soon as possible, but no later than 30 days following the date an identifiable Form 470-3826 is received in any department of human services or PROMISE JOBS office. A written notice of decision shall be issued to the family the next working day following a determination of eligibility or ineligibility for a hardship exemption.

The 30-day time standard shall apply except in unusual circumstances, such as when the department and the family have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

(2) When a Health and Financial Support Application is required to regain FIP eligibility, the 30-day time frame in rule 441—40.25(239B) shall apply.

(3) Income maintenance shall determine eligibility for a hardship exemption.

(4) The family shall provide supporting evidence of the hardship barrier and the impact of the barrier upon the family's ability to leave FIP. The department shall advise the applicant or recipient about how to obtain necessary documents. Upon request, the department shall provide reasonable assistance in obtaining supporting documents when the family is not reasonably able to obtain the documents. The type of supporting evidence is dependent upon the circumstance that creates the hardship barrier.

(5) Examples of types of supporting evidence may include:

1. Court, medical, criminal, child protective services, social services, psychological, or law enforcement records.

2. Statements from professionals or other individuals with knowledge of the hardship barrier.

3. Statements from vocational rehabilitation or other job training professionals.

4. Statements from individuals other than the applicant or recipient with knowledge of the hardship circumstances. Written statements from friends and relatives alone may not be sufficient to grant hardship status, but may be used to support other evidence.

5. Court, criminal, police records or statements from domestic violence counselors may be used to substantiate hardship. Living in a domestic violence shelter shall not automatically qualify an individual for a hardship exemption, but would be considered strong evidence.

6. Actively pursuing verification of a disability through the Social Security Administration may not be sufficient to grant hardship status, but may be used to support other evidence.

(6) The department shall notify the family in writing of additional information or verification that is required to verify the barrier and its impact upon the family's ability to leave FIP. The family shall be allowed ten days to supply the required information or verification. The ten-day period may be extended under the circumstances described in 441—subrule 40.24(1) or 441—paragraph 40.27(4)*"c."* Failure to supply the required information or verification, or refusal by the family to authorize the department to secure the information or verification from other sources, shall result in denial of the family's request for a hardship exemption.

(7) Rescinded IAB 12/12/01, effective 11/14/01.

(8) Rescinded IAB 12/12/01, effective 11/14/01.

(9) Recipients whose FIP assistance is canceled at the end of the sixtieth month shall be eligible for reinstatement as described at 441—subrule 40.22(5) when Form 470-3826 is received before the effective date of cancellation even if eligibility for a hardship exemption is not determined until on or after the effective date of cancellation.

(10) When Form 470-3826 is not received before the effective date of the FIP cancellation and a Health and Financial Support Application is required for the family to regain FIP eligibility, the effective date of assistance shall be no earlier than seven days from the date of application as described at rule 441—40.26(239B).

(11) Eligibility for a hardship exemption shall last for six consecutive calendar months. EXCEPTION: The six-month hardship exemption ends when FIP for the family is canceled for any reason and a Health and Financial Support Application is required for the family to regain FIP eligibility. In addition, when FIP eligibility depends on receiving a hardship exemption, the family shall submit a new Form 470-3826. A new hardship exemption determination shall be required prior to FIP approval.

(12) FIP received for a partial month of the six-month hardship exemption period shall count as a full month.

(13) There is no limit on the number of hardship exemptions a family may receive over time.

e. Six-month family investment agreement (FIA). Families who request a hardship exemption shall develop and sign a six-month family investment agreement (FIA) as defined at rule

441—93.109(239B) to address the circumstances that are creating the barrier. All adults as defined in subrule 41.30(1) shall sign the six-month FIA. The six-month FIA shall contain specific steps to enable the family to make incremental progress toward overcoming the barrier. Each subsequent hardship exemption shall require a new six-month FIA. Failure to develop or sign a six-month FIA shall result in denial of the family's hardship exemption request.

Families that request a hardship exemption shall be notified verbally and shall be hand-issued the notice of a scheduled appointment for orientation and FIA development. If the notice of appointment cannot be hand-issued, at least five working days shall be allowed from the date the notice is mailed for a participant to appear for the scheduled appointment for orientation and FIA development unless the applicant agrees to an appointment that is scheduled to take place in less than five working days.

Failure to attend a scheduled interview as required, except for reasons beyond the adult's control, shall result in a denial of the family's hardship exemption request. In two-parent families, both parents shall be required to participate in any scheduled interview. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may participate in the interview.

(1) PROMISE JOBS staff shall provide necessary supportive services as described in 441—Chapter 93 and shall monitor the six-month FIA. Periodic contacts shall be made with the family at least once a month. These contacts need not be in person. Time and attendance reports shall be required as specified at rule 441—93.135(239B).

(2) The six-month FIA shall be renegotiated and amended under the circumstances described at 441—subrule 93.109(2).

(3) Any family that has been granted a hardship exemption and that does not follow the terms of the family's six-month FIA will have chosen a limited benefit plan in accordance with 441—Chapters 41 and 93.

f. Any family that is denied a hardship exemption may appeal the decision as described in 441—Chapter 7.

This rule is intended to implement Iowa Code chapter 239B.

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CHAPTER 58
EMERGENCY ASSISTANCE

DIVISION I
DISASTER REIMBURSEMENT GRANT PROGRAM

PREAMBLE

This division implements a state program of financial assistance to meet disaster-related expenses, food-related costs, or serious needs of individuals or families who are adversely affected by a state-declared disaster emergency. The program is intended to meet needs that cannot be met by other means of financial assistance.

441—58.1(29C) Definitions.

"Emergency management coordinator" means the person appointed by the local emergency management commission pursuant to Iowa Code sections 29C.9 and 29C.10 to be responsible for development of the countywide emergency operations plan and for coordination and assistance to government officials when an emergency or disaster occurs.

"Household" means all adults and children who lived in the pre-disaster residence who request assistance, as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

"Necessary expense" means the cost associated with acquiring an item or items, obtaining a service, or paying for any other activity that meets a serious need.

"Safe, sanitary, and secure" means free from disaster-related health hazards.

"Serious need" means the item or service is essential to the household to prevent, mitigate, or overcome a disaster-related hardship, injury, or adverse condition.

441—58.2(29C) Program implementation. The disaster reimbursement grant program shall be implemented when the governor issues a declaration of a state of disaster emergency and shall be in effect only in those counties named in the declaration. Assistance shall be provided for a period not to exceed 120 days from the date of declaration.

441—58.3(29C) Application for assistance. To request reimbursement for disaster-related expenses, the household shall complete Form 470-4448, Individual Disaster Assistance Application, and submit it within 45 days of the disaster declaration to the county emergency management coordinator along with receipts for the claimed expenses.

58.3(1) Application forms are available from county emergency management coordinators and local offices of the department of human services, as well as the Internet Web site of the department at www.dhs.iowa.gov.

58.3(2) The application includes:

a. A declaration of the household's annual income.

b. A release of confidential information to personnel involved in administering the program.

c. A certification of the accuracy of the information provided.

d. An assurance that the household had no insurance coverage for claimed items.

e. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to local community development groups and charities, the Small Business Administration, or the Federal Emergency Management Administration.

441—58.4(29C) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.4(1) The household's residence was located in the area identified in the disaster declaration during the designated incident period and the household verifies occupancy at that residence.

58.4(2) Household members are citizens of the United States or are legally residing in the United States.

58.4(3) The household's self-declared annual income is at or less than 200 percent of the federal poverty level for a household of that size.

a. Poverty guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income.

58.4(4) The household has disaster-related expenses or serious needs that are not covered by insurance.

58.4(5) The household has not previously received assistance from this program or another program for the same loss.

441—58.5(29C) Eligible categories of assistance. The maximum assistance available to a household in a single disaster is $5,000. Reimbursement is available under the program for the following disaster-related expenses:

58.5(1) Reimbursement may be issued for personal property, including repair or replacement of the following items, based on the item's condition:

a. Kitchen items, up to a maximum of $560, including:

(1) Equipment and furnishings, up to a maximum of $560.

(2) Food, up to a maximum of $50 for one person plus $25 for each additional person in the household.

b. Personal hygiene items, up to a maximum of $30 per person and $150 per household.

c. Clothing and bedroom furnishings, up to a maximum of $875, including:

(1) Mattress, box spring, frame, and storage containers, up to a maximum of $250 per person.

(2) Clothing, up to a maximum of $145 per person.

d. Other items, including:

(1) Infant car seat, up to a maximum of $40.

(2) Dehumidifier, up to a maximum of $150.

(3) Sump pump (in a flood event only), up to a maximum of $200 installed.

(4) Electrical or mechanical repairs, up to a maximum of $300.

(5) Water heater, up to a maximum of $425 installed.

(6) Vehicle repair, up to a maximum of $500.

(7) Heating and air-conditioning systems, up to a maximum of $2,100 installed. Air conditioning is covered only with proof of medical necessity.

58.5(2) Reimbursement may be issued for home repair as needed to make the home safe, sanitary, and secure, up to a maximum of $1,000. Assistance will be denied if preexisting conditions are the cause of the damage. Reimbursement may be authorized for the repair of:

a. Structural components, such as the foundation and roof.

b. Floors, walls, ceilings, doors, windows, and carpeting of essential interior living space that was occupied at the time of the disaster.

58.5(3) Reimbursement may be issued for temporary housing assistance, up to a limit of $50 per day, for lodging at a licensed establishment, such as a hotel or motel, if the household's home is destroyed, uninhabitable, inaccessible, or unavailable to the household.

441—58.6(29C) Eligibility determination and payment.

58.6(1) The county emergency management coordinator or designee shall:

a. Certify the household's residence and disaster-related expenses; and

b. Submit the household's application form to the DHS Division of Results-Based Accountability, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The envelope shall be marked "DRGP application."

58.6(2) Designated disaster staff in the department of human services shall:

a. Review the application.

b. Determine eligibility and the amount of payment.

c. Notify the applicant household of the eligibility decision.

d. Authorize payment to an eligible household.

441—58.7(29C) Contested cases.

58.7(1) *Reconsideration.* The household may request reconsideration of the department's decisions regarding eligibility and the amount of reimbursement awarded.

a. To request reconsideration, the household shall submit a written request to the DHS Division of Results-Based Accountability, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the department's letter notifying the household of its decision.

b. The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days of receipt of the request.

58.7(2) *Appeal.* The household may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency.

441—58.8(29C) Discontinuance of program.

58.8(1) *Deferral to federal assistance.* Upon declaration of a disaster by the President of the United States under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Sections 5121 to 5206, the state disaster reimbursement grant program administered under this chapter shall be discontinued in the geographic area included in the presidential declaration. Upon issuance of the presidential declaration:

a. No more applications shall be accepted.

b. Any applications that are in process but are not yet approved shall be denied.

c. Persons seeking assistance under this program shall be advised to apply for federal disaster assistance.

58.8(2) *Exhaustion of funds.* The program shall be discontinued when funds available for the program have been exhausted. To ensure equitable treatment, applications for assistance shall be approved on a first-come, first-served basis until all funds have been depleted. "First-come, first-served" is determined by the date the application is approved for payment.

a. *Partial payment.* Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

b. *Reserved funds.* A portion of allocated funds shall be reserved for final appeal decisions reversing the department's denial that are received after funds for the program have been awarded.

c. *Untimely applications.* Applications received after the program is discontinued shall be denied.

These rules are intended to implement Iowa Code chapter 29C as amended by 2007 Iowa Acts, House File 896.

441—58.9 to **58.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—EMERGENCY ASSISTANCE
[Prior to 10/13/93, 441—58.1 to 58.11]

PREAMBLE

This division implements the emergency assistance program, which is designed to assist families who face homelessness or other types of emergencies. The purpose of the program is to provide financial assistance on behalf of a needy child or children and any other members of the household to meet needs that have been caused by an emergency and that the household is unable to fulfill. The program provides a means to deal with financial situations that threaten the health and well-being of an eligible family. It

is intended to meet an immediate need that would not otherwise be met. Assistance shall not be denied even if the assistance payment will provide only a temporary resolution to an ongoing problem.

441—58.21(234) Definitions.

"Child" means a person under age 18 who has not reached majority through marriage. Emergency assistance shall continue through the month in which the child turns 18. "Child" also means a person aged 18 who is a full-time student in a secondary school or in the equivalent level of vocational or technical training, who is expected to complete the program before reaching 19 and who has not reached majority through marriage. Emergency assistance shall continue through the month in which school or training is completed. In those cases in which the child reaches 19 in the same month as the child completes school or training, emergency assistance shall continue through the month of the child's nineteenth birthday.

"Destitution" means lack of shelter because of an emergency situation.

"Emergency" means, for the purposes of this program, a situation that threatens the family's living arrangements or will result in destitution unless immediate financial assistance is provided.

"Homelessness" means the lack of a fixed and regular nighttime residence or a residence which is:

1. A supervised shelter designed to provide temporary accommodations (such as a welfare hotel or congregate shelter).
2. A halfway house or similar institution that provides temporary residence for persons intended to be institutionalized.
3. A temporary accommodation in the residence of another person.
4. A place not designed for or ordinarily used as a regular sleeping accommodation for human beings (a hallway, a bus station, a lobby or similar places).

"Household" means, for the purposes of determining income, resources and household size, the following persons living in the household. The:

1. Applicant.
2. Applicant's legal or common-law spouse.
3. Applicant's child(ren).
4. Legal or biological parent of the child(ren).
5. Applicant's child(ren)'s sibling(s) of whole or half blood or adoptive.
6. Applicant and any child under the care of the applicant when the applicant meets the definition of "relative" as defined at 441—paragraph 41.22(3)*"a."*

Persons temporarily not living with the household at the time of the interview shall not be considered members of the household.

441—58.22(234) General provisions. Emergency assistance is available to families with children (including migrant families), who are faced with a crisis situation causing a threat to the families' living arrangements. Emergency assistance is also available to children who are living on their own but who have been living, within the six months prior to applying for the program, with a relative as defined at 441—paragraph 41.22(3)*"a,"* provided an emergency exists. The program is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expended prior to the end of the fiscal year, the program will be discontinued until funding is received for the next fiscal year in accordance with rule 441—58.30(234). Emergency assistance is not intended as a substitute for regular assistance grants from an ongoing program but is intended to be the program of last resort when no other sources of assistance are available. Emergency assistance shall also be provided for that portion of an emergency need not covered by benefits from other programs due to those programs' limitations.

441—58.23(234) Application procedures.

58.23(1) *Date of application.* The date of application shall be determined by the date a signed Form 470-2762, Emergency Assistance Application, is received in any local office or department-designated site. 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. To be considered valid, the application must contain a legible name and address and must be signed.

a. The emergency assistance case record must contain a completed application for each 30-day eligibility period. Whenever an initial application is denied, withdrawn, or more than 30 days old, the household shall be required to complete a new application form.

b. At least one face-to-face interview shall be conducted before approval of the application. The face-to-face interview may be held in the county office, at a department-designated site, or in the applicant's home.

(1) The applicant may appoint an authorized representative to attend the interview if the applicant is unable to attend. The authorized representative must be a person knowledgeable of the household's circumstances.

(2) If the applicant or authorized representative fails to attend the required interview, the application shall be denied.

(3) When it is impossible to hold a face-to-face interview within the ten-day time frame for processing applications as described at 58.23(2), the county office or department designee may waive the face-to-face interview and hold a telephone conference instead.

c. The household's declaration shall be accepted except when verification is required by these rules or information appears questionable. The decision with respect to eligibility shall be based largely on information provided by the household.

58.23(2) *Time limits.* Applications shall be processed within ten calendar days from the date of receipt to resolve the household's emergency. The ten-day time standard for approval shall apply except in unusual circumstances, such as when the department and the household have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expires; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

58.23(3) *Additional information required.* When additional information or verification is required, the household shall be requested in writing to provide that information within five calendar days. The written request shall also inform the household that failure to provide the required information within five calendar days or failure to authorize the local office to secure the information from other sources will result in denial of the application. The five-day period begins the day after the date the local office issues the written request.

The five-day time limit to provide additional information shall be extended if the household is unable to obtain the information by the requested date due to circumstances beyond the household's control, such as illness, or the source who is to provide the verification causes a delay, or due to emergencies like fire, flood, etc.

58.23(4) *Basis for decision on application.* The decision with respect to eligibility for emergency assistance shall be made based on the household's circumstances as they exist on the date of the interview.

58.23(5) *Subsequent requests for assistance.* Except for verifying that an emergency exists and applying for benefits from LIHEAP, general relief, or veterans affairs, the household is not required to reverify eligibility factors for approval of additional emergency assistance payment requests made within the 30-day authorization period. The time limits for processing additional requests for assistance remain the same as initial requests.

441—58.24(234) Eligibility requirements. A household, including a migrant household, shall be eligible for emergency assistance when the following conditions are met:

58.24(1) *Existence of an emergency.* An emergency shall exist, limited to eviction, foreclosure, utility shutoff, fuel shortage, loss of heating energy supply or equipment, or homelessness. An emergency does not exist for gas or electricity shutoff when a household is approved for LIHEAP and is protected by the moratorium on disconnection between November 1 and March 31.

a. An emergency also exists when there is a potential for eviction, foreclosure, utility shutoff, fuel shortage, loss of heating energy supply or equipment, or homelessness. For a household to qualify for emergency assistance, the potential emergency shall be expected to happen within the month of application or the following month.

b. The household shall be required to provide proof that an emergency exists. Acceptable verification includes, but is not limited to:

(1) An eviction notice.

(2) A foreclosure notice.

(3) A utility shutoff notice.

(4) A written statement to verify homelessness from the party or shelter where the household is staying.

(5) Other written documentation, as needed.

c. If the amount necessary to resolve the emergency exceeds the $500 maximum payment of the emergency assistance program, the applicant must be able to verify the ability to pay the difference from other resources, or the emergency assistance application shall be denied.

58.24(2) *Income and resources.* The household's available income and resources shall be within the limits as defined at rules 441—58.26(234) and 441—58.27(234).

58.24(3) *Receipt of assistance.* The household shall not have received assistance in Iowa from the program within one year prior to the date the first payment is authorized. The 12-month period begins on the date the first payment is approved. If any household member received emergency assistance within the past 12 months, the entire household is ineligible.

58.24(4) *Child in household.* The household shall contain at least one child who is living with the household.

58.24(5) *Child in need.* To be considered in need, the child shall be destitute or be without living arrangements unless assistance is provided.

a. The child is not in destitution or need if a member of the household (including the child aged 16 or older, who is not attending elementary, secondary or the equivalent level of vocational or technical school full-time) without identified problems with participation of a temporary or incidental nature as described at rule 441—93.133(239B) or barriers to participation as described at rule 441—93.134(239B), in the 30 days before application or subsequent request for emergency assistance:

(1) Refused a job offer or training for employment.

(2) Was dismissed from a job due to the member's own actions which meet the definition of "misconduct" in rule 441—93.132(239B).

(3) Quit employment.

(4) Reduced earnings.

(5) Began participation in a strike.

(6) Chose a limited benefit plan.

b. The 30-day period of ineligibility shall begin the day after the household member reduced earnings or was dismissed from a job.

(1) When a member quits a job, participates in a strike, or refuses employment, each day the job or offer for employment remains available or the household member participates in a strike is considered a day of job refusal. In these situations, the 30-day period of ineligibility shall begin the day the person returns to the job or accepts the job offer or the day after the job or offer for employment is no longer available.

(2) When a person chooses a first limited benefit plan, each day the person fails to reconsider by contacting IM or PROMISE JOBS counts as a day of refusal. The day the person reconsiders begins the 30-day period of ineligibility. When a person chooses a subsequent limited benefit plan, the 30-day ineligibility period shall begin the day after the date on the notice of decision establishing the person's limited benefit plan.

c. Whenever the household is determined to have good cause for refusing employment, quitting employment, or reducing earnings for the family investment program, no further determination is required for the emergency assistance program. Verification of the circumstances resulting in refusal, loss, or reduction of employment is not required unless information provided appears questionable.

58.24(6) *Application for other benefits.* The household shall apply for and accept benefits for which the household may be qualified from the energy assistance, county general relief and veteran's affairs programs before approval for emergency assistance.

a. Verification that the household has met the requirements of first seeking assistance from these programs shall be documented on Form 470-2804, Disposition of Application for Other Benefits. A separate form shall be completed for each program to which the applicant is referred.

b. Emergency assistance benefits shall not be approved while an application for other benefits is pending.

c. If a household is denied general relief within 30 days before emergency assistance application, and the denial was due to failure to work off past general relief assistance, emergency assistance shall also be denied.

58.24(7) *Citizenship and alienage.* The household shall contain at least one child who meets citizenship and alienage requirements as defined at 441—subrule 41.23(5). The household shall verify the alien status of at least one child to determine if the household contains an eligible child. There is no need to reverify the alien status unless it is subject to change.

58.24(8) *Utility service connection.* Applicants shall provide verification from the utility company that all requirements to provide service have been met before payment to the utility company for utility deposits for new or reconnected service will be approved. When a household applies for emergency assistance due to a disconnect notice, the household must provide verification from the utility company that the applicant either has signed a payment plan or is not eligible for a payment plan. Failure to provide this verification shall result in denial of the emergency assistance application.

441—58.25(234) Determination of need. Needs covered are limited to rent payments, house payments (including property taxes and homeowner's insurance if included in the house payment), rent and utility deposits, utilities, and purchase, repair, or rental of heating equipment. Utilities shall include heat (electric, gas, fuel oil, wood, etc.), lights, water, sewer, and garbage, but shall not include telephone. Heating equipment shall include, but is not limited to, furnace, space heater, kerosene heater, wood stove, etc. Air conditioners shall not be funded.

441—58.26(234) Income. The household's nonexempt gross income, with the exception of the deductions specified at subrule 58.26(2), shall not exceed 100 percent of the poverty level of the Office of Management and Budget (OMB). Changes in OMB's poverty guidelines shall go into effect the second month after the changes are published. When determining income and household size, the household shall be determined as defined in rule 441—58.21(234). All income reported by the household shall be verified.

58.26(1) *Income considered.* Income considered shall include, but is not limited to, all gross income received or reasonably anticipated to be received by the household in the month of application, such as the family investment program (FIP) grant, veteran's pension, social security benefits, supplemental security income (SSI), job insurance benefits, child support income, alimony, workers' compensation benefits, cash payments from any of the DHS diversion programs, adoption subsidies, foster care payments, retroactive payments from any source, lump-sum income, earnings from on-the-job training, work-study income, income tax refunds (if received in the month of application), loans and grants available for living expenses (including unprorated gross educational moneys received in the month of application that are not earmarked), interest income (if received in the month of application), maintenance payments, Volunteers in Service to America (VISTA) payments, gifts, refunds from rental and utility deposits, earned income credit, self-employment income (net profit expected to be received in the month of application, not annualized), earnings from employment, and earnings of a child aged 16 or over who is not attending elementary, secondary or the equivalent of vocational or technical school full-time. The following deductions shall be allowed from earned income:

a. The actual, verified amount of employment-related, nonreimbursed child care expenses incurred or reasonably expected to be incurred in the month of application. A child care deduction shall also be allowed for VISTA volunteers.

b. Allowable business expenses in a self-employment enterprise, as defined at 441—subrule 41.27(2).

58.26(2) *Exempt income.* Exempt income shall include reimbursements; earned as well as unearned income in-kind; vendor payments; earnings of a child under age 16, or age 16 or older, if the child is attending elementary, secondary or the equivalent level of vocational or technical training school full-time; training allowances designated for a specific purpose (such as those issued by the Workforce Investment Act, PROMISE JOBS, Vocational Rehabilitation Services, Food Stamp Employment and Training program, etc.); that amount of the lump sum expended for legal, medical or burial expenses; and legally obligated moneys. Legally obligated money means money that is otherwise payable to the household, but which is diverted by the provider of the payment to a third party for a household expense without the household's consent. Examples of legally obligated moneys are the amount withheld from job insurance benefits to recover an overpayment or for child support for a child not living with the household; or the amount of child support withheld from earnings for a child not living with the household.

58.26(3) *Exempt as income and resources.* Deposits into an individual development account (IDA) are exempt. The amount of the deposit is exempt as income and shall not be used in the 100 percent of poverty level eligibility test. The deposit must be deducted from nonexempt earned and unearned income that the client receives in the month of application, provided the deposit is made in the month of application. To allow a deduction, verification of the deposit must be provided within five calendar days as described in subrule 58.23(3). The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions described in 58.26(1)*"a"* and *"b"* shall be applied to earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. If the client has both earned and unearned income, the amount deposited into the IDA shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

441—58.27(234) Resources. The household's liquid resources shall not exceed $1000. Liquid resources are limited to cash on hand, money in checking, savings or credit union accounts, and savings certificates, with the following exceptions: The balance in an individual development account (IDA), including interest earned on the IDA, is exempt as a resource. Income in any given month is not counted as a resource in the same month. When liquid resources are owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the resources. When determining countable resources, the household shall be determined as defined in rule 441—58.21(234). All other resources are exempt. The household's declaration of the amount of liquid resources shall be accepted unless the declaration appears questionable or the amount declared is close to the resource limitation. The household is not required to apply its available resources toward the emergency as long as the resources are within the prescribed limits.

441—58.28(234) Payment.

58.28(1) *Maximum payment.* The maximum payment shall not exceed $500 per authorization period. This amount can be applied to a single need or to several needs, not to exceed the maximum amount. Payment shall be issued in the amount of the need, not to exceed $500. When the emergency need is greater than $500 (or more than the maximum amount still available to the applicant, if a subsequent request is being made), emergency assistance shall be approved only when the applicant provides verification that either:

a. The vendor will accept payment of up to $500 (or the maximum amount available) to resolve the emergency, or

b. Another source will supply the amount needed over and above the emergency assistance payment amount.

58.28(2) *Vendor payment.* Payment shall be issued directly to the vendor in form of a state warrant unless the vendor is a state employee.

a. Vendors shall be required to complete Form 470-2781, Approval for Vendor Payment, before payment shall be issued. The vendor shall provide a copy of IRS Form W-9, Request for Taxpayer

Identification Number and Certification, if necessary, to resolve vendor name or vendor number discrepancies.

b. Form 470-2781 shall also be used to notify the vendor of the amount approved for payment. Payment is owed to the vendor in the amount approved on Form 470-2781 even if emergency assistance funds are exhausted or emergency assistance eligibility is found not to exist when system entries are made. If the household provides verification of an emergency item and the cost of the item on another document, there is no need to send Form 470-2781 to the vendor to reverify the information.

c. Payment to state employees shall be made as follows:

(1) If the emergency assistance payment is for a service, such as furnace repair, the payment is included in the vendor's regular state paycheck as extra pay.

(2) If the emergency assistance payment is for goods, such as rent, rent deposit, or purchase of heating equipment, payment to the vendor is processed in the form of a travel voucher.

58.28(3) *Authorization period.* The authorization period is limited to a period of 30 consecutive days in a 12-month period, and payment shall be approved if the request is received within that period. The 30-day authorization period begins on the date the first emergency assistance payment is approved for an eligible household. The household may be eligible for more than one payment as long as the total amount of all payments does not exceed the maximum amount and all requests for additional payments are received within the period of 30 consecutive days. Any portion of the maximum payment amount not used in the 30-day authorization period cannot be carried forward to a future authorization period.

58.28(4) *Returned warrants and donations to emergency assistance.* Any refunds of emergency assistance money shall be returned to the DHS county office. Returned funds shall be deposited back into the emergency assistance account.

a. When an emergency assistance client or vendor returns the emergency assistance warrant or returns an emergency assistance payment in the form of a money order, personal check, or cash, the county office shall accept the repayment and complete Form 470-0009, Official Receipt.

b. The department may receive refunds of rent deposits that were paid on behalf of emergency assistance clients by a combination of assistance from the emergency assistance program and other persons or organizations.

c. Donations shall be handled in the same manner as refunds and shall be deposited into the emergency assistance account.

58.28(5) *Misdirected warrants.* Replacement of an emergency assistance warrant does not apply when the warrant is inadvertently delivered to the emergency assistance client rather than the vendor, and the client endorses it with the client's own name and cashes it. This is not an overpayment, because the warrant is issued on behalf of the same client who cashed it. It is up to the vendor to pursue the matter with the post office, the place of business that cashed the warrant, or the client and to work out possible repayment arrangements.

441—58.29(234) Notification and appeals. All emergency assistance households shall be given notice with respect to the decision on their application for assistance in accordance with 441—subrule 7.7(1). Households have the right to appeal the department's decision in accordance with rule 441—7.5(17A).

441—58.30(234) Discontinuance of the emergency assistance program. The program shall be discontinued when funds have been exhausted. To ensure equitable treatment, applications for emergency assistance shall be approved on a first-come, first-served basis until all funds have been depleted. First-come, first-served is determined by the date the application is approved for payment and entered into the emergency assistance computer system.

58.30(1) *Partial payment.* Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

58.30(2) *Reserved funds.* A portion of yearly emergency assistance funds shall be reserved for final appeal decisions reversing the department's denial that are received after funds for the program have run out.

58.30(3) *Untimely applications.* Emergency assistance applications received after the program is discontinued for the year and more than five working days before the program begins again the next year shall be denied.

441—58.31(234) Special information received from emergency assistance clients. Rescinded IAB 10/2/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 234.6.

441—58.32 to **58.40** Reserved.

DIVISION III
TEMPORARY MEASURES RELATED TO DISASTERS

441—58.41(217) Purpose. The rules in this division are intended to allow the department to deliver services more effectively during or following a disaster emergency declared by state or federal officials. These rules temporarily supersede departmental rules that would otherwise apply, with the primary purpose of reducing barriers to accessing and receiving services that may result from the emergency. The rules shall be tailored to meet special circumstances that arise from a specific disaster emergency and shall be time-limited.

This rule is intended to implement Iowa Code section 217.6.

441—58.42(234,237A,239B,249,249A,249J,514I) Extension of scheduled reporting and review requirements. Normal scheduled reporting, review, recertification, redetermination, or similar requirements related to continued eligibility are amended as follows:

58.42(1) *Scheduled actions due in June 2008.* For the month of June 2008, no quarterly report, six-month or 12-month review, or similar recertification or redetermination normally required under the following chapters shall be required of households residing in the most affected counties during the month. For all programs except food assistance, the designated counties are Black Hawk, Bremer, Butler, Johnson, and Linn.

1. 441—Chapter 40 (family investment program);
2. 441—Chapter 50 (state supplementary assistance);
3. 441—Chapter 65 (food assistance);
4. 441—Chapter 75, 76, or 83 (medical assistance and family planning waiver);
5. 441—Chapter 86 (HAWK-I);
6. 441—Chapter 92 (IowaCare); or
7. 441—Chapter 170 (child care assistance).

58.42(2) *Scheduled actions due in July and August 2008.* For the months of July and August 2008, no quarterly report, six-month or 12-month review, or similar recertification or redetermination normally required under the following chapters shall be required of households residing in any county of the state:

1. 441—Chapter 40 (family investment program);
2. 441—Chapter 50 (state supplementary assistance);
3. 441—Chapter 65 (food assistance);
4. 441—Chapter 75, 76, or 83 (medical assistance and family planning waiver);
5. 441—Chapter 86 (HAWK-I);
6. 441—Chapter 92 (IowaCare); or
7. 441—Chapter 170 (child care assistance).

58.42(3) *Next scheduled action due.* For those households affected under subrules 58.42(1) and 58.42(2), the next report, review, recertification, or redetermination shall be scheduled as if the action due in June, July, or August 2008 had occurred. For example, if a six-month review was to have occurred in June 2008, the next review will be due in December 2008. Likewise, if a 12-month recertification was due in July 2008, the next recertification will be due in July 2009.

58.42(4) *Continuing to report and act on changes.* Other than as provided by this rule, households shall continue to comply with program requirements for reporting changes in circumstances. Good cause

provisions for not reporting changes timely shall apply as provided by existing rules. The department shall continue to act on all changes reported or otherwise known to the department that may affect eligibility or benefits during the extended reporting, review, recertification and redetermination periods provided under this rule.

This rule is intended to implement Iowa Code chapters 234, 237A, 239B, 249, 249A, 249J, and 514I.

441—58.43(237A) Need for child care services. State child care assistance eligibility requirements concerning need for service in rule 441—170.2(237A,239B) shall be held in abeyance for households residing in governor-declared disaster counties during the months of June, July, and August 2008. Households in those counties that previously met the requirement shall be considered to continue to meet the requirement for those three months if the disaster and ensuing recovery temporarily prevent the household from otherwise meeting this requirement.

This rule is intended to implement Iowa Code section 237A.13.

441—58.44(249A,249J,514I) Premium payments. Individuals residing in any Iowa county declared by the governor to be a disaster area who would otherwise have their assistance under 441—Chapter 75 (medical assistance), 441—Chapter 86 (HAWK-I), or 441—Chapter 92 (IowaCare) canceled for failure to make a premium payment in the months of June or July 2008 shall not have their assistance canceled for this reason.

This rule is intended to implement Iowa Code chapters 249A, 249J, and 514I.

441—58.45(249A) Citizenship and identity. Citizenship and identity requirements under 441—Chapter 75 for medical assistance applicants shall be held in abeyance for the months of June, July, and August 2008, for individuals residing in counties declared disaster areas by the governor as provided in this rule.

58.45(1) An affidavit may be used to establish both citizenship and identity when other forms of verification are not available and the department is unable to obtain verification through a match with vital records maintained by the department of public health.

58.45(2) An individual approved for medical assistance under this rule shall be granted a certification period of only three months. At the end of the three-month period, the individual shall be required to provide documentation of citizenship and identity as otherwise required under 441—Chapter 75 to continue eligibility.

This rule is intended to implement Iowa Code chapter 249A.

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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 under the age of 18 living in a court-approved subsidized guardianship home.* Medical assistance will be available to individuals under the age of 18 living in a court-approved subsidized guardianship home under this subrule provided they are not otherwise eligible for medical assistance under a category for which federal financial participation is available.

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 of Medicaid-eligible mothers.* 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. Eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child lives with the mother and the mother remains eligible for Medicaid or would be eligible if she were still pregnant or qualified for emergency services for childbirth.

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 185 percent of the federal poverty level for pregnant women when establishing initial eligibility under these provisions and for infants (under one year of age) when establishing initial and ongoing eligibility. Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. Family income is the income remaining after disregards and deductions have been applied in accordance with the provisions of rule 441—75.57(249A).

In determining eligibility for pregnant women and infants, after the aforementioned disregards and deductions have been applied, an additional disregard equal to 15 percent of the applicable federal poverty level shall be applied to the family's income.

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with 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 the following percentage of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved:

(1) 85 percent effective January 1, 1989.

(2) 90 percent effective January 1, 1990.

(3) 100 percent effective January 1, 1991, and thereafter.

(4) Rescinded IAB 1/9/91, effective 1/1/91.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

c. The effective date of eligibility is the first of the month after the month of decision.

75.1(30) *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. 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 the following percentage of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved:

(1) 110 percent effective January 1, 1993.

(2) 120 percent effective January 1, 1995, and thereafter.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

c. The amount of 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.

(4) Rehabilitative treatment services pursuant to 441—Chapter 185.

i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy 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 twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

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 used to assess premiums will be adjusted annually on April 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	$29
180% of Federal Poverty Level	$53
220% of Federal Poverty Level	$80
240% of Federal Poverty Level	$110
262% of Federal Poverty Level	$140
318% of Federal Poverty Level	$170
342% of Federal Poverty Level	$200
390% of Federal Poverty Level	$230
425% of Federal Poverty Level	$260
460% of Federal Poverty Level	$291
500% of Federal Poverty Level	$323
548% of Federal Poverty Level	$354
607% of Federal Poverty Level	$392
666% of Federal Poverty Level	$430
725% of Federal Poverty Level	$471
824% of Federal Poverty Level	$535

(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 rule, 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.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

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) When a medical resource may be obtained by filing a claim or an application and cooperating in the processing of that claim or application, that resource shall be considered to be reasonably available, unless good cause for failure to obtain that resource is determined to exist.

a. The member, or one acting on the member's behalf, shall file a claim or submit an application for any reasonably available medical resource, and shall also cooperate in the processing of the claim or application. Failure to do so without good cause shall result in the termination of medical assistance benefits.

b. 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. 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(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) 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.

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.

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 precertified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules 191—Chapter 72. A person 65 years of age or older who is either the beneficiary of a certified long-term care policy or enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 72 and who is eligible for medical assistance under 75.1(3), 75.1(4), 75.1(5), 75.1(6), 75.1(7), 75.1(9), 75.1(12), 75.1(13), 75.1(17), 75.1(18), 75.1(23) or 75.1(27) except for excess resources may be eligible for medical assistance under this subrule if the excess resources causing ineligibility under the listed coverage groups do not exceed the "asset adjustment" provided in this subrule. "Asset adjustment" shall mean a $1 disregard of resources for each $1 that has been paid out under the person's long-term care policy for qualified Medicaid long-term care services.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4 and chapter 249G.

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 in 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 as defined in subrule 75.11(1) residing in the United States prior to August 22, 1996.

(3) A qualified alien who entered the United States on or after August 22, 1996, and who is:

- A refugee who is admitted to the United States under Section 207 of the Immigration and Nationality Act;
- Granted asylum under Section 208 of the Immigration and Nationality Act;
- An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act; or
- A veteran with a discharge characterized as an honorable discharge and not on account of alienage, an alien who is on active duty in the Armed Forces of the United States other than active duty for training, or the veteran's spouse or unmarried dependent child.

(4) A qualified alien who entered the United States on or after August 22, 1996, and who has resided in the United States for a period of at least five years.

b. As a condition of eligibility, each recipient shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the recipient's citizenship or alien status. The form shall be signed by the recipient, or when the recipient is incompetent or deceased, someone acting responsibly on the recipient's behalf. When both parents are in the home, both shall sign the form. An adult recipient shall sign the form for dependent children. 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. As a condition of continued eligibility, recipients of SSI-related Medicaid not actually receiving SSI who have been continuous recipients 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 who attest that they are citizens or nationals of the United States 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 who attests to status as a citizen or national of the United States 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.

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

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
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, applicants and recipients of Medicaid in households with an absent parent shall cooperate in obtaining medical support for the applicant or recipient as well as for any other person in the household for whom Medicaid is requested and for whom the person 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 recipient 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 recipient 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 recipient:

(1) Appearing at the county office 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 recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. The applicant or recipient shall cooperate with the county office 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 recipient 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 in the county office shall make the determination of whether or not the client has cooperated.

75.14(2) Failure of the applicant or recipient 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 applicant for or recipient of Medicaid 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 applicant for or recipient of Medicaid 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 recipient's own behalf or on behalf of any other family member for whom the applicant or recipient is applying. An assignment is effective the same date the county office enters the eligibility information 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 recipients. The county office 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 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.

"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 recipient 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 county office shall determine that cooperation is against the child's best interest when the applicant's or recipient's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical 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 county office shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the county office 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 recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm 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 applicant for or recipient of Medicaid 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 county office shall notify the applicant or recipient on 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. One copy of this form shall be given to the applicant or recipient and one copy shall be signed by the applicant or recipient and the worker and filed in the case record.

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

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

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

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

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

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

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

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

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

(3) Informs the applicant or recipient that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the county office 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 recipient that the child support recovery unit may review the county office's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

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

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

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

(2) Corroborate the good cause circumstances.

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

75.14(10) Determination of good cause. The county office shall determine whether good cause exists for each applicant for or recipient of the Medicaid program who claims to have good cause.

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

(1) Be in writing.

(2) Contain the county office'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 county office may exceed this time standard only when:

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

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

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

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

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

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

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

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

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

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

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

h. The county office shall:

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

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

75.14(11) Proof of good cause. The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the county office determines the applicant or recipient requires additional time because of the difficulty in obtaining the corroborative evidence, the county office shall allow a reasonable additional period of time 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 recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the county office wishes to request additional corroborative evidence which is needed to permit a good cause determination, the county office shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the county office shall:

(1) Advise the applicant or recipient how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The county office 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 recipient 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 county office may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the county office determines that it is necessary, it 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 county office 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) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or

putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the county office makes a determination that good cause exists, it 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. Prior to making the determination, the child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the county office shall consider any recommendations from the unit.

b. The determination shall be in writing, contain the county office's findings and basis or the determination, and be entered into the case record.

c. When the county office excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, it shall notify the applicant or recipient 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.

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 is a veteran or a surviving spouse of a veteran who receives a pension subject to limitation of $90 after the month of entry pursuant to 38 U.S.C. Section 5503, the veteran or the surviving spouse of a veteran shall retain $90 from the veteran's pension beginning the month after entry to a medical institution. The $90 allowance from a veteran's pension is in addition to the $50 allowance from any other income.

(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. 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.

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) Persons who may be excluded from the eligible group in determining FIP-related Medicaid eligibility. Rescinded IAB 10/8/97, effective 12/1/97.

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 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 directly.

75.21(1) *Condition of eligibility.* The recipient, or a person acting on the recipient's behalf, shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of group health insurance. Persons who are eligible to enroll in a group health insurance plan which the department has determined is cost-effective, and who are otherwise eligible for Medicaid, shall apply for enrollment in the plan as a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid-eligible persons through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

When a parent fails to provide information necessary to determine availability and cost-effectiveness of group health insurance, fails to enroll in a group health insurance plan that has been determined cost-effective, or disenrolls from a group health insurance plan the department has determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

a. There was a serious illness or death of the parent or a member of the parent's family.

b. There was a family emergency or household disaster, such as a fire, flood, or tornado.

c. The parent offers a good cause beyond the parent's control.

d. 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.

Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of the spouse of the employed person shall not be terminated due to the employed person's failure to cooperate when the spouse cannot enroll in the plan independently of the employed person.

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) *Non-employer related health insurance plans.* Participation in a health insurance plan that is not group health insurance as defined in rule 441—75.25(249A) is not a condition of Medicaid eligibility.

75.21(3) *Cost-effectiveness.* Cost-effectiveness 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 an insurance plan for those services. When determining the cost-effectiveness of the insurance plan, the following data shall be considered:

a. The cost of the insurance premium, coinsurance and deductibles. An employer-related group health insurance plan that provides major medical coverage and costs $50 or less per month shall be determined cost-effective when establishing eligibility for one-person Medicaid-eligible households. An employer-related group health insurance plan that provides major medical coverage and costs $100 or less per month shall be determined cost-effective when establishing eligibility for households of two or more Medicaid-eligible persons.

b. The scope of services covered under the insurance plan, including exclusions for preexisting conditions, etc.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for persons covered under the insurance plan.

d. The specific health-related circumstances of the persons covered under the insurance plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. Employer-related group health insurance plans that provide major medical coverage shall be determined cost-effective when there is a Medicaid-eligible pregnant woman who can be covered under the plan.

e. Annual administrative expenditures of $50 per Medicaid recipient covered under the health insurance policy.

f. Whether the estimated savings to Medicaid for persons covered under the health insurance plan are at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.* When it 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, the needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness and payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

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.

g. The person is eligible only for limited Medicaid services under the specified low-income Medicare beneficiary (SLMB) coverage group, in accordance with subrule 75.1(34).

h. Insurance coverage is being provided through the Iowa Comprehensive Health Insurance Association, 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.

75.21(6) *Duplicate policies.* When more than one cost-effective health insurance plan or policy is available, the department shall pay the premium for only one plan. The recipient may choose in which cost-effective plan to enroll. However, in situations where the department is buying in to the cost of Medicare Part A or Part B for eligible Medicare beneficiaries, the cost of premiums for a Medicare supplemental insurance policy may also be paid if the department determines it is likely to be cost-effective to do so.

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, a review shall be completed in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If it is determined the policy 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 policyholder ten calendar days in which to provide it.

d. If the policyholder leaves the household, premium payments shall be discontinued pending timely and adequate notice.

e. If the insurance coverage 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 cost-effective health insurance plans shall be determined as follows:

a. Premium payments shall begin no earlier than the first day of the month in which the Employer's Statement of Earnings, Form 470-2844, or the Health Insurance Premium Payment Application, Form 470-2875, is received by the division of medical services or the first day of the first month in which the plan is determined to be cost-effective, whichever is later.

b. If the person is not enrolled in the 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 policy is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time prior to the current effective date of coverage.

d. In no case shall payments be made for premiums which were used as a deduction to income when determining client participation, the amount of the spenddown obligation, or for premiums due for periods of time covered prior to July 1, 1991.

The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and premiums for persons enrolled in group health insurance plans.

75.21(9) *Method of premium payment.* Payments of health insurance premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to the employer in order to circumvent a payroll deduction.

b. When the 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 policyholder directly for payroll deductions or for payments made directly to the employer for the payment of health insurance premiums. The department shall issue reimbursement to the policyholder five working days prior to the policyholder'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 said withdrawals.

d. When the department is otherwise unable to make direct premium payments because the health insurance is offered through a contract that covers a group of persons identified as individuals by reference to their relationship to the entity, the department shall reimburse the policyholder for premium payments made to the entity.

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.* Reviews of cost-effectiveness shall be completed annually or at the time of the next health insurance contract renewal date for employer-related group health plans. Reviews may be conducted more frequently at the discretion of the department. The Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, shall be used for this purpose.

Reviews of cost-effectiveness shall be completed annually for non-employer-related group health plans. The recipient shall sign the Insurance Carrier Authorization to Release Information, Form 470-3015, as part of the review of non-employer-related plans so that the department may obtain pertinent information necessary to establish continued eligibility.

Failure of the policyholder 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).

Redeterminations shall also be completed whenever a predetermined premium rate, deductible, or coinsurance increases, some of the persons covered under the policy lose full Medicaid eligibility, employment terminates or hours are reduced which affects the availability of health insurance, the insurance carrier changes, the policyholder leaves the home, or there is a decrease in the services covered under the policy. 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. A HIPP Change Report, Form 470-3007, shall accompany all premium payments.

When employment terminates, hours of employment are reduced, or some other qualifying event affecting the availability of health insurance coverage occurs, the department shall verify whether insurance may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other insurance continuation provisions. The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose. If cost-effective, the department shall pay premiums to maintain insurance coverage for eligible Medicaid recipients after the occurrence of the qualifying 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 insurance plan and notify the recipient of the decision regarding payment of the premiums within 65 days from the date an Employer's Statement of Earnings, Form 470-2844, indicating the availability of group insurance or a Health Insurance Premium Payment Application, Form 470-2875, is received. Additional time may be granted when, for reasons beyond the control of the department or the recipient, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.* An adequate notice shall be provided to the household under the following circumstances:

a. To inform the household of the initial decision on cost-effectiveness and premium payment.

b. To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the policy.

c. The policy is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to the household informing them of a decision to discontinue payment of the health insurance premium because the department has determined the policy is no longer cost-effective or because the recipient 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 policy 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 recipient'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.

This rule is intended to implement Iowa Code section 249A.3.

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.

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, 2008, through June 30, 2009, this average statewide cost shall be $4,342.03 per month or $142.83 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 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 trust established solely for the benefit of a child who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(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 (4) of this paragraph.

(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 less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The annuity was purchased before February 8, 2006; or

(2) The annuity was purchased on or after February 8, 2006, and a condition described in 75.23(9)*"a"*(1) to (4) was 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 less 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.

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 633.707 to 633.711, the average statewide charges and Medicaid rates for the period from July 1, 2008, to June 30, 2009, shall be as follows:

(1) The average statewide charge to a private-pay resident of a nursing facility is $3,923 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 $17,954 per month.

(5) The average statewide charge to a resident of a mental health institute is $16,363 per month.

(6) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is $4,975 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.

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.

"Group health insurance" shall mean any plan of, or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"Health insurance" shall mean protection which provides payment of benefits for covered sickness or injury.

"Incurred medical expenses" for medically needy shall mean (1) medical bills paid by a 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.

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.

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).

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.*

a. A child under the age of 19 who is determined eligible for ongoing Medicaid under subrule 75.1(14), 75.1(15), or 75.1(28) shall retain that eligibility regardless of changes in family income or household composition until the earliest of the following dates:

(1) Twelve months after the month when the department received the household's latest application or review form;

(2) The month of the household's annual eligibility review; or

(3) The month when the child reaches age 19.

b. Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

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

t. Any income restricted by law or regulation which is paid to a representative payee living outside the home, 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.

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

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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.

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) may also apply at any Iowa Title X family planning clinic or any delegate agency as defined in rule 441—173.1(234) that provided family planning services as of July 1, 2004, or later.

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 each 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.

441—76.2(249A) Information and verification procedure. The decision with respect to eligibility shall be based primarily on information 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, an authorization to obtain the information or verification, or a request for an extension of the due date, the application shall be denied or assistance canceled. 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."*

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. The member shall give written permission for the release of information when the member is unable to furnish information needed to establish eligibility. Failure to supply the information or refusal to authorize the department to secure information from other sources shall serve as a basis for cancellation of Medicaid.

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 shall be completed on Form 470-2914, Foster Care and Subsidized Adoption Medicaid Review, according to the time schedule of the family medical assistance program or supplemental security income program for disabled children, as applicable.

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).

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. 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.

441—76.13(249A) Health insurance data match program.

76.13(1) *Agreement required.* Any insurance carrier providing a health benefit plan in Iowa subject to regulation by the Iowa commissioner of insurance shall enter into and maintain an agreement with the department or its designee to provide the data necessary to enable the department to match insureds against Medicaid members and identify third-party payers for members.

a. The initial provision of data shall include the data necessary to enable the department to match insureds and identify third-party payers for the two-year period before the initial provision of the data.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional insureds, 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.

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 Foundation for Medical Care (IFMC)" is the peer review organization on contract with the department to provide level of care determinations. The address of IFMC is 6000 Westown Parkway, West Des Moines, Iowa 50266.

"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.

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. Initial decisions on level of care shall be made for the department by the Iowa Foundation for Medical Care (IFMC) within two working days of receipt of medical information. After notice of an adverse decision by IFMC, the Medicaid applicant or recipient, the applicant's or recipient's representative, the attending physician, or the nursing facility may request reconsideration by IFMC by sending a letter requesting a review to IFMC not more than 60 days after the date of the notice of adverse decision. On initial and reconsideration decisions, IFMC 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). Adverse decisions by IFMC on reconsiderations may be appealed to the department pursuant to 441—Chapter 7.

a. If a timely request for reconsideration of an initial denial determination is made, IFMC will complete its reconsidered determination and send written notice including appeal rights to the Medicaid applicant or recipient, the applicant's or recipient's representative, the attending physician or the facility provider within the following time limits:

(1) Within three working days after IFMC receives the request for reconsideration and a copy of the medical record, if the initial determination was made before the Medicaid applicant or recipient was admitted to the nursing facility.

(2) Within ten working days after IFMC receives the request for reconsideration and a copy of the medical record, if the Medicaid applicant or recipient was admitted to the nursing facility when the initial determination was made and is still in the nursing facility when the request for reconsideration is received.

(3) Within 30 working days after IFMC receives the request for reconsideration and a copy of the medical record, if the Medicaid applicant or recipient was admitted to the nursing facility when the initial determination was made but is no longer in the nursing facility when the request for reconsideration is received.

b. If a copy of the medical record is not submitted with the reconsideration request, IFMC shall request a copy from the facility within two working days.

c. Written notice of the IFMC reconsidered determination shall contain the following:

(1) The basis for the reconsidered determination.

(2) A detailed rationale for the reconsidered determination.

(3) A statement explaining the Medicaid payment consequences of the reconsidered determination.

(4) A statement informing the parties of their appeal rights, including the information that must be included in the request for an administrative hearing, the locations for submitting a request for an administrative hearing, and the time period for filing a request.

d. If the request for reconsideration is mailed or delivered to IFMC within ten days of the date of the initial determination, any medical assistance payments previously approved will not be terminated until the decision on reconsideration. If the initial decision is upheld on reconsideration, medical assistance benefits continued pursuant to this subrule will be treated as an overpayment to be repaid to the department.

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 Iowa Foundation for Medical Care 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.

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, mental retardation and developmental disabilities.

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, mental retardation and developmental disabilities 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.

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.

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. Beginning July 1, 2001, patient days for purposes of the computation of administrative, environmental, and property expenses shall be inpatient days as specified in subrule 81.6(7) or 80 percent of the licensed capacity of the facility, whichever is greater.

Beginning July 1, 2003, and thereafter, patient days for purposes of the computation of administrative, environmental, and property expenses shall be inpatient days as determined in subrule 81.6(7) or 85 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. Accountability measures. Additional reimbursement for non-state-owned facilities, based on accountability measures, is available beginning July 1, 2008, as provided in this paragraph. Accountability measures are nursing facility characteristics that indicate the quality of care, efficiency, or commitment to care for certain resident populations. These characteristics are objective, measurable, and, when considered in combination with each other, 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.

Additional reimbursement for accountability measures 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 amount of additional reimbursement based on accountability measures.

To qualify for additional Medicaid reimbursement for accountability measures, a facility must achieve a minimum score of 3 points. The maximum available points are 11.

The Iowa Medicaid enterprise shall award points based on the measures described in subparagraphs (1) through (10).

(1) Deficiency-free survey.

1. Standard. Facilities shall be deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations. If a nursing 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, for purposes of this measure, be deemed to have a deficiency-free survey. Surveys are considered complete when all appeal rights have been exhausted.

2. Measurement period. The measurement period shall be the latest annual survey completed on or before December 31 of each year and any subsequent surveys, complaint investigations, or revisit investigations completed between the annual survey date and December 31.

3. Value. 2 points.

4. Source. The department shall request that the department of inspections and appeals furnish by May 1 of each year a listing of nursing facilities that have met the standard.

(2) Regulatory compliance with survey.

1. Standard. Facilities shall be considered to be in regulatory compliance if no on-site revisit is required for recertification surveys or for any substantiated complaint investigations during the measurement period.

2. Measurement period. The measurement period shall include any recertifiction survey or complaint investigations completed on or before December 31 of each year.

3. Value. 1 point. (A nursing facility that achieves a deficiency-free survey according to subparagraph (1) cannot also receive a point value for this standard.)

4. Source. The department shall request that the department of inspections and appeals furnish by May 1 of each year a listing of nursing facilities that have met the standard.

(3) Nursing hours provided.

1. Standard. A nursing facility's per resident day nursing hours are at or above the fiftieth percentile of per resident day nursing hours. Nursing hours include those of registered nurses, licensed practical nurses, certified nursing assistants, 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. The case-mix index used to normalize nursing hours shall be the facility cost report period case-mix index.

2. Measurement period. The measurement period shall be calculated using the latest financial and statistical report with a fiscal year end of December 31 or earlier.

3. Value. 1 point for a nursing facility that falls between the fiftieth and seventy-fifth percentiles. 2 points for a nursing facility at or above the seventy-fifth percentile.

4. Source. The fiscal consultant shall calculate whether the nursing facility has met this measure from Form 470-0030, Financial and Statistical Report.

(4) Resident satisfaction.

1. Standard. A nursing facility shall be at or above the fiftieth percentile of resident satisfaction. Resident satisfaction shall be measured using Form 470-3890, Resident Opinion Survey. To be considered for this measure, a nursing facility must have a minimum survey response rate of 35 percent from its residents or their responsible parties.

2. Measurement period. For purposes of determining the July 1, 2002, rate, Form 470-3890, Resident Opinion Survey, must be completed by April 1, 2002, and Form 470-3891, Resident Opinion Survey Transmittal Report, must be submitted to the department by May 1, 2002. For purposes of determining rates for years on or after July 1, 2003, Form 470-3890, Resident Opinion Survey, may be completed anytime during the period September through December of the preceding year and the transmittal report submitted to the department by April 1 of the following year.

3. Value. 1 point.

4. Source. The nursing facility shall distribute Form 470-3890, Resident Opinion Survey, and instructions to all residents or their responsible parties. The nursing facility shall have an independent party collect and compile the results of the survey and communicate the results to the department by May 1 of 2002 and April 1 of each year thereafter on Form 470-3891, Resident Opinion Survey Transmittal Report. The department or its contractor shall calculate whether the nursing facility has met this measure.

(5) Resident advocate committee resolution rate.

1. Standard. A nursing facility shall have a resident advocate committee resolution rate of issues and grievances pursuant to 321—Chapter 9 at or above 60 percent.

2. Measurement period. For the purpose of determining the July 1, 2002, rates, the resolution rate shall be computed for the period October 1, 2001, through March 31, 2002. For the purpose of determining rates for July 1, 2003, and thereafter, the resident advocate committee resolution rate shall be computed using data from the immediately preceding calendar year.

3. Value. 1 point.

4. Source. The department shall request that the office of the long-term care ombudsman furnish by May 1 of each year a listing of nursing facilities that have met the standard.

(6) High employee retention rate.

1. Standard. A nursing facility shall have an employee retention rate at or above the fiftieth percentile.

2. Measurement period. The high employee retention rate shall be calculated using Schedule I of the latest Form 470-0030, Financial and Statistical Report, with a fiscal year end of December 31 or earlier.

3. Value. 1 point.

4. Source. The department's fiscal consultant shall calculate whether the nursing facility has met this measure from Form 470-0030, Financial and Statistical Report, Schedule I.

(7) High occupancy rate.

1. Standard. A nursing facility shall have an occupancy rate at or above 95 percent. "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.

2. Measurement period. The high occupancy rate shall be calculated using the latest Form 470-0030, Financial and Statistical Report, with a fiscal year end of December 31 or earlier.

3. Value. 1 point.

4. Source. The department's fiscal consultant shall calculate whether the nursing facility has met this measure from Form 470-0030, Financial and Statistical Report.

(8) Low administrative costs.

1. Standard. A nursing facility's percentage of administrative costs to total costs shall be at or below the fiftieth percentile.

2. Measurement period. The low administrative costs shall be calculated using the latest Form 470-0030, Financial and Statistical Report, with a fiscal year end of December 31 or earlier.

3. Value. 1 point.

4. Source. The department's fiscal consultant shall calculate whether the nursing facility has met this measure from Form 470-0030, Financial and Statistical Report.

(9) Special licensure classification.

1. Standard. Nursing facility units shall be licensed for the care of residents with chronic confusion or a dementing illness (CCDI units).

2. Measurement period. The measurement period shall be the facility's status on December 31 of each year.

3. Value. 1 point.

4. Source. The department shall request that the department of inspections and appeals furnish the department by May 1 of each year a listing of nursing facilities that were licensed as CCDI units as of December 31.

(10) High Medicaid utilization.

1. Standard. A nursing facility shall have Medicaid utilization at or above the fiftieth percentile. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.

2. Measurement period. The Medicaid utilization rate shall be calculated using the latest Form 470-0030, Financial and Statistical Report, with a fiscal year end of December 31 or earlier.

3. Value. 1 point.

4. Source. The department's fiscal consultant shall calculate whether the nursing facility has met this measure from Form 470-0030, Financial and Statistical Report.

(11) Calculation of potential reimbursement. The number of points awarded shall be determined annually on the first day of the state fiscal year and shall be used to calculate the amount of the additional reimbursement for accountability measures as follows:

0 - 2 points	No additional reimbursement
3 - 4 points	1 percent of the direct care plus non-direct care cost component patient-day-weighted medians multiplied by 80 percent, subject to reduction as provided in subparagraph (12)
5 - 6 points	2 percent of the direct care plus non-direct care cost component patient-day-weighted medians multiplied by 80 percent, subject to reduction as provided in subparagraph (12)
7 or more points	3 percent of the direct care plus non-direct care cost component patient-day-weighted medians multiplied by 80 percent, subject to reduction as provided in subparagraph (12)

(12) Reduction of additional reimbursement. The additional reimbursement for accountability measures calculated according to subparagraph (11) shall be subject to reduction as follows:

1. A facility's additional reimbursement 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.

2. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the additional reimbursement shall be forfeited and the facility shall not receive any accountability measure payment for the year.

3. If a facility receives a citation for a deficiency resulting in actual harm or immediate jeopardy at a scope and severity level of H or higher pursuant to the federal certification guidelines, regardless of the amount of any fines assessed, the additional reimbursement shall be forfeited and the facility shall not receive any accountability measure payment for the year.

(13) Report of deficiencies. The department shall request that the department of inspections and appeals furnish by September 1, December 1, March 1 and August 1 of each year a list of nursing facilities subject to a reduction of the additional reimbursement for accountability measures pursuant to the criteria in subparagraph (12).

(14) Application of additional payments. The additional reimbursement for accountability measures 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 to the first day of the state fiscal year to include the amount of additional reimbursement for accountability measures calculated according to 81.6(16)*"g"*; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for accountability measures is effective to reflect the adjusted reimbursement rate.

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 85 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 85 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 assessment and quality assurance payment.* Rescinded IAB 7/6/05, effective 7/1/05.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)*"a,"* 249A.4, and 249A.16.

441—81.7(249A) Continued review. The Iowa Foundation for Medical Care shall review Medicaid recipients' need of continued care in nursing facilities, pursuant to the standards and subject to the reconsideration and appeals processes in subrule 81.3(1).

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)*"a."*

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 or hospitalization shall be made at 42 percent of the nursing facility's rate. Effective May 1, 2003, Medicaid reimbursement savings attributable to the limitation of payments to facilities for periods when residents are absent shall be used to pay costs associated with the design and implementation of that limitation before reversion to Medicaid.

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.

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 including 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, mental retardation, and developmental disabilities has approved the admission, based on an independent physical and mental health evaluation. This evaluation shall be reviewed by the Iowa Foundation for Medical Care prior to 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 nasalpharyngeal 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.

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 by 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.

NOTE: The Committee voted to retain this objection at their meeting held February 8, 1993.

CHAPTER 88
MANAGED HEALTH CARE PROVIDERS

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

PREAMBLE

This chapter contains rules governing the delivery of managed health care under the Medicaid program. These rules make provision for the following managed health care options: health maintenance organizations (HMOs), prepaid health plans (PHPs), patient management, known as Medicaid Patient Access to Service System (MediPASS), the managed care plan for the delivery of mental health and substance abuse services (Iowa Plan for Behavioral Health), and programs of all-inclusive care for the elderly (PACE). The rules cover eligibility of a provider to participate, reimbursement methodologies, record-keeping requirements, grievance procedures, and member enrollment and disenrollment procedures. Services covered or requiring authorization and member access to services are specified.

DIVISION I
HEALTH MAINTENANCE ORGANIZATION

441—88.1(249A) Definitions.

"Capitation rate" shall mean the fee the department pays monthly to an HMO for each enrolled recipient for the provision of covered medical and health services whether or not the enrolled recipient received services during the month for which the fee is intended.

"Contract" shall mean a contract between the department and an HMO for the provision of medical and health services to Medicaid recipients in which the HMO assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

"Covered services" shall mean all or a part of those medical and health services set forth in 441—Chapter 78 and covered in the contract between the department and an HMO.

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

"Emergency care" shall mean those medical services rendered for an emergent medical condition or protection of the public health.

"Emergent 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 it to result in:

1. Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient's medical condition, including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

"Enrolled recipient" shall mean a Medicaid recipient who is eligible for HMO enrollment as defined at subrule 88.2(4) and has been enrolled with an HMO as defined at subrule 88.3(2) or 88.3(7).

"Enrollment area" shall mean the county or counties or region or regions in which an HMO is licensed to operate by the state of Iowa and in which service capability exists as defined by the department and set forth in the contract. An enrollment area shall not be less than an entire county but may be less than a region. Regions shall be established by the department and outlined in the contract with the HMO.

"Extended-participation program" shall mean a mandatory six-month enrollment period with a managed care entity.

"Federally qualified HMO" shall mean an HMO qualified under Section 1315(a) of the Public Health Service Act as determined by the U.S. Public Health Service.

"Grievance" shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the HMO staff member receiving the complaint or any complaint received in writing.

"Health maintenance organization (HMO)" shall mean a public or private organization which is licensed as an HMO under commerce department rules 191—Chapter 40.

"Managed care entity" shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

"Managed health care" shall mean any one of the alternative deliveries of regular fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

"Managed health care review committee" shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

"Mandatory enrollment" shall mean mandatory participation in managed health care as specified in subrule 88.3(3).

"Mandatory project county" shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

"Noncovered services" shall mean services covered under Medicaid which are not included in the HMO's contract with the department. Payment for these services will be made under regular Medicaid procedures.

"Participating providers" shall mean the providers of covered medical and health services who subcontract with or who are employed by an HMO.

"Recipient" shall mean any person determined by the department to be eligible for Medicaid and for HMO enrollment. See subrule 88.2(4) for a list of Medicaid eligibles who are not eligible for HMO enrollment.

"Region" shall mean an area consisting of two or more contiguous counties, as established by the department and specified in contracts with health maintenance organizations.

"Routine care" shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient's life or health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

"Urgent care" shall mean those medical services rendered for an urgent medical condition or protection of the public health.

"Urgent medical condition" shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy.
2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

441—88.2(249A) Participation.

88.2(1) *Contracts with HMOs.* The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with an HMO licensed under the provisions of commerce department rules 191—Chapter 40.

a. The department must determine that the HMO meets the following additional requirements:

(1) It shall make the services it provides to its Medicaid enrollees at least as accessible to them (in terms of timeliness, duration and scope) as those services are accessible to nonenrolled Medicaid recipients in the area served by the HMO.

(2) It shall provide satisfaction to the department against the risk of insolvency and assure that Medicaid recipients shall not be responsible for its debts if it does become insolvent. Compliance

shall exist with commerce department rules regarding deposit requirements at 191—40.12(514B) and reporting requirements at 191—40.14(514B).

(3) For any contract executed or extended to be in effect on or after July 1, 2002, an HMO must have accreditation by the National Committee on Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationship.

(8) Be made with the licensee by the department.

(9) Specify the enrollment area which shall be at least a county and effective July 1, 1998, a region of two or more contiguous counties.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the HMO, specifying the number of days the HMO has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The HMO may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.2(2) *Method of selection of HMO.* In those counties served by a single HMO, the department shall attempt to negotiate a contract. In those counties served by two or more HMOs, the department shall initiate communication and attempt to negotiate as many contracts as are cost-effective and administratively feasible. The department reserves the right to contract with more than one HMO serving any enrollment area.

a. *Request for proposal.* Rescinded IAB 11/10/93, effective 11/1/93.

b. *Minimum contract requirements.* Rescinded IAB 11/10/93, effective 11/1/93.

88.2(3) *Termination of contract.* The department and an HMO may by mutual consent terminate a contract by either party giving 60 days' written notice to the other party. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based on factors including, but not limited to, the following:

a. The HMO's delivery system does not ensure Medicaid recipients adequate access to medical services.

b. The HMO's delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of financial solvency on the part of the HMO.

d. There is not substantial compliance with all provisions of the contract.

e. The HMO has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.2(4) *Recipients eligible to enroll.* Any Medicaid-eligible recipient is eligible to enroll in a contracting HMO except for the following:

a. Recipients who are medically needy as defined at 441—subrule 75.1(35).

b. Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.

c. Recipients who are supplemental security income-related case members.

d. Rescinded IAB 10/3/01, effective 12/1/01.

e. Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).

f. Recipients who are foster care and subsidized adoption-related case members.

g. Recipients who are Medicare beneficiaries.

h. Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).

i. Recipients who are Native American Indians or Alaskan natives.

j. Recipients who are receiving services from a Title V provider.

441—88.3(249A) Enrollment.

88.3(1) *Enrollment area.* Counties in an HMO enrollment area shall be designated as either voluntary or mandatory. In voluntary counties enrollment is not required but eligible recipients may choose to join the HMO. See subrule 88.3(2) for information about voluntary enrollment. In mandatory counties enrollment is required for eligible recipients. See subrule 88.3(3) for information about mandatory enrollment.

88.3(2) *Voluntary enrollment.* When only one HMO in any county has a contract with the department, and the county is not a mandatory project county for Medicaid Patient Management (MediPASS) under subrule 88.43(1), enrollment by Medicaid recipients in the HMO is voluntary. The state encourages recipients to enroll in an HMO. Applicants and recipients eligible for HMO enrollment as set forth in subrule 88.2(4) are offered the option of HMO enrollment. Persons who enroll with the HMO shall have the right to request disenrollment at any time as defined at subrule 88.4(3).

Applicants or recipients can designate their choices on a form designated by the managed health care contractor or in writing to or with a verbal request to the Medicaid managed health care contractor. The form shall be available through the county office, provider offices, the HMO office, the managed health care contractor, or other locations at the department's discretion. If the HMO (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the HMO in the order in which they enroll without restrictions.

Recipients who choose not to enroll in an HMO shall be covered under regular Medicaid.

88.3(3) *Mandatory enrollment.* Participation in managed health care, if available, is required as specified in this subrule for covered eligibles who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.3(4) *Effective date.* The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the designated managed health care choice form or written or verbal request except as defined at 88.4(4)*"b."* The recipients shall be entitled to regular Medicaid until the effective date of HMO enrollment which shall always be the first day of the month. The effective date shall be earlier than the second subsequent month where computer cutoff allows.

88.3(5) *Identification card.* The HMO may issue an appropriate identification card to the enrollee or request the department to do it on its behalf. The identification card shall be issued so the recipient receives it prior to the effective date of enrollment.

88.3(6) *Limitations on enrollment.* Contracting managed care entities may specify in a contract a limit to the number of recipients who can be assigned under subrule 88.3(7). If a limit is specified, the contracting entity must still provide services to all enrolled recipients who voluntarily select enrollment in that option. If a specified limitation is reached, the remaining assignment needs in that county shall be met by the other managed care entities who are contracting with the department in that county.

88.3(7) *Enrollment procedures.* In mandatory enrollment counties, recipients shall be required to choose their managed care entity. When no choice is made by the recipient, the recipient shall be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence

when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. If not, the household shall be assigned to another physician. MediPASS patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.4(2) dealing with the effective date.

a. Timely notice. Recipients shall be sent timely notice of the managed care entity assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. Enrollment. Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

(1) Attains initial eligibility for a covered category of service in a mandatory project county.

(2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.

(3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or from a voluntary project county to a mandatory project county.

(4) Reattains eligibility.

(5) Has a new member of the household receiving a covered category of assistance.

c. Selection of a managed health care provider. A list of health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers, the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Request to change enrollment. An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request may be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.4(2) dealing with effective date.

e. Managed care entity extended-participation program (EPP). After the initial 90 days from timely notice, recipients will remain enrolled with the chosen entity for the following six months, with three exceptions:

(1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3)*"a."*

(2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3)*"b."*

(3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

f. *Enrollment cycle.* Prior to the end of any EPP period, recipients shall be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

441—88.4(249A) Disenrollment.

88.4(1) *Disenrollment request.* Rescinded IAB 5/6/98, effective 7/1/98.

88.4(2) *Effective date.* Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the HMO and the HMO will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.4(3) *Disenrollment process.* The recipient may complete the form designated by the managed health care contractor which can be obtained through the locations described in subrule 88.3(2). The recipient may also make a verbal or written request through the managed health care contractor. If the HMO or any other entity described in subrule 88.3(2) receives a request to disenroll from the recipient, the request shall be forwarded to the Medicaid managed health care contractor office within three working days. If the recipient must show good cause for disenrollment or if the HMO is requesting disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or HMO disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. The HMO may request disenrollment of a recipient by showing good cause and completing Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three days.

a. *Request for disenrollment by the recipient.* The enrolled recipient may request disenrollment by completing a choice form designated by the managed health care contractor, in writing or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from timely notice date. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality or inadequately provided. In a mandatory county, a disenrollment request must be accompanied by a choice for another managed health care provider.

b. *Request for disenrollment by the HMO.* With prior approval of the DHS/HMO Review Committee a recipient may be disenrolled when:

(1) There is evidence of fraud or forgery in the use of HMO services or in the application for HMO coverage.

(2) There is evidence of unauthorized use of the HMO identification card.

(3) Upon documentation that the HMO has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient. Examples include, but are not limited to, repeated failure to follow a prescribed treatment plan, disruptive or abusive behavior with office or clinic staff, documented pattern of missed appointments or "drop-in" requests for service without making appointments.

88.4(4) *Disenrollments by the department.* Disenrollments will occur when:

a. The contract between the department and the HMO is terminated.

b. The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the HMO will also be reinstated.

c. The recipient permanently moves outside the HMO's enrollment area.

d. The recipient transfers to an eligibility group excluded from HMO enrollment. See definition of recipient in rule 441—88.1(249A).

e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

f. The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in rule 441—76.9(249A), would be more cost-effective for the department.

88.4(5) *No disenrollment for health reasons.* No recipient will be disenrolled from an HMO because of an adverse change in health status.

441—88.5(249A) Covered services.

88.5(1) *Amount, duration, and scope of services.* Except as provided for in the contract, HMOs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

a. The recipient shall be issued Form 470-1911, Medical Assistance Eligibility Card, and information about those services not covered by the HMO.

b. To the maximum extent possible, the HMO shall make enrolled recipients aware of alternate providers for services not covered by the HMO.

88.5(2) *Required services.*

a. The HMO shall cover as a minimum the following services:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services.

(4) Family planning services.

(5) Home health agency services.

(6) Early periodic screening, diagnosis and treatment for individuals under the age of 21.

(7) Laboratory and X-ray services.

(8) Rural health clinic services (where available).

(9) Advanced registered nurse practitioners.

(10) Optometric and ophthalmology services.

(11) Clinic services.

(12) Ambulance services.

(13) Rescinded IAB 11/5/97, effective 1/1/98.

(14) Other practitioner services (e.g., speech therapy, audiology, physical therapy, and occupational therapy).

(15) Rehabilitation agencies.

b. HMOs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and maternal and child health centers funded by Title V moneys. The attempt to contract by the HMO is expected to be a reasonable and good faith effort. The determination of whether or not a good faith effort was made shall be completed by the department.

88.5(3) *Excluded services.* Unless specifically included in the contract, HMOs will not be required to cover:

a. Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state hospital schools, or intermediate care facilities for the mentally retarded).

b. Inpatient psychiatric care provided at state-administered mental health institutes.

c. Services provided by the area education agencies.

d. Services provided at psychiatric medical institutions for children.

e. Dental services.

f. Hospice services.

g. Mental health services as defined in rule 441—88.65(249A).

h. Rescinded IAB 8/1/07, effective 9/5/07.

i. Psychiatric services.

j. Infant and toddler program services.

k. Local education agency services.

Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the HMO. The department will continue to reimburse as it currently does for this service.

88.5(4) *Restrictions and limitations.* If the HMO covers a type of service which is also covered under Medicaid, the HMO shall offer the same scope of procedures available under regular Medicaid as described in the provisions at 441—Chapter 78. The HMO may not impose limitations on days of service or length of stay not pertinent to regular Medicaid. The HMO may, however, require the use of certain providers, as defined in subrule 88.5(5); require preauthorization for services other than those meeting the definition of emergency, as defined in rule 441—88.1(249A); direct enrollees to the appropriate level of care for receipt of covered services; and deny payment if these enrollment requirements are not met by the enrollee. The HMO may at its discretion offer services to recipients beyond the scope of Medicaid as defined in 441—Chapter 78.

88.5(5) *Recipient use of HMO services.* A recipient enrolled in an HMO must use HMO providers of service, unless the HMO has authorized a referral to a provider outside the HMO for provision of a service or treatment plan. Payment shall be denied by the HMO on claims for services provided by non-HMO providers if the same service is covered by the HMO under its contract with the department except as provided in rule 441—88.6(249A), as allowed for by a referral to a non-HMO provider, or as an additional service permitted by subrule 88.5(4).

441—88.6(249A) Emergency and urgent care services.

88.6(1) *Availability of services.* The HMO shall ensure that emergency services are available on an emergency basis 24 hours a day, seven days a week, either through the HMO's own providers or through arrangements with other providers. In addition the HMO must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have arrangements with the HMO to provide services but were provided because they were needed immediately as defined at rule 441—88.1(249A) and in which cases the medical emergency does not permit a choice of provider.

88.6(2) *HMO payment liability.* HMO payment liability on account of injury or emergency illness is limited to emergency care as defined in rule 441—88.1(249A). If an ambulance is medically necessary to transport the recipient to follow-up treatment the HMO shall be financially liable. The HMO may require that follow-up treatment to an emergency be provided by HMO-participating providers.

If a recipient is injured or becomes ill and receives emergency services while temporarily outside the HMO's enrollment area, the HMO shall pay the facility or person who rendered the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.6(3) *Notification and claim filing time spans.* The HMO may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or file claims within those time limitations will not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.

88.6(4) *Provision of urgent care.* If the recipient is assigned to a patient manager by the HMO, the patient manager shall arrange for urgent care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

441—88.7(249A) Access to service.

88.7(1) *Choice of provider.* Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the HMO providers participating in the Medicaid project.

88.7(2) *Medical service delivery sites.* Medical service delivery sites must have the following specific characteristics:

a. Be located within 30 miles of and accessible from the personal residences of enrolled recipients.

b. Have sufficient staff resources to adequately provide the medical services contracted for by the site including physicians with privileges at one or more participating acute care hospitals.

c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.

d. Meet the applicable standards for participating in the Medicaid program.

e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.7(3) *Adequate appointment system.* The HMO shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

a. Patients with urgent symptoms shall be seen within one day of contacting their HMO provider at an HMO medical service delivery site.

b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.

c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.

d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.7(4) *Adequate after hours call-in coverage.* The HMO must have in effect the following arrangements which provide for adequate after hours call-in coverage.

a. Twenty-four-hour-a-day phone coverage shall exist.

b. If a physician does not respond to the initial telephone call there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided by the physician within 30 minutes.

c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.7(5) *Adequate referral system.* The HMO must effect the following arrangements which provide for an adequate referral system:

a. A network of referral sources for all services which are covered in the contract and not provided by the HMO directly.

b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physician, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.

c. A notation for hospitalized patients in the medical record indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.8(249A) Grievance procedures.

88.8(1) *Written procedure.* The HMO must have a written procedure by which enrolled recipients may express grievances, complaints, concerns, or recommendations, either individually or as a class and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of a grievance to the grievant.

c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.

d. Ensures the participation of persons with authority to require corrective action.

e. Includes at least one level of appeal.

f. Ensures the confidentiality of the grievant.

g. Ensures issuance of a departmentally approved notice of decision for each adverse action and for each decision on requests for HMO reconsideration. These notices shall contain the enrollee's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

88.8(2) *Written record.* All grievances, including informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be maintained and made available at the time of audit and must include progress notes and resolutions.

88.8(3) *Information concerning grievance procedures.* The HMO's written grievance procedure must be provided to each newly covered recipient not later than the effective date of coverage.

88.8(4) *Appeals to the department.* A recipient shall exhaust the established grievance procedure of the HMO before appealing the issue to the department under the provisions of 441—Chapter 7. The HMO appeal process shall not be more stringent in requirements and time frames than the department's appeal process. The HMO shall issue a written notice stating the outcome of all appeals.

88.8(5) *Periodic report to the department.* The HMO must make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

441—88.9(249A) Records and reports.

88.9(1) *Medical records system.* The HMO 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 HMO must maintain a medical records system which:

a. Identifies each medical record by state identification number.

b. Identifies the location of every medical record.

c. Places medical records in a given order and location.

d. Provides a specific medical record on demand.

e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.9(3).

f. Maintains inactive medical records in a specific place.

g. Permits effective professional review in medical audit processes.

h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.

i. Meets state and federal reporting requirements applicable to HMOs.

88.9(2) *Content of individual medical record.* The HMO must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.9(3) *Confidentiality of records.* HMOs must maintain the confidentiality of medical record information and release the information only in the following manner:

a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or responsible party.

b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities who are providing services to enrolled recipients under a subcontract with the HMO. This provision also applies to specialty providers who are retained by the HMO to provide services which are infrequently used, provide a support system service to the operation of the HMO, or are of an unusual nature. This provision is also intended to waive the need for written consent for department staff assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the HMO itself, and other subcontractors which require information as described under paragraph *"e"* of this subrule.

c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—88.6(249A).

d. Written consent is required for the transmission of the medical record information of a former enrolled recipient to any physician not connected with the HMO.

e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

f. Medical records maintained by subcontractors must meet the requirements of this rule.

88.9(4) *Reports to the department.* Each HMO shall submit reports to the department as follows:

a. Annual audited financial statements no later than 120 days after the close of the HMO's fiscal year or other additional terms as specified by the contract.

b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

c. Time-specific reports required by the contract which define activity for child health care, grievances, and other designated activities which may, at the department's discretion, vary among HMOs, depending on the services covered and other contractual differences.

88.9(5) *Audits.* The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the HMO. The department or HHS may audit and inspect any records of an HMO, or the subcontractor of the HMO that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

441—88.10(249A) Marketing.

88.10(1) *General requirements.* An HMO may not distribute directly or through any agent or independent contractor any marketing materials, without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

a. *Service market.* An HMO shall distribute any marketing materials to its entire service area or region.

b. *Prohibition of tie-ins.* An HMO, or any agency of the entity, may not seek to influence an individual's enrollment with the HMO in conjunction with the sale of any other insurance.

c. *Prohibiting marketing fraud.* Each HMO shall comply with the procedures and conditions the department prescribes in the contract in order to ensure that, before an individual is enrolled with the HMO, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

d. *Prohibition of "cold-call" marketing.* HMOs shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment.

88.10(2) *Marketing representatives.* Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The HMO's marketing representatives must represent the HMO in an honest and straightforward manner. In its marketing presentations the HMO must include information which ensures that the marketing representative is not mistaken for a state or county employee.

88.10(3) *Marketing presentations.* The HMO may make marketing presentations in the local offices of the department or otherwise include the department in their marketing efforts at the discretion of the department.

88.10(4) *Marketing materials.* Written material must include a marketing brochure or a member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to Medicaid recipients as specified in the contract.

441—88.11(249A) Patient education.

88.11(1) *Health education procedures.* The HMO will have written procedures for health education designed to prepare patients for participation in and reaction to specific medical procedures and to instruct patients in self-management of medical problems and in disease prevention. This service may be provided by any health practitioner or by any other person approved by the HMO.

88.11(2) *Use of services.* The HMO will have procedures in effect to orient covered persons in the use of all services provided. This includes but is not limited to written instructions regarding appropriate use of the referral system, grievance procedure, after hours call-in system, and provisions for emergency treatment.

88.11(3) *Patient rights and responsibilities.* The HMO shall have in effect a written statement of patient rights and responsibilities which is available to patients upon request and which is sent to all new enrolled recipients. The rights of the recipient to request disenrollment shall be included.

441—88.12(249A) Reimbursement.

88.12(1) *Capitation rate.* In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each enrolled recipient. This

capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

A portion of any increase in capitation payments may be reserved for an incentive payment to be paid based on the percentage of counties in a region included in an HMO's enrollment area. Incentive payments shall be made retroactively to the beginning of a state fiscal year if an HMO increases the percentage of counties in a region included in its enrollment area.

88.12(2) *Determination of rate.* The capitation rate is actuarially determined for the beginning of each new fiscal year using statistics and data about Medicaid fee-for-service expenses for HMO-covered services to a similar population during a base fiscal year. The capitation rate shall not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. HMOs electing to share risk with the department shall have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.12(3) *Amounts not included in rate.* The capitation rate does not include any amounts for the recoupment of losses suffered by the HMO for risks assumed under the contract or any previous risk contract. Any savings realized by the HMO due to the expenditure for necessary health services by the enrolled population being less than the capitation rate paid by the department will be wholly retained by the HMO.

88.12(4) *Third-party liability.* If an enrolled recipient has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses it is the right and responsibility of the HMO to investigate these third-party resources and attempt to obtain payment. The HMO will retain all funds collected for third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

441—88.13(249A) Quality assurance. The HMO shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.14(249A) Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs). In the case of services provided pursuant to a contract between an FQHC or RHC and a managed care organization, the organization shall provide payment to the FQHC or RHC that is not less than the amount of payment that it would make for the services if furnished by a provider other than an FQHC or RHC. The payment from the managed care organization to the FQHC or RHC shall be supplemented by a direct payment from the department to the FQHC or RHC to provide reimbursement at 100 percent of reasonable cost as determined by Medicare cost reimbursement principles. FQHCs and RHCs shall be required to submit Form 470-3495, Managed Care Wraparound Payment Request Form, to the Iowa Medicaid enterprise provider audits and rate-setting unit to document Medicaid encounters and differences between payments by the managed care organization and 100 percent of reasonable cost as determined by Medicare cost reimbursement principles.

441—88.15 to **88.20** Reserved.

DIVISION II
PREPAID HEALTH PLANS

441—88.21(249A) Definitions.

"Capitation rate" shall mean the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical services whether or not the enrolled recipient received services during the month for which the fee is intended.

"Contract" shall mean a contract between the department and a PHP for the provision of medical services to enrolled Medicaid recipients for whom the PHP assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

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

"Emergency service" shall mean those medical services rendered under unforeseen conditions which require hospitalization for the treatment of accidental injury and relief of acute pain, which, if not immediately diagnosed and treated, would result in risk of permanent danger to the patient's health.

"Enrollment area" shall mean the county or counties which the PHP has capability to serve and is defined in the contract with the department. An enrollment area shall not be less than an entire county.

"Grievance" shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the PHP staff member receiving the complaint or any complaint received in writing.

"Managed health care" shall mean any one of the alternative deliveries of regular, fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), or prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

"Managed health care review committee" shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

"Managed services" shall mean all or part of those medical services set forth in 441—Chapter 78 and covered in the contract between the department and a PHP.

"Nonmanaged services" shall mean medical services covered under regular Medicaid, but which are not covered in the PHP's contract with the department. Payment for nonmanaged services incurred by an enrolled recipient shall be made under regular Medicaid procedures.

"Participating providers" shall mean the providers of covered medical services who subcontract with or who are employed by the PHP.

"Prepaid health plan (PHP)" shall mean an entity defined in Section 1903(m)(2)(B)(iii) of the Social Security Act and considered to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3) as amended to March 31, 1991.

"Recipient" shall mean any person determined by the department to be eligible for Medicaid and for PHP enrollment. See subrule 88.22(4) for a list of Medicaid eligibles who are not eligible for PHP enrollment.

"Routine care" shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient's life or health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

"Urgent, nonemergency need" shall mean the existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

441—88.22(249A) Participation.

88.22(1) *Contracts with PHPs.* The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with a PHP which has verified to the department that the criteria set forth in the Social Security Act have been met. This verification shall be reviewed by Centers for Medicare and Medicaid Services (CMS) staff to ensure that the status of PHP is rightfully conferred.

a. The department shall also determine that the PHP meets the following additional requirements:

(1) The PHP shall make the services it provides to enrolled recipients at least as accessible (in terms of timeliness, duration, and scope) to them as those services are accessible to recipients in the enrollment area who are not enrolled.

(2) The PHP shall provide satisfaction to the department that insolvency is not likely to occur and that enrolled Medicaid recipients shall not be responsible for its debts if the PHP should become insolvent.

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.
(5) List conditions for nonrenewal, termination, suspension, and modification.
(6) Specify the method and rate of reimbursement.
(7) Provide for disclosure of ownership and subcontractor relationship.
(8) Be made with the licensee by the department.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the PHP, specifying the number of days the PHP has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The PHP may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.22(2) *Method of selection of PHP.* In counties served by a single prospective PHP, the department shall attempt to negotiate directly with the PHP. In counties where two or more prospective PHPs exist, the department shall initiate communication and attempt to negotiate as many contracts as are administratively feasible.

88.22(3) *Termination of contract.* Either party may, by mutual consent, terminate a contract. Either party may give 60 days written notice to the other party. The effective date of termination must be the first day of a month. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based upon, but not limited to, the following:

a. The PHP's delivery system does not ensure enrolled recipients adequate access to medical services.

b. The PHP's delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of solvency on the part of the PHP.

d. There is not substantial compliance with all provisions of the contract.

e. The PHP has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.22(4) *Recipients eligible to enroll.* Any Medicaid-eligible recipient is eligible to enroll in a contracting PHP except for the following:

a. Recipients who are medically needy as defined at 441—subrule 75.1(35).

b. Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.

c. Recipients who are supplemental security income-related case members.

d. Rescinded IAB 10/3/01, effective 12/1/01.

e. Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).

f. Recipients who are foster care and subsidized adoption-related case members.

g. Recipients who are Medicare beneficiaries.

h. Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).

i. Recipients who are Native American Indians or Alaskan natives.

j. Recipients who are receiving services from a Title V provider.

441—88.23(249A) Enrollment.

88.23(1) *Enrollment area.* Counties in a PHP enrollment area shall be designated as voluntary or mandatory. In voluntary counties, enrollment is not required but eligible recipients may choose to join the PHP. Recipients not excluded in rule 441—88.21(249A) may volunteer to enroll in the PHP. In mandatory counties, enrollment in managed health care is required for eligible recipients.

88.23(2) *Voluntary enrollment.* When only one managed health care option is providing service in a county, enrollment by recipients is voluntary. The department encourages recipients to enroll in a managed health care option. Applicants and recipients are offered the option of managed health care enrollment or regular Medicaid coverage. Applicants and recipients who do not choose one option or the other shall be assigned to a managed health care provider as defined in subrule 88.23(6). These persons shall have the right to request disenrollment at any time as defined in subrule 88.24(3).

Applicants or recipients may designate their choices of providers on a form designated by the managed health care contractor or in writing to or through a verbal request to the managed health care contractor. The form shall be available through the county office, the PHP office, provider offices, the managed health care contractor, or other locations at the department's discretion. If the PHP (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the PHP as they are enrolled by the department unless a maximum limit has been specified in the contract.

Recipients who choose not to enroll in a PHP shall be covered under regular Medicaid.

88.23(3) *Mandatory enrollment.* In a county where the department has a contract with more than one PHP, HMO, or other managed health care provider, the department shall require whenever it is administratively feasible that all eligible recipients enroll with a managed health care provider of their own choosing. Administrative feasibility is determined by whether the managed health care providers have the capacity to adequately serve all potential enrolled recipients. Recipients may enroll by completing the choice form designated by the managed health care contractor, in writing to or through verbal request to the managed health care offices. Recipients may also contact the managed health care contractor by the publicized toll-free telephone number for enrollment assistance.

88.23(4) *Effective date.* The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the form designated by the managed health care contractor.

88.23(5) *Identification card.* The PHP may issue an appropriate identification card to the enrolled recipient or request the department to do so on its behalf. The identification card shall be issued so that the recipient receives it prior to the effective date of enrollment.

88.23(6) *Assignment methodology.* When no choice is made, the recipient shall be systematically assigned to, between, or among the contracting managed health care providers.

a. *Notification.* Recipients who are assigned to a managed health care provider shall receive notification of the assignment and the name of the provider in a timely fashion prior to the effective date of enrollment.

b. *Limitations.* Contracting providers may specify in the contract a limit to the number of recipients who can be assigned under this subrule. If a specified limitation is attained, the remaining assignment needs in that county shall be met by the other managed health care providers who are contracting with the department in that county.

c. *Household member enrollment.* Inasmuch as persons within a household are allowed to make individual decisions about choosing enrollment in managed health care, it is possible that a case may exist where some household members have made a choice and some have not (so that assignment is required). In these instances, a systematic search of household member choices regarding managed health care option shall be completed. Assignment of those who have made no choice shall be made whenever possible to the managed health care provider with whom the first household member is already enrolled.

d. *Assigned recipients who desire another choice.* Recipients who are assigned to a managed health care provider as described in this subrule shall have at least 30 days in which to request enrollment in a different available managed health care plan. The change of plan is subject to provisions in subrules 88.23(4) and 88.24(2) dealing with effective date.

441—88.24(249A) Disenrollment.

88.24(1) *Disenrollment request.* An enrolled recipient may request disenrollment at any time. In voluntary counties, this request shall be approved and acted upon within ten days of receipt without

requiring the recipient to demonstrate good cause. In mandatory counties as defined at subrule 88.23(3), the disenrollment shall not be acted upon by the health care contractor unless the request includes an alternate choice of managed health care.

88.24(2) *Effective date.* Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the PHP and the PHP will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.24(3) *Disenrollment process.* If the recipient is requesting disenrollment, the recipient shall complete the choice form designated by the managed health care contractor which can be obtained through the PHP, the county office, or the managed health care contractor. If the PHP receives a request from the recipient, the PHP shall forward the form to the managed health care contractor within three working days. If the recipient must show good cause for disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or the PHP disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. If the PHP is requesting disenrollment, the PHP shall complete Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three working days.

a. *Request for disenrollment by the recipient.* In voluntary counties, the request shall be approved and acted upon within ten days of receipt by the managed health care contractor. In mandatory counties, a request for disenrollment shall be denied unless a choice of another managed health care provider is requested simultaneously or good cause can be demonstrated to the review committee. Examples of good cause include services received which were untimely, inaccessible, of insufficient quality, or inadequately provided by all of the contracting managed health care providers in the recipient's county of residence. If the recipient has not experienced the above conditions in all the other available managed health care programs, enrollment in one of the alternative managed health care programs shall be a condition of approving disenrollment.

b. *Request for disenrollment by the PHP.* With prior approval of the managed health care review committee, a request for disenrollment of an enrolled recipient may be approved when:

(1) There is evidence of fraud or forgery in the use of PHP services or in the choice for PHP services.

(2) There is evidence of unauthorized use of the PHP identification card.

(3) Upon documentation, the PHP has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient.

88.24(4) *Disenrollments by the department.* Disenrollments will occur when:

a. The contract between the department and the PHP is terminated.

b. The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the PHP will also be reinstated.

c. The recipient permanently moves outside the PHP's enrollment area.

d. The recipient transfers to an eligibility group excluded from PHP enrollment. See definition of recipient in rule 441—88.21(249A).

e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

88.24(5) *No disenrollment for health reasons.* No recipient shall be disenrolled from a PHP because of an adverse change in health status.

441—88.25(249A) Covered services.

88.25(1) *Amount, duration, and scope of services.* Except as provided for in the contract, PHPs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

88.25(2) *Mandatory services.*

a. Although the contract may specify additional services covered (with the exception of those defined in 88.25(3)), the PHP shall cover as a minimum the following services:

(1) Inpatient hospital services.
(2) Outpatient hospital services.
(3) Physician services.
(4) Family planning services.
(5) Home health agency services.
(6) Laboratory and X-ray services.
(7) Early periodic screening, diagnosis and treatment for persons under age 21.
(8) Rural health clinic services (where available).
(9) Advanced registered nurse practitioners.

b. PHPs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and all maternal and child health centers funded by Title V moneys.

c. According to the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, recipients enrolled in managed health care options (including PHPs) may seek family planning services anywhere without referral, even if they are minors. The PHP must pay any claims submitted by a provider of family planning services when the service has been provided to a recipient in a month for which a capitation rate has been paid on the recipient's behalf to the PHP by the department.

88.25(3) *Excluded services.* Unless specifically included in the contract, PHPs will not be required to cover long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state resource centers, or intermediate care facilities for the mentally retarded), inpatient psychiatric care provided at the state-administered mental health institutes, services provided by the area education agencies, services provided at specialized adolescent psychiatric facilities, day treatment and partial hospitalization services for persons aged 20 or under, or the enhanced services provided to certain eligible recipients. Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the PHP; the department will continue to reimburse through its fee-for-service methodology for this service.

88.25(4) *Restrictions and limitations.* If the PHP covers a type of service which is also covered under Medicaid, the PHP may not impose any restrictions or limitations on that service more stringent than those applicable in Medicaid according to the provisions at 441—Chapter 78. The PHP may, at its discretion, offer services to its enrolled recipients beyond the scope of Medicaid as defined at 441—Chapter 78.

88.25(5) *Recipient use of PHP services.* An enrolled recipient must utilize PHP participating providers of service. No payment by the PHP will be made for services provided by non-PHP providers if the same type of service is available through the PHP under its contract with the department except as provided in subrule 88.25(2)*"c,"* and rule 441—88.26(249A).

441—88.26(249A) Emergency services.

88.26(1) *Availability of services.* The PHP will ensure that the services of a primary care physician are available on an emergency basis 24 hours a day, seven days a week, either through the PHP's own providers or through arrangements with other providers. In addition, the PHP must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have contractual arrangements with the PHP to provide services but which were needed immediately because of an injury or illness and in which case the illness or injury did not permit a choice of provider.

88.26(2) *PHP payment liability.* PHP payment liability on account of injury or emergency illness is limited to emergency care required before the recipient can, without medically harmful consequences, return to the enrollment area or to the care of a provider with whom the PHP has arrangements to provide services. If an ambulance is necessary to transport the recipient to follow-up treatment, the PHP shall be financially liable. Benefits for continuing the follow-up treatment are provided only in the PHP's enrollment area.

If an enrolled recipient is injured or becomes ill and receives emergency services outside the PHP's enrollment area, the PHP shall pay the facility or person who provided the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.26(3) *Notification and claim filing time span.* The PHP may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or to file claims within those time limitations will not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible.

441—88.27(249A) Access to service.

88.27(1) *Choice of provider.* Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the PHP providers participating in the Medicaid contract.

88.27(2) *Medical service delivery sites.* Medical service delivery sites shall have the following specific characteristics:

a. Be located within 30 miles of and be accessible from the personal residences of enrolled recipients.

b. Have sufficient staff resources to adequately provide the medical services for which the contract is in effect including physicians with privileges at one or more acute care hospitals.

c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.

d. Meet the applicable standards for participating in the Medicaid program.

e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.27(3) *Adequate appointment system.* The PHP shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

a. Patients with urgent nonemergency needs shall be seen within one hour of presentation at a PHP medical service delivery site.

b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.

c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.

d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.27(4) *Adequate after hours call-in coverage.* The PHP must have in effect the following arrangements which provide for adequate after hours call-in coverage:

a. Twenty-four-hour-a-day telephone coverage shall exist.

b. If a physician does not respond to the initial telephone call, there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided within 30 minutes.

c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.27(5) *Adequate referral system.* The PHP must effect the following arrangements which provide for an adequate referral system:

a. A network of referral sources for all services which are covered in the contract, but not directly provided by the PHP.

b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physicians, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.

c. A notation in the medical record for hospitals' patients indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.28(249A) Grievance procedures.

88.28(1) *Written procedure.* The PHP must have a written procedure by which enrolled recipients may express grievances, complaints, or recommendations, either individually or as a class and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of a grievance to the grievant.

c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.

d. Ensures the participation of persons with authority to require corrective action.

e. Includes at least one level of appeal.

f. Ensures the confidentiality of the grievant.

88.28(2) *Written record.* All grievances, including all informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be retained and made available at the time of audit and must include progress notes and method of resolution.

88.28(3) *Information concerning grievance procedures.* The PHP's written grievance procedure must be provided to each newly enrolled recipient not later than the effective date of coverage.

88.28(4) *Appeals to the department.* A recipient who has exhausted the grievance procedure of the PHP may appeal the issue to the department under the provisions of 441—Chapter 7. Instances where the substance of the grievance relates to department policy shall be appealed directly to the department.

88.28(5) *Periodic report to the department.* The PHP shall make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

441—88.29(249A) Records and reports.

88.29(1) *Medical records system.* The PHP shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and, in addition, the PHP must maintain a medical record system which:

a. Identifies each medical record by the departmentally assigned state identification number.

b. Identifies the location of every medical record.

c. Places medical records in a given order and location.

d. Provides a specific medical record on demand.

e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.29(3).

f. Maintains inactive medical records in a specific place.

g. Permits effective professional review in medical audit processes.

h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.

i. Meets state and federal reporting requirements applicable to PHPs.

88.29(2) *Content of individual medical record.* The PHP must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.29(3) *Confidentiality of records.* PHPs must maintain the confidentiality of medical record information and release the information only in the following manner:

a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or the responsible party acting on behalf of the enrolled recipient.

b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities which are providing services to enrolled recipients under a subcontract with the PHP. This provision also applies to specialty providers who are retained by the PHP to provide services which are infrequently used or are of an unusual nature.

c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—89.26(249A).

d. Written consent is required for the transmission of medical record information of a former enrolled recipient to any medical provider not connected with the PHP.

e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or facility requesting the information.

f. Medical records maintained by subcontracting providers must meet the requirements of this rule.

88.29(4) *Reports to the department.* Each PHP shall submit reports to the department as follows:

a. Annual audited financial statements no later than 120 days after the close of the PHP's fiscal year.

b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

88.29(5) *Audits.* The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means, the quality, appropriateness, and timeliness of services performed by the PHP. The department or HHS may audit and inspect any records of a PHP, or the subcontractors of a PHP, which pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.30(249A) Marketing.

88.30(1) *Marketing procedures.* All marketing plans, procedures, and materials used by the PHP must be approved in writing by the department prior to use. Random door-to-door marketing of low-income families or the offering of financial incentives will not be approved.

88.30(2) *Marketing representatives.* Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The PHP's marketing representatives must represent the PHP in an honest and straightforward manner. In its marketing presentations, the PHP must include information which ensures that the representative is not mistaken for a department employee. Marketing presentations which intentionally belittle or maliciously downplay the benefit package, services, or providers of another participating managed health care option will not be approved.

88.30(3) *Marketing presentations.* The PHP may make marketing presentations in the local office(s) of the department or otherwise include the department in marketing efforts at the discretion of the department.

88.30(4) *Marketing materials.* Written material must include a marketing brochure or a member handbook which fully explains the services available, how and when to obtain them, and special factors applicable to enrolled recipients as specified in the contract.

441—88.31(249A) Patient education.

88.31(1) *Use of services.* The PHP shall have procedures in effect to orient enrolled recipients in the use of services the PHP is contracting to provide. This includes what to do if the recipient requires medical care while out of the enrollment area, a 24-hour-a-day telephone number, appropriate use of the referral system, grievance procedures, and how emergency treatment is to be provided.

88.31(2) *Patient rights and responsibilities.* The PHP shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrolled recipients. This statement may be part of an informational brochure provided to all new enrollees. The right of the enrolled recipient to request disenrollment must be included.

441—88.32(249A) Payment to the PHP.

88.32(1) *Capitation rate.* In consideration for all services rendered by a PHP under a contract with the department, the PHP will receive a payment each month for each enrolled recipient. This capitation

rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

88.32(2) *Determination of rate.* The capitation rate is actuarially determined by the department for the beginning of the new fiscal year using statistics and data about Medicaid fee-for-service expenses for PHP-covered services to a similar population during the preceding fiscal year. (For example, fiscal year 1990 rates are predicted with fiscal year 1988 dates of service for Medicaid fee-for-service expenditures.) The capitation rate may not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. A 1 percent incentive will be available to PHPs who contract to cover all services except those specified in subrule 88.25(3). PHPs electing to share risk with the department will have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.32(3) *Amounts not included in rate.* The capitation rate does not include any amounts for the recoupment of losses suffered by the PHP for risks assumed under the current or any previous contract. The PHP accepts the rate as payment in full for the contracted services. Any savings realized by the PHP due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the PHP.

88.32(4) *Third-party liability.* If an enrolled recipient has health coverage or a responsible party other than the Medicaid program available for purposes of payment for medical expenses, it is the right and responsibility of the PHP to investigate these third-party resources and attempt to obtain payment. The PHP 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.

441—88.33(249A) Quality assurance. The PHP shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.34 to **88.40** Reserved.

DIVISION III
MEDICAID PATIENT MANAGEMENT

441—88.41(249A) Definitions.

"Contract" shall mean a contract between the department and a Medicaid-participating provider or clinic as specified in rule 441—88.44(249A) and subrule 88.45(1) for the purpose of providing patient management to enrolled recipients.

"Covered eligibles" shall mean those groups of Medicaid-eligible recipients specified in subrule 88.42(1) who are eligible to receive services under patient management.

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

"Designee" shall mean an organization designated by the department of human services to act on behalf of the department in the administration of Medicaid managed health care.

"Eligible providers" shall mean those providers specified in rule 441—88.44(249A) and subrule 88.45(1) with whom the department may contract to be patient managers.

"Emergency care" shall mean those medical services rendered for an emergent medical condition or protection of the public health.

"Emergent 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 it to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient's medical condition including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

"Enrolled recipient" shall mean a covered eligible who has been enrolled with a patient manager according to procedures set forth in rule 441—88.46(249A).

"Extended-participation program" shall mean mandatory six-month enrollment period with a managed care entity.

"Grievance" shall mean a complaint expressed verbally or in writing by an enrolled recipient or provider relative to services under patient management. A grievance at the informal level is one which can be resolved by short-term intervention on the part of the department or its designee via the toll-free managed health care telephone line or through informational correspondence. A formal grievance is one which must be taken to another level for quality of care or policy determination.

"Managed care entity" shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

"Managed health care" shall mean any of the options for alternative delivery of Medicaid services that provides coordinated delivery of health care. The current options offered by the department are Medicaid patient management, known as MediPASS, health maintenance organization (HMO) enrollment and prepaid health plan (PHP) enrollment.

"Managed health care review committee" shall mean a committee composed of representatives from the department and its designee. The committee shall review and render decisions on all requests for disenrollment from managed health care that are not automatically approvable, all requests for exception to eligible provider provisions, and other exceptions to managed health care procedures.

"Mandatory enrollment" shall mean a mandatory participation in managed health care as specified in subrule 88.46(1).

"Mandatory project county" shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

"Managed services" shall mean services as specified in subrule 88.48(1) that require preauthorization from the patient manager in order to be payable by Medicaid.

"Medical service area" means a geographic area within which recipients must reside in order to enroll in the managed health care MediPASS option.

"MediPASS" shall mean Medicaid patient access to service system and shall be the acronym used to identify the Medicaid patient management program.

"Nonmanaged services" shall mean services as specified in subrule 88.48(2) that do not require authorization by the patient manager in order to be payable by Medicaid.

"Patient management" shall mean the provision of services to enrolled recipients by a patient manager in accordance with the contract.

"Patient manager" shall mean an eligible provider who has signed a contract with the department to perform patient management for enrolled recipients.

"Urgent care" shall mean those medical services rendered for an urgent medical condition or protection of the public health.

"Urgent medical condition" shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy,
2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

If the recipient is assigned to a patient manager (e.g., MediPASS or HMO), the patient manager shall arrange for necessary care within 24 hours by either providing it or referring and authorizing another appropriate provider to provide care.

441—88.42(249A) Eligible recipients.

88.42(1) *Included categories of assistance.* All categories of Medicaid-eligible recipients except those specified as excluded in subrule 88.42(2) are required to participate in Medicaid managed health care if they reside in a mandatory project county as described in subrule 88.43(1). Recipients who reside in a voluntary project county as described in subrule 88.43(2) may participate if they so choose.

A choice to enroll in any other form of Medicaid managed health care available in the recipient's county of residence shall fulfill the requirements to participate in mandatory project counties.

88.42(2) *Excluded categories of assistance.* The following categories of Medicaid-eligible recipients shall not be allowed to participate in Medicaid patient management in either mandatory or voluntary project counties:

a. Medically needy recipients as defined in 441—subrule 75.1(35).

b. Recipients over age 65 and under age 21 in psychiatric institutions as defined in 441—Chapter 85.

c. Recipients who are supplemental security income-related case members.

d. Rescinded IAB 10/3/01, effective 12/1/01.

e. Automatic redetermination recipients as defined in rule 441—76.11(249A).

f. Recipients who are foster care and subsidized adoption-related case members.

g. Recipients who are Medicare beneficiaries.

h. Pregnant women who are determined presumptively eligible in accordance with provisions in 441—subrule 75.1(30).

i. Recipients who are Native American Indians or Alaskan natives.

j. Recipients who are receiving services from a Title V provider.

441—88.43(249A) Project area.

88.43(1) *Designation as a mandatory project county.* The department shall designate mandatory enrollment counties included in the project. In order for a county to be considered a mandatory project county, the number of MediPASS providers willing to serve as patient managers shall be sufficient to meet the needs of the size and makeup of the recipient population in the county, and the county shall be included in the department's freedom of choice waiver from the Centers for Medicare and Medicaid Services.

88.43(2) *Voluntary project counties.* The department shall designate voluntary enrollment counties included in the project. A county may be voluntary where provider participation is not sufficient to be designated mandatory but providers may choose to participate on a voluntary enrollment basis.

88.43(3) *Expansion to other counties.* Rescinded IAB 11/10/93, effective 11/1/93.

441—88.44(249A) Eligible providers.

88.44(1) *Specialties allowed.* Providers shall be allowed to contract with the department to provide patient management to enrolled recipients as long as the provider:

a. Is a licensed doctor of medicine or osteopathy or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 and possessing evidence of certification pursuant to board of nursing rules under 655—Chapter 7 in a specialty area listed in paragraph 88.44(1)*"d."*

b. Is otherwise eligible to enroll as an Iowa Medicaid provider.

c. Is a provider in good standing with the Medicaid agency as defined in subrule 88.45(1).

d. Is practicing in one of the following specialties in the medical services area:

(1) Family practice.

(2) General practice.

(3) Pediatrics.

(4) Internal medicine.

(5) Obstetrics and gynecology.

88.44(2) *Clinic or group practice participation.* A provider may participate as an individual practitioner or as a partner or employee of a clinic or group practice. The clinic or group shall be the contractor. Federally qualified health centers and rural health clinics that employ providers in the specialties specified in subrule 88.44(1) may contract. However, each provider participating within the clinic, group, federally qualified health center, or rural health clinic shall sign and be bound by the terms of the clinic or group contract as if the provider was in individual practice.

88.44(3) *Exceptions.* Other providers licensed as doctors of medicine or osteopathy or as advanced registered nurse practitioners may request exception to subrule 88.44(1) for specific individual patients in accordance with the procedures set forth in this subrule.

a. If the request is being made in order to allow a different type of specialist to be a patient manager, or to allow a provider practicing outside the recipient's medical service area to serve the recipient, the provider shall make a written request to the department.

(1) The request shall identify the provider by name, address, telephone number, specialty, and Medicaid provider number, indicating the practice location, or date of application to be a Medicaid provider. The request shall specify the members in question and state agreement to provide primary care and patient management as specified in subrule 88.45(2) to those members.

(2) If the request comes initially from the recipients as specified in paragraph 88.46(2)*"c,"* the department shall contact the provider in question to offer the provider the opportunity to request the exception.

b. Rescinded IAB 11/10/93, effective 11/1/93.

c. Rescinded IAB 11/10/93, effective 11/1/93.

d. The managed health care review committee shall consider the request and respond within ten working days of receipt of the request. If the request is approved, a contract will be forwarded to the physician and procedures for contracting with a physician as specified in rule 441—88.45(249A) shall be followed.

e. The following factors shall be taken into account when considering the physician's request:

(1) Mutual agreement between physician and patient regarding the arrangement.

(2) Existence of an already established physician-patient relationship.

(3) Transportation barriers, if requesting a patient manager outside the medical service area.

(4) Customary practice by the specialist to provide primary care.

(5) A new medical condition which necessitates the proposed physician-patient relationship.

441—88.45(249A) Contracting for the provision of patient management.

88.45(1) *Eligibility to contract.* Only Medicaid-participating providers and clinics in good standing shall be eligible to contract with the department to provide patient management.

88.45(2) *Contract provisions.* The department shall enter into a contract arrangement with all providers who are eligible as specified in rule 441—88.44(249A) and who wish to provide patient management. Form 470-2615, Agreement for Participation as a Primary Care Physician Patient Manager in the Medicaid Patient Access to Service System, shall be the form designated as the contract. At a minimum, the contract shall include provisions as follows:

a. The patient manager shall provide managed health care to enrolled recipients by providing primary health care and providing or referring the patient appropriately and authorizing payment for all other care covered under the program as specified in subrule 88.48(1). The patient manager is also responsible for monitoring and coordinating all covered care.

b. The patient manager shall provide or arrange for 24-hour-per-day, seven-day-per-week provider availability to enrolled recipients.

c. The patient manager shall maintain records that at a minimum:

(1) Identify the patient as a patient management recipient.

(2) Document all authorizations for medical services provided by other providers and the extent of those authorizations.

(3) Contain the name, state identification number, age, sex and address of the patient.

(4) Document services provided and where and by whom they are provided.

(5) Contain medical diagnosis, treatment, therapy and drugs prescribed or administered.

(6) Contain the name of the person making the entry and the date of the contact.

d. The patient manager shall review and take action upon periodic utilization review reports, according to instructions that the department will provide each patient manager.

e. The department shall specify the fees and method of payment to patient managers.

f. The department shall specify the manner in which providers shall be notified of the recipients enrolled with them.

88.45(3) *Contract compliance.* The department shall put into place procedures for the monitoring of contract compliance on the part of patient managers to ensure appropriate access to adequate quality care. Those procedures may include, but are not limited to, on-site review of medical records by appropriate professional medical personnel and review of utilization patterns of participating patient managers. The procedures shall also include establishment of a grievance procedure defined in rule 441—88.49(249A).

88.45(4) *Corrective action and sanctions.* The department shall establish procedures for corrective action and sanctions when monitoring activities reveal possible contract noncompliance.

88.45(5) *Termination of contract.* The contract may be terminated in any of the following ways:

a. The patient manager may terminate the contract or a clinic may remove a provider from a clinic contract by providing the department with written notice of the desire to terminate the contract 60 days in advance of the desired date of termination in order to allow the department or its designee time to disenroll and reenroll the MediPASS patients with other patient managers.

(1) In no situation shall the provider stop providing patient management or primary care to the patient until the patient can be reenrolled with another provider except as specified in subrule 88.48(4).

(2) Failure to provide the specified period of notice or failure to continue providing patient management or primary care before the reenrollment shall result in forfeiture of all remaining patient management fees that would otherwise have been due the patient manager.

b. The department may terminate the contract with the patient manager with 60 days' advance notice for any of the following reasons:

(1) The department has imposed any sanction described at 441—subrule 79.2(3).

(2) Recommendations of contract termination made in accordance with the procedures described in rule 441—88.51(249A), after opportunity for corrective action has been unsuccessful or rejected by the patient manager in question.

Sixty days' advance notice is not required for situations described in subrule 88.48(4).

c. Any patient manager who has had a contract terminated by the department shall have the right to appeal the termination as provided in 441—Chapter 7.

441—88.46(249A) Enrollment and changes in enrollment.

88.46(1) *Mandatory enrollment.* Participation in managed health care, if available, is required for covered eligibles as specified in subrule 88.42(1) who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.46(2) *Enrollment procedures.* In mandatory enrollment counties, recipients shall be required to choose their managed health care provider. When no choice is made by the recipient, the recipient will be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member

has selected, if that provider is appropriate according to age parameters. MediPass patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.46(4) dealing with the effective date.

a. Timely notice. Recipients shall be sent timely notice of the managed health care assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. Enrollment. Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

(1) Attains initial eligibility for a covered category of service in a mandatory project county.

(2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.

(3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or voluntary project county to a mandatory project county.

(4) Reattains eligibility.

(5) Has a new member of the household receiving a covered category of assistance.

If the covered eligible in a mandatory project county does not make another selection before the due date specified in the notice, the covered eligible shall be enrolled with the managed health care provider listed on the notice.

c. Selection of a managed health care provider. A list of managed health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers as described in subrule 88.44(3), the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Rescinded IAB 5/7/97, effective 7/1/97.

e. Request to change enrollment. An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request shall be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.46(3) dealing with effective date.

f. Managed care entity extended-participation program (EPP). After the initial 90 days from timely notice, recipients will remain enrolled with the chosen provider for the following six months, with three exceptions:

(1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3)*"a."*

(2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3)*"b."*

(3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

g. Enrollment cycle. Prior to the end of any extended-participation program (EPP) period, recipients will be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

88.46(3) *Voluntary enrollment procedures.* Voluntary enrollment procedures shall be the same guidelines as mandatory enrollment procedures except:

a. Recipients shall not be informed at the face-to-face interview that enrollment is required.

b. Notice to recipient shall not include assignment language.

c. Recipients shall not be assigned if no selection is made voluntarily.

d. A managed health care provider must be available for enrollment.

88.46(4) *Effective date.* Enrollment or changes in enrollment shall always be effective on the first day of a month. The effective date of enrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives a choice as specified in subrules 88.46(1) and 88.46(2) or the deadline given a recipient to indicate the recipient's managed health care choice, whichever is applicable. The effective date shall be earlier where computer cutoff allows.

88.46(5) *Identification card.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to all enrolled recipients.

Providers of medical services shall access the department's eligibility verification system (ELVS) via telephone or access the department's secure Web site at the time of service in order to establish that the patient is Medicaid-eligible and whether the services being provided require the authorization of the patient manager.

88.46(6) *Enrollment limits.*

a. Unless one or more of the following special situations exist, enrollment shall be limited to 1500 enrollees per full-time patient manager with an additional 300 enrollees allowed for each full-time nurse practitioner or physician's assistant employed by the MediPASS provider or clinic:

(1) The provider treats a disproportionate share of Medicaid patients in the provider's current practice.

(2) A special group practice arrangement exists with a demonstrated ability to manage a large number of enrollees.

(3) Other exceptional situations may be considered as special demonstration projects on a case-by-case basis.

b. Patient managers wishing to receive consideration for one of these special situations must make a request for consideration in writing to the department and provide sufficient documentation that they fit one or more of the special situations.

c. Providers or clinics may set a lower self-imposed maximum number of enrollees at the time they sign the initial contract and may revise that number by notifying the department or its designee in writing.

(1) If the patient manager decreases the patient manager's own maximum to a number below which the patient manager currently has enrolled, the patient manager must continue to serve those recipients until normal disenrollments put the provider below the provider's new maximum.

(2) No minimum number of enrollees shall be required.

88.46(7) *Reinstatement of patient management status.* When an enrolled recipient loses Medicaid eligibility and is subsequently reinstated before the effective date of cancellation, the enrollment in patient management will also be reinstated.

441—88.47(249A) Disenrollment.

88.47(1) *Disenrollment request.* An enrolled recipient may be disenrolled from a patient manager in one of three ways:

a. The enrolled recipient may request disenrollment by completing a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from the date of the enrollment notice. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality, or inadequately provided. If the recipient is a covered eligible specified in subrule 88.42(1) as a mandatory participant, the recipient's disenrollment request shall not be approved until another patient manager or managed health care option is chosen.

b. The patient manager may request that an enrolled recipient be disenrolled by completing Form 470-2169, Managed Health Care Provider Request for Recipient Disenrollment.

(1) Disenrollment may be approved for good cause, such as but not limited to inability after reasonable effort to establish or maintain a satisfactory provider-patient relationship with the recipient. Documentation of the reason for disenrollment shall be included with or attached to the disenrollment request.

(2) The department shall respond within 30 days as to whether the disenrollment request is approved.

(3) If the request is approved, the patient manager shall continue to serve a mandatory recipient until the recipient can be enrolled with another patient manager or another managed health care option. In no case shall that time exceed 60 days from the date of receipt of the form.

c. The department may disenroll an enrolled recipient in the following situations:

(1) The contract with the patient manager is terminated.

(2) The patient manager dies, retires or leaves the medical service area.

(3) The recipient loses Medicaid eligibility. If the recipient regains eligibility as specified in subrule 88.46(7), the enrollment to patient management will be automatically reinstated.

(4) The recipient moves to a nonproject county.

(5) The recipient's eligibility changes to a category of assistance as specified in subrule 88.42(2) that is excluded from participation in patient management.

(6) The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

(7) The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in 441—Chapter 76, would be more cost-effective for the department.

The department shall request that recipients whose participation is mandatory as specified in subrule 88.42(1) select a new patient manager or other managed health care option if disenrollment is for reasons listed in 88.47(1)*"c"* (1) or (2). If the recipient does not make the selection the recipient will be assigned a new patient manager by the department.

88.47(2) *Effective date.* Disenrollment shall always be effective on the first day of a month. The effective date of disenrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives an enrollment change request as specified in subrule 88.47(1) or the date the department approves a disenrollment request from a physician or the date the department becomes aware of an event which causes the department to disenroll an enrolled recipient, whichever is applicable. The effective date shall be earlier whenever possible.

441—88.48(249A) Services.

88.48(1) *Managed services.* Provision of the following services by any provider other than the patient manager requires authorization from the patient manager in order to be payable by Medicaid except that mental health and substance abuse services for all managed health care recipients are provided under the Iowa Plan program and do not require authorization (see rule 441—88.61(249A)):

a. Inpatient hospital.

b. Outpatient hospital.

c. Home health.

d. Physician (except services provided by an ophthalmologist).

e. Clinic (rural health clinic, federally qualified health center, maternal health center, ambulatory surgical center, birthing center).

f. Laboratory, X-ray.

g. Medical supplies.

h. Physical therapy, audiology, rehabilitation agency, advanced registered nurse practitioner.

i. Rescinded IAB 11/5/97, effective 1/1/98.

j. Podiatric.

These services require authorization even if the need for the service is considered urgent. However, in case of urgent medical conditions, the patient manager shall arrange for necessary care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

88.48(2) *Nonmanaged services.* Provision of any services not listed in subrule 88.48(1) does not require authorization from the patient manager in order to be payable by Medicaid.

88.48(3) *Authorizing managed services.* The patient manager may make referrals to another provider for specialty care or for primary care during the patient manager's absence or nonavailability.

a. No special authorization or referral form is required, and referrals should occur in accordance with accepted practice in the medical community. To ensure that payment is made for properly authorized services, the patient manager shall provide the specialist or other provider with the patient manager's Medicaid provider number (the national provider identifier number or Iowa-specific provider identifier number), which must be entered on the billing form to signify that the service has been authorized.

b. After the patient manager's initial referral of a patient to a specialist for ongoing treatment, the specialist shall not be required to receive further specific authorizations for the duration of the illness, or at the discretion of the patient manager, for a period of time specified by the patient manager.

c. The referral shall include necessary services rendered by the specialist and referrals for related services made by the specialist. With the patient manager's approval, the patient manager's number may be relayed by the referred specialist to other providers considered necessary for proper treatment of the patient. All authorizations and referrals shall be documented by both the patient manager and the referred-to provider in the patient's medical record.

d. Emergency services are excluded from the authorization requirement, even though these services may be ones customarily requiring authorization under patient management. Urgent care requires authorization in order for Medicaid services to be paid. The unauthorized use of a patient manager's authorization number shall be considered to be a false or fraudulent claim submission and may subject the provider to recoupment or to sanctions described at 441—subrule 79.2(3).

88.48(4) *Special authorizations.* Special authorization for the provision of managed services shall be given to providers by the department in situations such as, but not limited to, the death of the enrolled recipient's patient manager, the patient manager has left medical practice, moved from the medical service area or has been removed as a Medicaid provider and the department has not yet been able to establish a new patient manager or other managed health care option for the recipient. The procedure for obtaining this special authorization shall be specified in the provider handbook. The special authorization procedures shall only be used until the department is able to enroll the recipient with another patient manager or managed health care option. Additionally, special authorizations may be given when contracting patient managers fail to comply with contract provisions such as, but not limited to, failure to maintain 24-hour access as specified in subrule 88.45(2), paragraph *"b."*

441—88.49(249A) Grievance procedure. The department shall establish a procedure whereby enrolled recipients or providers may express complaints or concerns either verbally or in writing specific to managed health care services.

88.49(1) *Written record.* The department or its designee shall maintain a written record of all grievances. A log shall be maintained that includes the date of the grievance, member name and state identification number, provider name and national provider identifier number or Iowa-specific provider identifier number, nature of complaint, resolution and date of resolution.

88.49(2) *Formal grievance resolution and response.* The department or its designee shall record the facts involved in all grievances. Pertinent facts shall be obtained, as necessary and appropriate, from interviews with involved parties, on-site visits and consultation with professional medical consultants or an education and review committee. The department or its designee shall respond to all grievances within 15 working days of receipt. The response shall be in writing and copies shall be provided to the recipient, the provider and to the department's patient manager file. Appeal rights shall be included in the response.

88.49(3) *Repeated grievances.* Providers or recipients who file repeated grievances, or providers or recipients against whom repeated grievances are filed, will be reviewed in-depth and a possible on-site visit will be made to resolve any misunderstandings as to patient management policies and procedures.

88.49(4) *Quality of care grievances.* In grievances involving quality of care, the case shall be referred to appropriate persons or agencies, including the board of medicine, for investigation.

88.49(5) *Information concerning grievance procedures.* The department grievance procedure shall be published on appropriate forms and brochures for the information of recipients and in provider handbooks for the information of patient managers and other providers.

88.49(6) *Appeals to the department.* A recipient who has exhausted the formal grievance procedure may appeal the issue to the department under the provisions of 441—Chapter 7.

441—88.50(249A) Payment.

88.50(1) *Fee.* Patient managers shall be paid a monthly fee of $2 per enrolled recipient for the provision of patient management, including referrals. Payment for other services rendered shall be reimbursed in accordance with rules governing Medicaid payment. Providers such as federally qualified health centers who are reimbursed on a 100 percent of cost basis are not eligible to receive patient management fees separate from other reimbursement.

88.50(2) *Basis for payment.* Payment shall be based on the number of recipients enrolled with the patient manager as of automated benefit calculation system cutoff day in the month for which payment is being calculated.

88.50(3) *Mode of payment.* The provider shall be paid individually unless a clinic or group practice elects to receive payment for all providers participating under the clinic or group contract. The same mode of payment must be used for both patient management and regular Medicaid claims.

88.50(4) *Payment limit.* Payment shall be limited to $3000 per month per patient manager no matter how many recipients are enrolled with the patient manager.

441—88.51(249A) Utilization review and quality assessment. Patient managers shall be monitored to ensure that recipients are able to access quality care and that utilization patterns and costs fall within acceptable standards. If overutilization or underutilization is apparent or quality of management service is inadequate, efforts shall be made to determine the reason and resolve problems, as necessary.

88.51(1) *Measured services.* Cost and units of service data will be reviewed for selected categories of service. This data shall be used to monitor overall utilization patterns and compare peer utilization patterns.

88.51(2) *Reports to patient managers.* Utilization information shall be provided on a periodic basis to patient managers to enable them to review their own utilization patterns and to review utilization by their enrollees. Patient managers will be responsible for reporting any discrepancies detected in this information to the department. The patient manager will be responsible for attempting to correct utilization behavior of recipients who appear from utilization reports to be inappropriate utilizers of medical services.

88.51(3) *Managed health care advisory committee.* Participating managed health care providers will be invited to assist the department or its agent in establishing and assessing goals of the state's Medicaid managed health care program. The department shall form a managed health care advisory committee made up of persons deemed appropriate by the department to review, advise and plan managed care goals with the department. Members may include representatives of MediPASS providers, HMO providers, FQHC providers, RHC providers, association representatives, and other public agencies as deemed appropriate by the department. The committee's functions may include, but are not limited to, the following:

a. Assist the department in developing procedures and parameters for utilization review and conduct further review of the utilization of patient managers whose pattern of utilization falls outside established parameters.

b. Assist the department in establishing options for managed health care quality assessment.

c. Assist the department in reviewing and making recommendations for action on quality of service-related grievances under the grievance procedure outlined in rule 441—88.49(249A).

d. Assist the department in developing corrective action steps and recommendations for managed health care providers who have identifiable utilization or quality of management service deficiencies.

e. Assist the department in developing standards and procedures for managed health care providers to use in performing review functions.

f. Prepare or provide educational or informative articles to be used for patient education and health promotion.

441—88.52(249A) Marketing. A MediPASS provider may not distribute directly or through any agent or independent contractor marketing materials without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

88.52(1) *Service market.* A MediPASS provider shall distribute any marketing materials to the entire service area or region.

88.52(2) *Prohibition of "cold-call" marketing.* MediPASS providers shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment.

441—88.53 to **88.60** Reserved.

DIVISION IV
IOWA PLAN FOR BEHAVIORAL HEALTH

441—88.61(249A) Definitions.

"Accredited" shall mean an entity approved by the division of mental health and disability services of the department to provide mental health services.

"Appeal" shall mean the process defined in 441—Chapter 7 by which a Medicaid member, or the member's designee, may request review of a certain decision made by the department or the contractor.

"ASAM-PPC-2R" shall mean the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised, published by the American Society of Addiction Medicine in 2001.

"Assertive community treatment (ACT) program" shall mean a program of comprehensive outpatient services provided in the community directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of persons with severe and persistent mental disorders and persons with complex symptomatology who require multiple mental health and supportive services to live in the community.

"Capitation rate" shall mean the fee the department pays monthly to the contractor for each enrolled Medicaid member for the provision of covered, required, and optional services, whether or not the enrollee received services during the month for which the fee is paid.

"Certification" shall mean the process of determining that a facility, equipment or an individual meets the requirements of federal or state law.

"Clinical decision review" shall mean the process by which enrollees and participating and nonparticipating providers may request a review by the contractor of a decision made by an employee of the contractor regarding the prior authorization, denial, or payment for services.

"Contract" shall mean the contract between the department and the entity or entities selected by the department to implement the Iowa Plan. Contract sections related to Medicaid-funded services shall be interpreted to meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996. The department of public health also shall be party to the contracts in relationship to the provision of substance abuse services to non-Medicaid persons served through the Iowa Plan.

"Contractor" shall mean each entity with whom the department contracts to provide covered, required and optional services for those members enrolled in the Iowa Plan.

"Coverage group" shall mean a category of members who meet certain common eligibility requirements.

"Covered services" shall mean mental health and substance abuse treatment services reimbursable based on provisions of the Medicaid state plan and paid through the fee-for-service payment system administered by the Iowa Medicaid enterprise.

"Department" shall mean the Iowa department of human services acting in cooperation with the department of public health for governance of the contract.

"Designee" shall mean an organization, person, or group of persons designated by the director to act on behalf of the department in the review or evaluation of services provided through the Iowa Plan.

"Director" shall mean the director of the Iowa department of human services.

"Disenrollment" shall mean the removal of an enrollee from the contractor's enrollment list either through loss of eligibility or some other cause.

"Emergency services" shall mean those services required to meet the needs of an enrollee who is experiencing an acute crisis of a level of severity requiring immediate treatment where a failure to treat could result in death, injury, or lasting harm to the enrollee or serious danger to others.

"Encounter data" shall mean information reflecting a face-to-face meeting or other billable service furnished by a provider to a person served through the Iowa Plan. Medicaid encounter data must be submitted by the contractor to the department in an electronic format specified by the department.

"Enrollee" shall mean any Medicaid member who is enrolled in the Iowa Plan in accordance with the provisions of the contract.

"Enrollment" shall mean the inclusion of a Medicaid member on a contractor's Medicaid enrollment file.

"Enrollment area" shall mean the geographical area in which the enrollees that are assigned by the department to the contractor reside.

"Fee-for-service" shall mean the method of making payment for Medicaid services reimbursable under the Medicaid state plan in which reimbursement is based on fees set by the department for defined services. Payment of the fee is based upon delivery of the defined services and is done through the Iowa Medicaid enterprise.

"Grievance" shall mean a nonclinical incident, nonclinical complaint, or nonclinical concern which is received verbally and which cannot be resolved in a manner satisfactory to enrollees or participating or nonparticipating providers by the immediate response of the contractor's staff member or a nonclinical incident, nonclinical complaint, or nonclinical concern which is received in writing.

"Insolvency" shall mean a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

"Integrated mental health services and supports" shall mean individualized mental health services and supports planned jointly by the contractor, the enrollee, and others significant to the enrollee as appropriate, which are not regularly defined services otherwise offered by the contractor.

"Iowa Plan" shall mean the Iowa Plan for Behavioral Health, established by this division as the managed care plan to provide mental health and substance abuse treatment.

"Licensed" shall mean a facility, equipment, individual or entity that has formally met state requirements for licensure and has been granted a license.

"Member" shall mean a person determined eligible for Medicaid.

"Mental health services" shall mean those clinical, rehabilitative, or supportive services provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any mental disorder listed in the International Classification of Diseases—Ninth Edition (ICD-9). At a minimum, covered disorders include the following ranges of the ICD-9: 290-302.9; 306-309.9; and 311-314.9. Additional code ranges may be included in the contract. Mental health services shall include, but not be limited to, those services listed at subrule 88.65(3).

"MHI" shall mean a state mental health institute operated by the department.

"Open panel" shall mean that the contractor shall subcontract with all providers who are appropriately licensed, certified, or accredited to provide covered, required, or optional services, and who meet the credentialing criteria, agree to the standard contract terms, and wish to participate.

"Participating providers" shall mean the providers of mental health and substance abuse services who subcontract with the contractor.

"Prepaid health plan (PHP)" shall mean an entity defined at Section 1903(m)(2)(B)(iii) of the Social Security Act and determined to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3), as amended to March 13, 1991.

"Prior authorization" shall mean the process by which an enrollee or a provider obtains approval prior to the initiation or continuation of a service as to the appropriateness of a service. The contractor may require prior authorization as a condition of payment. Prior authorization of a mental health service shall be based on psychosocial necessity. Prior authorization of a substance abuse service shall be based on service necessity.

"Psychosocial necessity" shall mean that clinical, rehabilitative, or supportive mental health services meet all of the following conditions. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health diagnosis.
2. Provided for the diagnosis or direct care and treatment of a mental disorder.
3. Within standards of good practice for mental health treatment.
4. Required to meet the mental health needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

The determination of psychosocial necessity shall be made after consideration of the enrollee's clinical history, including the impact of previous treatment and service interventions; services being provided concurrently by other delivery systems; the potential for services and supports to avert the need for more intensive treatment; the potential for services and supports to allow the enrollee to maintain functioning improvement attained through previous treatment; unique circumstances which may impact the accessibility or appropriateness of particular services for an individual enrollee (e.g., availability of transportation, lack of natural supports including a place to live); and the enrollee's choice of provider or treatment location.

"Required services" shall mean mental health and substance abuse treatment services and supports which are not reimbursable though the Iowa Medicaid fee-for-service program but which are the contractual responsibility of the contractor.

"Retroactive eligibility" shall mean the period of time consisting of the three months preceding the month in which an application for Medicaid is filed, during which the person may be eligible for Medicaid coverage as determined by the department.

"Routine care" shall mean those clinical, rehabilitative, or supportive mental health or substance abuse services which are typically arranged through regular, scheduled appointments with a provider. Conditions requiring routine care are not likely to substantially worsen or cause damage or disruption to the recipient's life without immediate intervention.

"Service necessity" shall mean that substance abuse services for the treatment of conditions related to substance abuse meet the following requirements according to the criteria of the ASAM-PPC-2R. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered substance abuse diagnosis.
2. Provided for the diagnosis or direct care and treatment of a substance abuse disorder.
3. Within standards of good practice for substance abuse treatment.
4. Required to meet the substance abuse treatment needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

"Substance abuse licensed PMIC" shall mean a psychiatric medical institution for children (PMIC) which also is licensed in accordance with Iowa Code chapter 125 to provide substance abuse treatment services.

"Substance abuse services" shall mean those clinical, rehabilitative, supportive and other services provided in response to and to alleviate the symptoms of any substance abuse disorder listed in the

International Classification of Diseases—Ninth Edition (ICD-9), disorders 303 through 305.9, provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any of these substance abuse disorders. Services include, but are not limited to, services listed at subrule 88.65(4).

"Targeted case management services" shall mean MR/CMI/DD case management services targeted to adults with a primary diagnosis of chronic mental illness as defined at rule 441—90.1(249A), with standards set forth in 441—Chapter 24 and Medicaid requirements set forth in 441—Chapter 90.

"Third party" shall mean an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of mental health and substance abuse services related to any medical assistance covered by Medicaid.

"Urgent, nonemergency care" shall mean those clinical, rehabilitative, or supportive services provided for conditions which, although they do not present immediate risk of death, injury, or lasting harm, may risk significant damage or disruption to the recipient's life or require expeditious treatment to alleviate the prospect that the condition will substantially worsen without immediate intervention.

441—88.62(249A) Participation.

88.62(1) *Contract.* The department may enter into a contract for the provision of mental health and substance abuse services specified in 441—Chapter 78, or any portion thereof, with a prepaid health plan.

a. The department shall also determine that the contractor meet the following additional requirements:

(1) The contractor shall make the services it provides to enrollees at least as accessible as those services were to members prior to the implementation of the Iowa Plan.

(2) The contractor shall comply with insolvency requirements established by the department in the contract and shall ensure that neither Medicaid enrollees nor the state shall be responsible for its debts if the contractor should become insolvent.

(3) The contractor shall be licensed by the department of commerce, division of insurance, as a limited service organization.

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Specify the duration of the contract period.

(3) List the services which must and may be covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationships.

(8) Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the contractor, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.

88.62(2) *Assessment of penalties.* Penalties shall be assessed according to terms of the contract for failure to perform in either of the following areas:

a. Substantial failure to provide necessary covered and required services included in this contract when the failure has seriously and adversely affected an enrollee.

b. Failure to comply with any provision of the contract.

441—88.63(249A) Enrollment.

88.63(1) *Enrollment area.* The enrollment area shall be set forth in the contract between the department and the contractor. The department has determined that all counties of the state will be covered by the Iowa Plan, whether by a single statewide contractor or by multiple regional contractors.

88.63(2) *Members subject to enrollment.* All Medicaid members shall be subject to mandatory enrollment in the Iowa Plan.

a. Members who are enrolled in the Iowa Plan are notified of enrollment and the effective date of the enrollment.

b. When a coverage group is included in or excluded from Iowa Plan enrollment, the department and the contractor shall jointly notify members and participating and nonparticipating Medicaid providers before implementation of the change. The department shall implement a transition plan to ensure continuity of services to members.

88.63(3) *Others to be served.* The department may include other recipients of mental health and substance abuse services in the Iowa Plan. The department shall specify in the contract the services, persons to be served, and reimbursement methodology when other recipients are included.

88.63(4) *Voluntary enrollment.* There will be no voluntary enrollment in the Iowa Plan.

88.63(5) *Effective date.* For new members, the effective date of enrollment with the contractor shall be the first day of the month the Medicaid application was filed in the county office. Members under the age of 21 served at an MHI and members served at a substance abuse licensed PMIC will be enrolled for months of retroactive eligibility for Medicaid when the member resided in a substance abuse licensed PMIC or MHI during those months.

For current members who are no longer in an eligibility group excluded from the Iowa Plan, the effective date of enrollment shall be the first day of the month following the month they leave the excluded group.

88.63(6) *Medical card.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to each member. Before delivering mental health or substance abuse services, the provider shall access the department's eligibility verification system (ELVS) to verify the member's enrollment in the Iowa Plan.

441—88.64(249A) Disenrollment.

88.64(1) *Disenrollments by the department.* Disenrollments shall occur when:

a. The enrollee becomes ineligible for Medicaid. If the enrollee becomes ineligible and is later reinstated to Medicaid, enrollment in the Iowa Plan shall also be reinstated.

b. The enrollee is transferred to a coverage group excluded from the Iowa Plan.

c. The enrollee dies.

88.64(2) *Effective date.* Disenrollment shall be effective the first day of the month following the month of disenrollment.

88.64(3) *No disenrollment for health reasons.* No enrollee shall be disenrolled from the Iowa Plan because of an adverse change in health status, including mental health and substance abuse status.

441—88.65(249A) Covered services.

88.65(1) *Amount, duration, and scope of services.* The contractor may not impose limitations on the amount, duration, or scope of services provided which are not allowable under the Medicaid state plan. The contractor may, however, require the use of participating providers, require prior authorization for services other than emergency services as set forth in rule 441—88.66(249A), and direct enrollees to the appropriate level of care for receipt of those services which are the responsibility of the contractor.

88.65(2) *Enrollee use of Iowa Plan services.* Enrollees shall receive all Medicaid-funded covered, required, and optional mental health and substance abuse services only through the Iowa Plan. An enrollee shall use only participating providers of service unless the contractor has authorized a referral to a nonparticipating provider for provision of a service or treatment plan. Payment shall be denied under Medicaid fee-for-service on claims for covered, required, and optional mental health and substance abuse services provided to enrollees. The contractor shall implement policies to ensure that no participating or nonparticipating provider bills an enrollee for all or any part of the cost of a covered, required, or optional service.

88.65(3) *Covered, required and optional mental health services.*

a. The contractor shall ensure, arrange, monitor and reimburse, at a minimum, the following covered mental health services:

(1) Ambulance services for psychiatric conditions.

(2) Emergency room services for psychiatric conditions available 24 hours per day, 365 days per year.

(3) Inpatient hospital care for psychiatric conditions.

(4) Outpatient hospital care for psychiatric conditions including intensive outpatient services.

(5) Partial hospitalization.

(6) Day treatment.

(7) Psychiatric physician services including consultations requested for enrollees receiving treatment for other medical conditions.

(8) Services of a licensed psychologist for testing, evaluation and treatment of mental illness.

(9) Services in state MHIs for enrollees under the age of 21 or through the age of 22 if the enrollee is hospitalized on the enrollee's twenty-first birthday.

(10) Services provided through a community mental health center.

(11) Targeted case management services to persons with chronic mental illness.

(12) Medication management.

(13) Psychiatric nursing services by a home health agency.

(14) Psychiatric or psychological screenings required subsequent to evaluations for persons applying for admission to nursing homes.

(15) Mental health services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.

b. The contractor shall ensure, arrange, monitor and reimburse the following required mental health services which are not reimbursable by Medicaid fee-for-service:

(1) Concurrent substance abuse and mental health services for those diagnosed with both chronic substance abuse and chronic mental illness.

(2) Services of a licensed social worker for treatment of mental illness.

(3) Mobile crisis services.

(4) Mobile counseling services.

(5) Integrated mental health services and supports.

(6) Psychiatric rehabilitation services.

(7) Peer support services for persons with chronic mental illness.

(8) Community support services.

(9) Periodic assessment of the level of functioning for each enrollee who meets the criteria of either a child with a serious emotional disability or a person with serious and persistent mental illness. The assessment is to be conducted by appropriately credentialed participating providers.

(10) Programs of assertive community treatment.

c. The contractor may develop optional services and supports to address the mental health needs of enrollees. These optional services and supports shall be implemented only after approval by the department. Optional services and supports shall be provided by or under the supervision of qualified mental health professionals or appropriately accredited agencies.

d. The department may require the coverage of other mental health services and supports under the terms of the contract.

88.65(4) *Covered and required substance abuse services.* The contractor shall ensure, arrange, monitor and reimburse the following services for the treatment of substance abuse:

a. Outpatient services (all Level I services according to the ASAM-PPC-2R).

b. Intensive outpatient and partial hospitalization services (all Level II services according to the ASAM-PPC-2R).

c. Residential or inpatient services (all Level III services according to the ASAM-PPC-2R).

d. Medically managed intensive inpatient services (all Level IV services according to the ASAM-PPC-2R).

e. Detoxification.

f. PMIC substance abuse treatment services.

g. Emergency room services for substance abuse conditions available 24 hours a day, 365 days a year.

h. Ambulance services for substance abuse conditions.

i. Substance abuse treatment services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.

j. Intake, assessment, evaluation and diagnostic services, including testing for alcohol and drugs, to determine a substance abuse diagnosis.

88.65(5) *Covered diagnoses.* Services for a covered diagnosis cannot be denied solely on the basis of an individual's also having a noncovered diagnosis. Mental health services, including inpatient care, cannot be denied solely on the basis of an individual's having no Axis I diagnosis. The contractor will be responsible for ensuring, arranging, monitoring, and reimbursing services necessary for the behavioral care and treatment of the covered diagnoses for Iowa Plan enrollees who are diagnosed with a covered diagnosis and a noncovered diagnosis.

The services defined at subrules 88.65(3) and 88.65(4) shall be provided to all Iowa Plan enrollees who meet the diagnostic criteria for the following disorders listed in the International Classification of Diseases—Ninth Edition (ICD-9):

1. Mental health: 290-302.9; 306-309.9; 311-314.9.
2. Substance abuse: 303-305.9.

88.65(6) *Excluded services.* Unless the service is specifically included in the contract, the contractor shall not be required to provide long-term care (e.g., residential care facilities, nursing facilities, state resource centers, or intermediate care facilities for persons with mental retardation) or remedial services.

441—88.66(249A) Emergency services.

88.66(1) *Availability of services.* The contractor shall ensure that emergency services for covered diagnoses are available 24 hours a day, seven days a week, either through participating providers or through arrangements with other providers.

88.66(2) *Payment for emergency room services.* Emergency room services for covered diagnoses shall be reimbursed for enrollees regardless of whether authorized in advance or whether the provider of service is a participating provider.

a. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor may:

(1) Establish policies requiring notification of the provision of emergency room service within a stated time frame which shall be no less than 48 hours.

(2) Require authorization of any services beyond those provided in the emergency room.

b. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor shall:

(1) Provide a minimum triage fee to the emergency room, regardless of whether the facility notifies the contractor. The triage fee shall be no less than is paid under payment mechanisms established for the Medicaid fee-for-service program.

(2) Reimburse the emergency room for emergency room services provided, contingent upon the facility's compliance with notification policies. Reimbursement to nonparticipating providers shall be no less than the average payment which would be made to a participating provider.

88.66(3) *Contractor payment liability.* The contractor's payment liability for the provision of emergency mental health and substance abuse services by nonparticipating providers is limited to emergency mental health and substance abuse services provided before the enrollee can, without danger or harmful consequences to the enrollee or others, return to the care of a participating provider. If transportation is necessary to transport the enrollee from a nonparticipating provider to a participating provider, the contractor shall be financially liable for the transportation. In reimbursing nonparticipating providers, the contractor's liability is limited to the average reimbursement which the contractor would pay to a participating provider for the same services.

88.66(4) *Notification and claim filing time spans.* The contractor may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers and shall notify enrollees of these provisions. However, failure to give notice or to file claims within those time limitations shall not invalidate any claim if it can be shown that it was not reasonably possible to

give the notice and that notice was, in fact, given as soon as was reasonably possible. In addition, the contractor shall provide payment for emergency services to nonparticipating providers within 60 days of receipt of a bill which complies with all billing requirements established by the contractor's policies.

441—88.67(249A) Access to service.

88.67(1) *Choice of provider.* Enrollees shall have the opportunity to choose their mental health care and substance abuse treatment professionals and service providers from any of the participating providers to the extent clinically appropriate.

88.67(2) *Open panel requirement.* The contractor shall establish and implement policies to ensure an open panel approach to the recruitment of participating providers.

88.67(3) *Requirements for participating provider panel.* The contractor shall develop and maintain a panel of participating providers which meets the following requirements. The panel shall:

a. Have sufficient staff resources to adequately provide mental health and substance abuse services to meet the needs of enrollees or have arrangements for services to be provided by other providers where capability of participating providers to serve specific mental health and substance abuse needs does not exist.

b. Maintain treatment sites in compliance with all applicable local, state, and federal standards related to the services provided as well as those for fire and safety.

88.67(4) *Adequate appointment system.* The contractor shall require that participating providers have procedures for the scheduling of enrollee appointments, which are appropriate to the reason for the service, as follows:

a. Enrollees with emergency needs shall be seen within 15 minutes of presentation at a service delivery site.

b. Persons with urgent nonemergency needs shall be seen within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or contractor.

c. Persons with persistent symptoms shall be seen within 48 hours of reporting symptoms.

d. Persons with need for routine services shall be seen within three weeks of the request for appointment.

88.67(5) *Adequate after-hours call-in coverage.* The contractor shall ensure crisis counseling and referral are available 24 hours a day, 365 days per year via a toll-free telephone line, the number for which is regularly made available to all enrollees.

88.67(6) *Adequate referral system.* The contractor shall have in effect arrangements which provide for an adequate referral system for any specialty mental health and substance abuse treatment services not available through participating providers.

88.67(7) *Discharge planning.* The contractor shall implement policies to ensure that no enrollee who has been receiving services in a 24-hour setting funded by the contractor is discharged from that setting until a discharge plan has been developed which provides appropriate follow-up care and treatment which is accessible to that enrollee.

88.67(8) *Lack of discharge plan.* When a discharge plan as described in subrule 88.67(7) has not been developed or cannot be implemented, the following shall apply:

a. If the contractor is not required to pay for services at the 24-hour level of care as set forth in subrule 88.73(2) because the services do not meet the criteria of psychosocial necessity or service necessity, the contractor is required (keep kids safe policy) to authorize up to 14 calendar days of additional funding on an administrative basis for enrollees under the age of 18 if a safe and appropriate living arrangement is not available because:

(1) A court order is in effect that must be modified to allow the placement of the child into that living arrangement;

(2) A court order is required to allow placement of the child into the appropriate living arrangement;

(3) A bed is not available in the level of care which has been determined as clinically appropriate for the child; or

(4) Services and support must be arranged to assist the natural family, foster family, or other living arrangement to become ready to assist the enrollee after the enrollee's return to that environment.

b. If 24-hour services provided through the Iowa Plan are being decertified, payment is limited in accordance with subrule 88.73(2) except as provided in paragraph 88.67(8)*"a."*

441—88.68(249A) Review of contractor decisions and actions.

88.68(1) *Clinical decision review.* The contractor shall have written procedures by which enrollees and participating and nonparticipating providers may request a clinical decision review. The clinical decision review, when requested, shall be conducted by staff other than the person or persons who made the original clinical care decision. All policies related to clinical decision review shall be approved by the department prior to implementation. The contractor's clinical decision review policies shall further:

a. Require acknowledgment of the receipt of a request for a clinical decision review to the enrollee and to the provider if applicable within three working days.

b. Allow for participation by the enrollee and the provider.

c. Set time frames for resolution including emergency procedures which are appropriate to the nature of the clinical decision under review.

d. Require that 95 percent of all clinical decision reviews be resolved within 14 days of receipt of all required documentation and that 100 percent of all clinical decision reviews be resolved within 90 days of the receipt of all required documentation.

e. Ensure the participation of contractor staff with authority to require corrective action.

f. Include at least one level of internal review.

g. Ensure the confidentiality of the enrollee.

88.68(2) *Appeal to department.* Enrollees may appeal clinical care decisions in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7 if the enrollee is not satisfied with the final decision rendered by the contractor through the contractor's clinical decision review process.

88.68(3) *Review of nonclinical decisions.* The contractor shall have available to all enrollees and other persons who do business with the contractor a process for the review of any complaints or grievances concerning nonclinical matters. All policies related to the review of nonclinical decisions shall be approved by the department prior to implementation. Policies regarding the process for the review of nonclinical decisions shall incorporate the following:

a. Allow initiation both verbally and in writing.

b. Require a review conducted by someone other than the person who made the original decision.

c. Require written notice acknowledging the receipt of a complaint or grievance.

d. Require resolution of 95 percent of all complaints or grievances within 14 days of the receipt of all required documentation and resolution of 100 percent within 90 days of the receipt of all required documentation.

88.68(4) *Written record.* All requests for review of contractor decisions and actions, including all informal or verbal complaints which must be referred or researched for resolution, shall be recorded in writing. A log shall be retained and made available at the request of the department. The log shall include progress notes and method of resolution to allow determination of compliance with subrules 88.68(1) and 88.68(3).

88.68(5) *Information concerning procedures relating to the review of contractor decisions and actions.* The contractor's written procedures for the review of contractor decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.

88.68(6) *Periodic reports to the department.* The contractor shall make reports to the department summarizing the review of contractor decisions and actions and resolutions to the reviews at a frequency specified in the contract.

441—88.69(249A) Records and reports.

88.69(1) *Records system.* The contractor shall document and maintain clinical and fiscal records throughout the course of the contract. The record system shall:

a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.

b. Provide a rationale for and documentation of clinical care decisions made by the contractor based upon psychosocial necessity for mental health services and service necessity for substance abuse services.

c. Permit effective professional review for medical audit processes.

d. Facilitate an adequate system for monitoring treatment reimbursed by the contractor including follow-up of the implementation of discharge plans and referral to other providers.

e. Meet contract reporting requirements and federal reporting requirements applicable to prepaid health plans.

88.69(2) *Content of individual treatment record.* The contractor shall have contractual requirements with participating providers which ensure an adequate record-keeping system, including documentation of all Iowa Plan services provided to each enrollee, in compliance with the provisions of rule 441—79.3(249A).

88.69(3) *Confidentiality of mental health information.* The contractor shall protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with participating providers which allow release of mental health information only as allowed by Iowa Code chapter 228.

88.69(4) *Confidentiality of substance abuse information.* The contractor shall protect and maintain the confidentiality of substance abuse information by implementing policies for staff and through contract terms with participating providers which allow release of substance abuse information only in compliance with policies set forth in the Code of Federal Regulations at Title 42, Part 2, as amended to May 5, 1995, and other applicable state and federal law and regulations.

88.69(5) *Reports to the department.* The contractor shall submit reports to the department as follows:

a. Encounter data on a monthly basis.

b. Annual audited financial statements no later than 180 days after the close of each contract year.

c. Periodic financial, utilization, and statistical reports as required by the department in the contract.

d. Other reporting requirements as specified in the contract.

88.69(6) *Audits.* The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the contractor, participating providers, nonparticipating providers, and subcontractors pertaining to services performed and reimbursed under the contract. The department or its designee or HHS may audit and inspect any records of the contractor, participating providers, nonparticipating providers and subcontractors of the contractor, pertaining to services performed and the determination of amounts paid under the contract. These records shall be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.70(249A) Marketing. The marketing of Iowa Plan services is prohibited.

441—88.71(249A) Enrollee education.

88.71(1) *Use of services.* The contractor shall provide written information to all enrollees on the use of services the contractor is responsible to ensure, arrange, monitor, and reimburse. Information must include services covered; how to access services; providers participating; explanation of the process for the review of contractor decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how

to request a change in providers; statement of consumer rights and responsibilities; out-of-area use of service; availability of toll-free telephone information and crisis assistance; appropriate use of the referral system; and the method of accessing Medicaid-funded services not covered by the Iowa Plan, especially pharmacy services.

88.71(2) *Outreach to members with special needs.* The contractor shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, mental retardation or other cognitive impairments, homeless persons, illiterate persons, non-English-speaking persons and persons with visual or hearing impairments.

88.71(3) *Patient rights and responsibilities.* The contractor shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of enrollment information provided to all new enrollees.

441—88.72(249A) Payment to the contractor.

88.72(1) *Capitation rate.* In consideration for all services rendered by the contractor under a Medicaid contract with the department, the contractor shall receive a payment each month for each enrollee. This Medicaid capitation rate represents the total obligation of the department with respect to the costs of Medicaid mental health and substance abuse services provided to enrollees under the contract. The contractor accepts the rate as payment in full for the Medicaid-contracted services.

88.72(2) *Determination of rate.* The Medicaid capitation rates shall be established in the contract and shall not exceed the cost to the department of providing the same covered services on a fee-for-service basis to the same group of Medicaid members eligible for the plan.

88.72(3) *Payment for services to other recipients.* When the department chooses to include mental or substance abuse services for recipients other than enrollees, the department shall establish rates and reimbursement procedures in the contract.

88.72(4) *Third-party liability.* If an enrollee has health coverage or a responsible party other than the Medicaid program available for purposes of payment for mental health and substance abuse expenses, it is the right and responsibility of the contractor to investigate these third-party resources and attempt to obtain payment. The contractor may retain all funds collected through third-party sources. A complete record of third-party liability shall be maintained and made available to the department at the end of each contract year.

441—88.73(249A) Claims payment.

88.73(1) *Claims payment by contractor.* The contractor shall meet the following time lines for the payment of all claims for covered, required and optional mental health and substance abuse services submitted which meet the contractor's requirements for claim submission:

a. For at least 85 percent of claims submitted, payment shall be mailed or claims shall be denied within 14 days of the date the claim is received by the contractor.

b. For at least 90 percent of claims submitted, payment shall be mailed or claims shall be denied within 30 days of the date the claim is received by the contractor.

c. For 100 percent of claims submitted, payment shall be mailed or claims shall be denied within 90 days of the date the claim is received by the contractor.

88.73(2) *Limits on payment responsibility for services.*

a. The contractor is not required to reimburse providers for the provision of mental health services that do not meet the criteria of psychosocial necessity.

b. The contractor is not required to reimburse providers for the provision of substance abuse services that do not meet the criteria of service necessity.

c. The contractor is not required to reimburse providers for the provision of MR/CMI/DD case management services that do not meet the criteria and requirements set forth in 441—Chapter 90.

d. The contractor has the right to require prior authorization of covered, required and optional services and to deny reimbursement to providers who do not comply with such requirements.

e. Payment responsibilities for emergency room services are as provided at subrule 88.66(2).

f. Payment responsibility for services provided under the "keep kids safe" policy is set forth at subrule 88.67(8).

88.73(3) *Payment to nonparticipating providers.* In reimbursing nonparticipating providers, the contractor is obligated to pay no more than the average rate of reimbursement which the contractor pays to participating providers for the same service.

88.73(4) *Payment of crossover and copayments.* Rescinded IAB 1/9/02, effective 3/1/02.

441—88.74(249A) Quality assurance. The contractor shall have in effect an internal quality assurance system which meets the requirements of 42 CFR, Part 434.34 as amended to March 12, 1984, and complies with all other requirements specified in the contract.

441—88.75(249A) Iowa Plan advisory committee. The department shall appoint an advisory committee to advise the department in the implementation and operation of the Plan and to provide for ongoing public input in its operation.

441—88.76 to **88.80** Reserved.

DIVISION V
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

441—88.81(249A) Scope and definitions.

88.81(1) *Purpose.* A program of all-inclusive care for the elderly (PACE) organization provides prepaid, capitated, comprehensive health care services designed to meet the following objectives:

a. Enhance the quality of life and autonomy of frail older adults.

b. Maximize the dignity of and respect for frail older adults.

c. Enable frail older adults to live in the community as long as medically and socially feasible.

d. Preserve and support frail older adults' family units.

88.81(2) *Scope.* PACE programs may serve Medicaid members, Medicare beneficiaries, persons eligible for both Medicare and Medicaid benefits, and private-pay individuals. Enrollment to receive services from a PACE organization is voluntary.

a. Enrollment is limited to persons who are 55 years of age or older and who need care at the nursing facility level but are able to live in a community setting without jeopardizing their health and safety.

b. If a Medicaid member chooses to enroll in a PACE program, the member must receive Medicaid benefits solely through the PACE organization while enrolled in the program.

88.81(3) *Authorization.* A PACE organization must enter into a three-way agreement with the department and the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

88.81(4) *Definitions.* For purposes of this division:

"Alternate PACE service site" means a location outside a primary or alternate PACE center in which one or more PACE services are offered to PACE enrollees.

"Capitation rate" means the monthly fee the department pays to a PACE organization for each Medicaid enrollee for the provision of covered medical and health services, whether or not the enrollee received services during the month for which the fee is intended.

"CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

"Contract year" means the term of a PACE program agreement. The term is a calendar year, with the exception that a PACE organization's initial contract year is determined by CMS and may be from 12 to 23 months.

"Department" means the Iowa department of human services.

"Enrollee" means a person who is enrolled in a PACE program.

"Federal PACE regulations" means the standards published in 42 CFR Part 460, Programs of All-Inclusive Care for the Elderly. These rules shall be interpreted so as to comply with the federal PACE regulations.

"Interdisciplinary team" means the team designated by the PACE organization to assess the needs of and develop a comprehensive plan of care for each enrollee.

"Medicaid enrollee" means a Medicaid member who is enrolled in a PACE program.

"Medicare beneficiary" means a person who is entitled to Medicare Part A benefits, is enrolled under Medicare Part B, or both.

"Medicare enrollee" means a Medicare beneficiary who is enrolled in a PACE program.

"PACE" means programs of all-inclusive care for the elderly.

"PACE center" means a facility operated by a PACE organization where primary care is furnished to PACE enrollees. A primary PACE center is the principal facility operated by a PACE organization. An alternate PACE center is another facility operated by a PACE organization outside its primary center. "Primary care" shall include all program components in accordance with 42 CFR Section 460.92 as amended to December 8, 2006.

"PACE enrollment agreement" means the contract between the PACE organization and the enrollee that includes, at a minimum, all information identified in 42 CFR Section 460.154 as amended to December 8, 2006.

"PACE organization" means an entity that has in effect a PACE program agreement with the department and CMS to operate a PACE program in Iowa.

"PACE program" means a program of all-inclusive care for the elderly operated by an approved PACE organization that provides comprehensive health care services to enrollees in Iowa in accordance with a PACE program agreement.

"PACE program agreement" means a three-way agreement between CMS, the department, and an entity approved to be a PACE organization for the operation of a PACE program.

"Service area" means the specific counties in which a PACE provider may provide services, as identified in the PACE program agreement.

"Services" means both items and services provided to an enrollee by the PACE organization.

"Trial period" means the first three contract years in which a PACE organization operates under a PACE program agreement.

441—88.82(249A) PACE organization application and waiver process. This rule sets forth the application requirements for an entity that seeks approval from the department as a PACE organization and the process by which a prospective PACE organization may request department review and approval of requests to CMS for waiver of federal requirements.

88.82(1) *Application requirements.* A person authorized to act on behalf of an entity seeking approval as a PACE organization shall prepare an application in the format suggested by CMS at: http://www.cms.hhs.gov/PACE/06_ProviderApplicationandRelatedResources.asp.

a. The application shall:

(1) Describe how the entity meets the requirements of this division and of the federal PACE regulations; and

(2) Identify the counties in which the entity proposes to provide PACE services.

b. Upon completion of the application sections designated for PACE providers, the prospective PACE organization shall submit the application to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

88.82(2) *Waiver of federal requirements.* A prospective PACE organization must also receive CMS approval as a PACE organization. A prospective PACE organization must submit any request for waiver of federal PACE regulations to the department for initial review before submitting the request to CMS.

a. The waiver request shall be submitted as a document separate from the application. The request may be submitted:

(1) In conjunction with and at the same time as the application; or

(2) At any time during the approval process.

b. The prospective PACE organization shall submit the waiver request and documentation to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

88.82(3) *Review of applications and requests for waiver of federal requirements.* The department may conduct on-site visits and may request additional information from an entity in connection with an application for approval as a PACE organization or a request for waiver of federal requirements.

88.82(4) *Department action on applications.* Upon review of an application for approval as a PACE organization and action by CMS on any request for waiver of federal requirements, the department shall determine whether it considers the entity qualified to be a PACE organization and whether it is willing to enter into a PACE program agreement with the entity. If so, the department shall complete the application sections designated for the state administering agency and submit the completed application in its entirety to CMS.

441—88.83(249A) PACE program agreement. An entity that has been approved by the department and CMS to be a PACE organization must enter into an agreement with CMS and the department for the operation of a PACE program under Medicare and Medicaid. The agreement must be signed by an authorized official of CMS, the PACE organization, and the department.

88.83(1) *Content and terms of agreement.*

a. *Required content.* A PACE program agreement must include the following information:

(1) A designation of the service area of the PACE organization's program, identified by county. The department and CMS must approve any change in the designated service area.

(2) The PACE organization's commitment to meet all applicable requirements under federal, state, and local laws and regulations, including provisions of the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

(3) The effective date and term of the agreement.

(4) A description of the organizational structure of the PACE organization and information on the organization's administrative contacts.

(5) An enrollee bill of rights approved by CMS and an assurance that the listed rights and protections will be provided.

(6) A description of the process for handling enrollee grievances and appeals.

(7) A statement of the PACE organization's policies on eligibility, enrollment, voluntary disenrollment, and involuntary disenrollment.

(8) A description of the services available to enrollees.

(9) A description of the PACE organization's quality assessment and performance improvement program.

(10) A statement of the levels of performance required in CMS standard quality measures.

(11) A statement of the data and information required by the department and CMS to be collected on enrollee care.

(12) The Medicaid capitation rate and the methodology used to calculate the Medicare capitation rate.

(13) A description of procedures that the PACE organization will follow if the PACE program agreement is terminated, including how the organization will:

1. Inform enrollees, the community, CMS, and the department, in writing, about the organization's termination and transition procedures.

2. Initiate contact with income maintenance staff in the local department office and assist enrollees in obtaining reinstatement of conventional Medicare and Medicaid benefits.

3. Transition enrollees' care to other providers.

4. Terminate marketing and enrollment activities.

b. *Optional content.* An agreement may:

(1) Provide additional requirements for individuals to qualify as PACE enrollees in accordance with subparagraph 88.84(1)*"a"*(5).

(2) Contain any additional terms and conditions agreed to by the parties.

88.83(2) *Duration of agreement.* A PACE program agreement shall be effective for a contract year but may be extended for additional contract years in the absence of a notice by a party to terminate.

88.83(3) *Enforcement of agreement.* If the department determines that the PACE organization is not in substantial compliance with requirements of the federal PACE regulations or of this division, the department may take one or more of the following actions:

a. Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

b. Withhold some or all payments under the PACE program agreement until the PACE organization corrects the deficiency.

c. Terminate the PACE program agreement.

88.83(4) *Termination of agreement by the department.*

a. *Grounds for termination.* The department may terminate a PACE program agreement at any time for cause, including but not limited to the following circumstances:

(1) Termination due to uncorrected deficiencies. The department may terminate a PACE program agreement if both of the following circumstances exist:

1. The department has determined through a review pursuant to subrule 88.87(4) that the PACE organization has significant deficiencies in the quality of care furnished to enrollees or has failed to comply substantially with the conditions for a PACE organization or PACE program under this division, the federal PACE regulations, or the terms of its PACE program agreement.

2. The PACE organization has failed to develop and successfully initiate a plan to correct the deficiencies within 30 days of the date of receipt of a written notice of deficiencies, as confirmed by certified mail, or has failed to continue implementation of the corrective action plan.

(2) Termination due to health and safety risk. The department may terminate a PACE program agreement if the department determines that the PACE organization cannot ensure the health and safety of its enrollees. This determination may result from the identification of deficiencies that the department determines cannot be corrected.

b. *Notice and opportunity for hearing.* Except as provided in paragraph *"c"* of this subrule, before terminating an agreement, the department shall furnish the PACE organization with the following:

(1) A reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that are the basis of the department's determination that cause exists for termination.

(2) Reasonable notice and opportunity for hearing (including the right to appeal an initial determination) before terminating the agreement.

c. *Immediate termination.* The department may terminate an agreement without invoking the procedures described in paragraph *"b"* of this subrule if the department determines that a delay in termination resulting from compliance with those procedures before termination would pose an imminent and serious risk to the health of the enrollees.

88.83(5) *Termination of agreement by PACE organization.* A PACE organization may terminate an agreement after timely notice issued as follows:

a. To CMS and the department, 90 days before termination.

b. To enrollees, 60 days before termination.

88.83(6) *Transitional care during termination.* A PACE organization whose PACE program agreement is being terminated must provide assistance to each enrollee in obtaining necessary transitional care by making appropriate referrals and making the enrollee's medical records available to new providers.

441—88.84(249A) Enrollment and disenrollment. A PACE organization must comply with the federal enrollment requirements stated in 42 CFR Sections 460.152 through 460.156 as amended to December 8, 2006.

88.84(1) *Eligibility for Medicaid enrollees.* To enroll in a PACE program as an Iowa Medicaid enrollee, a person must meet the eligibility requirements specified in this subrule.

a. *Basic eligibility requirements.*

(1) The person must be 55 years of age or older.

(2) The person must reside in the service area of the PACE organization.

(3) The department must determine that the person is eligible for Iowa Medicaid pursuant to 441—Chapter 76.

(4) The department must determine that the person needs the nursing facility level of care.

(5) The person must meet any additional program-specific eligibility conditions imposed under the PACE program agreement. These additional conditions shall not modify the requirements stated in this subrule.

b. *Other eligibility requirements.*

(1) At the time of enrollment, the person must be able to live in a community setting without jeopardizing the person's health or safety, pursuant to the criteria specified in the PACE program agreement.

(2) To continue to be eligible for PACE as an Iowa Medicaid enrollee, a person must meet the annual recertification requirements specified in subrule 88.84(4).

88.84(2) *Effective date of enrollment.* A person's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

88.84(3) *Duration of enrollment.* Enrollment continues until the enrollee's death unless either of the following actions occurs:

a. The enrollee voluntarily disenrolls. An enrollee may voluntarily disenroll from the program without cause at any time.

b. The enrollee is involuntarily disenrolled, as described in subrule 88.84(5).

88.84(4) *Annual recertification.*

a. At least annually, the department shall:

(1) Reevaluate whether each enrollee continues to need the nursing facility level of care; and

(2) Review all financial and nonfinancial eligibility requirements for Medicaid enrollees. The enrollee shall complete Form 470-3118 or 470-3118(S), Medicaid Review.

b. Deemed continued eligibility. If the department determines that an enrollee no longer needs the nursing facility level of care, the department, in consultation with the PACE organization, shall determine whether, in the absence of continued PACE coverage, the enrollee reasonably would be expected to meet the nursing facility level-of-care requirement within the next six months. This determination shall be based on a review of the enrollee's medical record and plan of care, applying criteria specified in the PACE program agreement. If the enrollee reasonably would be expected to meet the level-of-care requirement within six months, the enrollee's eligibility for the PACE program may continue until the next annual reevaluation.

88.84(5) *Involuntary disenrollment.* An involuntary disenrollment shall not become effective until the Department has determined that the PACE organization has adequately documented acceptable grounds for disenrollment.

a. *Reasons for involuntary disenrollment.* An enrollee may be involuntarily disenrolled for any of the following reasons:

(1) After a 30-day grace period, the enrollee fails to pay any amount due to the PACE organization pursuant to subrule 88.88(2) or refuses to make satisfactory arrangements to pay.

(2) The enrollee engages in disruptive or threatening behavior as described in paragraph 88.84(5)*"b."*

(3) The enrollee moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The department determines that the enrollee no longer needs the nursing facility level of care and the enrollee is not deemed eligible pursuant to paragraph 88.84(4)*"b."*

(5) The PACE program agreement with CMS and the department is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers.

b. *Disruptive or threatening behavior.* "Disruptive or threatening behavior" refers to either of the following:

(1) Behavior that jeopardizes the enrollee's health or safety or the safety of others; or

(2) Consistent refusal by the enrollee to comply with the enrollee's individual plan of care or the terms of the PACE enrollment agreement when the enrollee has decision-making capacity.

c. *Documentation of disruptive or threatening behavior.* If a PACE organization proposes to disenroll an enrollee who is disruptive or threatening, the organization must document the following information in the enrollee's medical record:

(1) The reasons for proposing to disenroll the enrollee.

(2) All efforts to remedy the situation.

d. *Noncompliant behavior.* A PACE organization may not disenroll an enrollee on the grounds that the enrollee has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the enrollee, unless the enrollee's behavior jeopardizes the enrollee's health or safety or the safety of others. "Noncompliant behavior" includes repeated noncompliance with medical advice and repeated failure to keep appointments.

88.84(6) *Effective date of disenrollment.*

a. In disenrolling a Medicaid enrollee, the PACE organization must:

(1) Use the most expedient process allowed under the PACE program agreement;

(2) Coordinate the disenrollment date between Medicare and Medicaid for an enrollee who is eligible for both Medicare and Medicaid; and

(3) Give reasonable advance notice to the enrollee.

b. Until the date when enrollment is terminated, the following requirements must be met:

(1) The PACE organization must continue to furnish all needed services.

(2) The enrollee must continue to use PACE organization services.

88.84(7) *Documentation of disenrollment.* A PACE organization must meet the following requirements:

a. Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.

b. Make documentation available for review by CMS and the department.

c. Use the information on voluntary disenrollments in the PACE organization's internal quality assessment and performance improvement program.

88.84(8) *Reinstatement in other Medicare and medicaid programs.* After a disenrollment, the PACE organization shall work with CMS and the department to facilitate the former enrollee's reinstatement in other Medicare and Medicaid programs by:

a. Making appropriate referrals to other Medicare and Medicaid programs for which the enrollee may be eligible; and

b. Ensuring that medical records are made available to new providers in a timely manner.

88.84(9) *Reinstatement in PACE.* A previously disenrolled enrollee may be reinstated in a PACE program.

441—88.85(249A) Program services. A PACE organization shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.

88.85(1) *Required services.* The PACE benefit package for all enrollees, regardless of the source of payment, must include the following:

a. All Medicare-covered items and services.

b. All Medicaid-covered items and services as specified in 441—Chapters 78, 81, 82, 85, and 90. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost sharing do not apply to PACE services.

c. Other services determined necessary by the enrollee's interdisciplinary team to improve or maintain the enrollee's overall health status.

88.85(2) *Excluded services.* The following services are excluded from coverage under PACE:

a. Any service that is not authorized by the enrollee's interdisciplinary team, even if it is a required service, unless it is an emergency service.

b. In an inpatient facility:

(1) A private room and private-duty nursing services unless medically necessary; and

(2) Nonmedical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the interdisciplinary team as part of the enrollee's plan of care.

c. Cosmetic surgery. "Cosmetic surgery" does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

d. Experimental medical, surgical, or other health procedures.

e. Services furnished outside the United States, except in accordance with 42 CFR Sections 424.122 and 424.124 as amended to September 29, 1995, or as otherwise permitted under the Iowa Medicaid program.

88.85(3) *Service delivery.* The PACE organization must establish and implement a written plan to furnish care that meets the needs of each enrollee in all care settings 24 hours a day, every day of the year.

a. *Provision of services.* PACE services must be furnished in at least:

(1) The PACE center,

(2) The enrollee's home, and

(3) Inpatient facilities.

b. *PACE center operation.* A PACE organization must ensure accessible and adequate services to meet the needs of its enrollees. The interdisciplinary team shall determine the frequency of each enrollee's attendance at a PACE center, based on the needs and preferences of the enrollee.

(1) A PACE organization must operate at least one PACE center either in or contiguous to its defined service area. A PACE center must be certified as an adult day services program pursuant to Iowa Code chapter 231D and the department of elder affairs' rules at 321—Chapter 24.

(2) If necessary to maintain sufficient capacity to allow routine attendance by enrollees, a PACE organization must add staff or develop alternate PACE centers or service sites. If a PACE organization operates more than one center, each alternate PACE center must offer the full range of services and have sufficient staff to meet the needs of enrollees.

88.85(4) *Minimum services furnished at a PACE center.* At a minimum, the following services must be furnished at each primary or alternate PACE center:

a. Primary care, including physician and nursing services.

b. Social services.

c. Restorative therapies, including physical therapy and occupational therapy.

d. Personal care and supportive services.

e. Nutritional counseling.

f. Recreational therapy.

g. Meals.

88.85(5) *Primary care.* Primary medical care must be furnished to an enrollee by a PACE primary care physician. Each primary care physician is responsible for:

a. Managing an enrollee's medical situations; and

b. Overseeing an enrollee's use of medical specialists and inpatient care.

88.85(6) *Out-of-network emergency care.* A PACE organization must pay for out-of-network emergency care when the care is needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the enrollee's health.

a. *Definitions.* As used in this subrule, the following definitions apply:

"Emergency medical condition" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Serious jeopardy to the health of the enrollee.
2. Serious impairment to bodily functions of the enrollee.
3. Serious dysfunction of any bodily organ or part of the enrollee.

"Emergency services" means inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and are furnished by a qualified emergency services provider other than the PACE organization or one of its contract providers, either inside or outside the PACE organization's service area.

"Poststabilization care" means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized but that do not meet the definition of emergency services.

"Urgent care" means care that is provided to an enrollee outside the service area because the enrollee believes that an illness or injury is too severe to postpone treatment until the enrollee returns to the service area but that does not meet the definition of emergency services because the enrollee's life or functioning is not in severe jeopardy.

b. Plan. A PACE organization must establish and maintain a written plan to handle out-of-network emergency care. The plan must ensure that CMS, the department, and the enrollee are held harmless if the PACE organization does not pay for out-of-network emergency services. The plan must provide for the following:

(1) An on-call provider available 24 hours per day to address enrollee questions about out-of-network emergency services and to respond to requests for authorization of out-of-network urgent care and poststabilization care following emergency services.

(2) Coverage of out-of-network urgent care and poststabilization care when either of the following conditions is met:

1. The PACE organization has approved the services.
2. The PACE organization has not approved the services because the PACE organization did not respond to a request for approval within one hour after being contacted or because the PACE organization cannot be contacted for approval.

c. Explanation to enrollee. The organization must ensure that the enrollee or caregiver, or both, understand:

(1) When and how to access out-of-network emergency services, and

(2) That no prior authorization is needed.

441—88.86(249A) Access to PACE services. An enrollee's access to PACE services is governed by a comprehensive plan of care developed for each enrollee by an interdisciplinary team based on a comprehensive assessment of the enrollee's health and social status.

88.86(1) *Interdisciplinary team.* A PACE organization shall establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each enrollee.

a. Team composition. The members of the interdisciplinary team must primarily serve PACE enrollees. At a minimum, the interdisciplinary team shall be composed of the following members:

(1) Primary care physician.
(2) Registered nurse.
(3) Master's-level social worker.
(4) Physical therapist.
(5) Occupational therapist.
(6) Recreational therapist or activity coordinator.
(7) Dietitian.
(8) PACE center manager.
(9) Home care coordinator.
(10) Personal care attendant or attendant's representative.
(11) Driver or driver's representative.

b. Team responsibilities. Each enrollee shall be assigned to an interdisciplinary team functioning at the PACE center that the enrollee attends. The interdisciplinary team is responsible for the initial

assessment, periodic reassessments, plan of care, and coordination of 24-hour care delivery for each assigned enrollee. Each interdisciplinary team member is responsible for the following:

(1) Regularly informing the team of the medical, functional, and psychosocial condition of each enrollee.

(2) Remaining alert to pertinent input from other team members, enrollees, and caregivers.

(3) Documenting changes in an enrollee's condition in the enrollee's medical record, consistent with documentation policies established by the medical director.

c. *Exchange of information.* The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and enrollees and their caregivers consistent with the federal requirements for confidentiality in 42 CFR Section 460.200(e) as amended to November 24, 1999.

88.86(2) *Initial assessment.* The interdisciplinary team must conduct an initial comprehensive assessment of each enrollee promptly following enrollment.

a. Each of the following members of the interdisciplinary team must evaluate the enrollee, at appropriate intervals, and develop a discipline-specific assessment of the enrollee's health and social status:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Physical therapist.

(5) Occupational therapist.

(6) Recreational therapist or activity coordinator.

(7) Dietitian.

(8) Home care coordinator.

b. At the recommendation of interdisciplinary team members, other professional disciplines (such as speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

c. The assessment of each enrollee must include, but not be limited to, assessment of the following:

(1) Physical and cognitive function and ability.

(2) Medication use.

(3) Enrollee and caregiver preferences for care.

(4) Socialization and availability of family support.

(5) Current health status and treatment needs.

(6) Nutritional status.

(7) Home environment, including home access and egress.

(8) Enrollee behavior.

(9) Psychosocial status.

(10) Medical and dental status.

(11) Enrollee language.

88.86(3) *Plan of care.* The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each enrollee through discussion in team meetings and consensus of the entire team.

a. *Development.* The interdisciplinary team must develop, review, and reevaluate the plan of care in collaboration with the enrollee or caregiver, or both, to ensure that there is agreement with the plan of care and that the enrollee's concerns are addressed. In developing the plan of care, female enrollees must be informed that they are entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

b. *Content.* The plan of care must:

(1) Specify the care needed to meet the enrollee's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment.

(2) Identify measurable outcomes to be achieved.

c. Documentation. The interdisciplinary team shall document in the enrollee's medical record the plan of care and any changes made to the plan of care.

d. Implementation. The interdisciplinary team shall:

(1) Implement, coordinate, and monitor the plan of care, whether the services are furnished by PACE employees or contractors; and

(2) Continuously monitor the enrollee's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from enrollees and caregivers, and communications among team members and other providers.

e. Evaluation. On at least a semiannual basis, the interdisciplinary team shall reevaluate the plan of care, including defined outcomes, and make changes as necessary.

88.86(4) *Reassessment.*

a. Semiannual reassessment. On at least a semiannual basis, or more often if an enrollee's condition dictates, the following interdisciplinary team members must conduct an in-person reassessment:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Recreational therapist or activity coordinator.

(5) Other interdisciplinary team members actively involved in the development or implementation of the enrollee's plan of care, such as the home care coordinator, physical therapist, occupational therapist, or dietitian.

b. Annual reassessment. On at least an annual basis, the following interdisciplinary team members must conduct an in-person reassessment:

(1) Physical therapist.

(2) Occupational therapist.

(3) Dietitian.

(4) Home care coordinator.

c. Unscheduled reassessments. In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following:

(1) A change in enrollee status. If the health or psychosocial status of an enrollee changes, the interdisciplinary team members listed in paragraph 88.86(2)*"a"* must conduct an in-person reassessment.

(2) A request by the enrollee or designated representative. If an enrollee (or the enrollee's designated representative) believes that the enrollee needs to initiate, eliminate, or continue a particular service, the appropriate interdisciplinary team members, as identified by the interdisciplinary team, must conduct an in-person reassessment.

d. Changes to plan of care. Interdisciplinary team members who conduct a reassessment must:

(1) Reevaluate the enrollee's plan of care.

(2) Discuss any changes in the plan of care with the interdisciplinary team.

(3) Obtain approval of the revised plan of care from the interdisciplinary team and the enrollee or the enrollee's designated representative.

(4) Document all assessment and reassessment information in the enrollee's medical record.

(5) Furnish to the enrollee any services included in the revised plan of care as a result of a reassessment as expeditiously as the enrollee's health condition requires.

88.86(5) *Procedures for resolving enrollee request to change the plan of care.* The PACE organization must have explicit procedures for timely resolution of a request by an enrollee or an enrollee's designated representative to initiate, eliminate, or continue a particular service.

a. Except as provided in paragraph *"b"* of this subrule, the interdisciplinary team must notify the enrollee or the enrollee's designated representative of its decision to approve or deny the request from the enrollee or the designated representative as expeditiously as the enrollee's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request.

b. The interdisciplinary team may extend the 72-hour period for notifying the enrollee or the designated representative of its decision to approve or deny the request by no more than five additional days if:

(1) The enrollee or designated representative requests the extension; or

(2) The interdisciplinary team documents its need for additional information and how the delay is in the interest of the enrollee.

c. The PACE organization must:

(1) Explain to the enrollee or the enrollee's designated representative orally and in writing any denial of a request to change the plan of care; and

(2) Provide the specific reasons for the denial in understandable language.

d. The PACE organization is responsible for:

(1) Informing the enrollee or the enrollee's designated representative of the enrollee's right to appeal the decision as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(2) Describing both the standard and expedited appeals processes of the PACE organization, including the right to obtain and conditions for obtaining expedited consideration of an appeal of a denial of services as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(3) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in 42 CFR Section 460.122(e) as amended to December 8, 2006.

e. If the interdisciplinary team fails to provide the enrollee with timely notice of the resolution of the request or fails to furnish the services required by the revised plan of care, this failure constitutes an adverse decision. The enrollee's request must be automatically processed by the PACE organization as an appeal in accordance with 42 CFR Section 460.122 as amended to December 8, 2006.

f. The PACE organization must submit all documentation related to an appeal to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

441—88.87(249A) Program administrative requirements. A PACE organization shall comply with the federal administrative requirements stated in 42 CFR Sections 460.60 through 460.82 as amended to December 8, 2006, including requirements relating to organizational structure, governing body, qualifications for staff who have direct contact with enrollees, training, program integrity, contracted services, oversight of direct care services, physical environment, infection control, transportation services, dietary services, fiscal soundness, and marketing.

88.87(1) *Enrollee rights.* A PACE organization shall comply with the federal participant rights requirements stated in 42 CFR Sections 460.110 through 460.124 as amended to December 8, 2006. Upon exhaustion of the PACE organization's appeal process, a Medicaid enrollee has the right to appeal to the department any adverse coverage or payment decision regarding any service, including any denial, reduction, or termination of any service, pursuant to 441—Chapter 7.

88.87(2) *Data collection, record maintenance, and reporting.* A PACE organization shall comply with federal data collection, records maintenance, and reporting requirements stated in 42 CFR Sections 460.200 through 460.210 as amended to December 8, 2006.

88.87(3) *Quality assessment and performance improvement.* A PACE organization shall comply with the federal quality assessment and performance improvement requirements stated in 42 CFR Sections 460.130 through 460.140 as amended to November 24, 1999.

88.87(4) *Federal and state monitoring.*

a. The PACE program shall cooperate with federal and state monitoring pursuant to 42 CFR Sections 460.190 through 460.196 as amended to Nov. 24, 1999, including:

(1) Corrective action required pursuant to 42 CFR Section 460.194; and

(2) Disclosure of review results pursuant to 42 CFR Section 460.196(c) and (d).

b. The PACE program is subject to sanctions or termination pursuant to subrules 88.83(3) and 88.83(4).

c. During the trial period, CMS, in cooperation with the department, shall conduct comprehensive annual reviews of the operations of a PACE organization to ensure compliance with PACE federal regulations and 441—Chapter 88, Division V.

d. After the trial period, the department, in cooperation with CMS, shall conduct on-site reviews of a PACE organization at least every two years.

e. After a review, CMS and the department shall report the results of the review to the PACE organization, along with any recommendations for changes to the organization's program.

f. Within 30 days of issuance of the report, the PACE organization shall develop and implement a corrective action plan to address any deficiencies identified through the review.

g. CMS or the department shall monitor the effectiveness of the corrective actions implemented.

441—88.88(249A) Payment.

88.88(1) *Medicaid payment to PACE organization.* Under a PACE program agreement, the department shall make a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid enrollee. The monthly capitation payment amount shall be negotiated between the PACE organization and the department and shall be specified in the PACE program agreement.

a. The amount of the capitation payment:

(1) Shall be less than the amount that would otherwise have been paid under the Medicaid program if the enrollees were not enrolled under the PACE program.

(2) Shall be a fixed amount regardless of changes in the enrollee's health status.

(3) May be renegotiated on an annual basis.

b. The PACE organization must accept the capitation payment amount as payment in full for Medicaid enrollees. The organization shall not collect or receive any other form of payment from the department or from, or on behalf of, the enrollee except for any amounts due from the enrollee pursuant to subrule 88.88(2).

88.88(2) *Liability of Medicaid enrollee.* A Medicaid enrollee shall contribute toward the cost of the enrollee's care according to the terms of this subrule. A PACE organization may not charge a premium to a Medicaid enrollee except for any amounts due pursuant to this subrule.

a. *Institutionalized enrollees.* Medicaid enrollees who reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the exceptions allowed by 441—subrule 75.16(1) and the deductions allowed by 441—subrule 75.16(2).

b. *Noninstitutionalized enrollees.* Medicaid enrollees who do not reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the deductions required by 42 CFR Section 435.726(c) as amended to July 25, 1994, with maintenance needs amounts set at the following levels:

(1) The amount for the maintenance needs of the enrollee is set at 300 percent of the maximum SSI grant for an individual.

(2) The additional amount for the maintenance needs of a spouse at home is set at the Iowa Medicaid program's medically needy income standard for one person.

(3) The additional amount for the maintenance needs of a family at home is set at the Iowa Medicaid program's medically needy income standard for a family of the same size, to the extent that amount exceeds any amount allowed for the maintenance needs of a spouse at home.

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

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CHAPTER 92
IOWACARE

PREAMBLE

This chapter defines and structures the IowaCare program administered by the department pursuant to Iowa Code Supplement chapter 249J. It is the department's intent that all state expenditures under the IowaCare program shall qualify for federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to Section 1115 of the Social Security Act (42 U.S.C. §1315). Therefore, this chapter shall remain in effect only as long as such waivers are effective. Further, this chapter shall be construed to comply with the requirements of Title XIX or with the terms of any applicable waiver of Title XIX requirements. To the extent that these rules may be found to be inconsistent with any applicable requirement of Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—92.1(249A,249J) Definitions.

"Applicant" means an individual who applies for medical assistance under the IowaCare program described in this chapter.

"Clean claim" means a claim that can be adjudicated in the Medicaid claims payment system to result in either a paid or denied status.

"Department" means the Iowa department of human services.

"Dependent child" means the child or stepchild of an applicant or member who is living in the applicant's or member's home and is under the age of 18 or is 18 years of age and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching the age of 19. Correspondence school is not an allowable program of study. "Dependent child" shall also include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.

"Enrollment period" means the entire period that a member receives IowaCare without a break, which may include multiple certification periods.

"Federal poverty level" means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

"Group health insurance" means any plan of or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"Initial application" means the first application for IowaCare or an application that is filed after a break in assistance of one month or more.

"IowaCare" means the medical assistance program explained in this chapter.

"Medical expansion services" means the services described in Iowa Code Supplement section 249J.6.

"Member" means an individual who is receiving assistance under the IowaCare program described in this chapter.

"Newborn" means an infant born to a woman as defined in paragraph 92.2(1)*"b."*

441—92.2(249A,249J) Eligibility. IowaCare eligibility shall be determined according to the requirements of rules 441—75.2(249A) to 441—75.4(249A), 441—75.7(249A), 441—75.10(249A), and 441—75.12(249A) and the provisions of this rule.

92.2(1) *Persons covered.* Medical assistance under IowaCare shall be available to the following people as provided in this chapter:

a. Persons 19 through 64 years of age who:

(1) Are not eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40) or 75.1(42), including persons unable to meet spenddown under 441—subrule 75.1(35); and

(2) Have countable income at or below 200 percent of the federal poverty level.

b. Pregnant women whose:

(1) Gross countable income is below 300 percent of the federal poverty level; and

(2) Allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below.

c. Newborn children born to women defined in paragraph *"b."*

92.2(2) *Citizenship.* To be eligible for IowaCare benefits, a person must meet the requirements in 441—paragraph 75.11(2)*"a."* A person who claims a qualified alien status shall provide documentation of this status.

92.2(3) *Other disqualification.* A person who has been disqualified from Medicaid for reasons other than excess income, excess resources, or lack of categorical eligibility is not eligible for IowaCare benefits.

92.2(4) *Group health insurance.* A person who has access to group health insurance is not eligible for IowaCare. An applicant or member shall not be considered to have access to group health insurance if any of the following conditions exist:

a. The applicant or member is not enrolled in the available group health plan and states that:

(1) The coverage is unaffordable; or

(2) Exclusions for preexisting conditions apply; or

(3) The needed services are not services covered by the plan.

b. The applicant or member is enrolled in a group health plan but states that:

(1) Exclusions for preexisting conditions apply; or

(2) The needed services are not covered by the plan; or

(3) The limits of benefits under the plan have been reached; or

(4) The plan includes only catastrophic health care coverage.

92.2(5) *Payment of assessed premiums.* As a condition of eligibility for IowaCare, an applicant or member must pay premiums in accordance with 441—92.7(249A,249J). Premiums incurred and unpaid from a previous certification period must be paid in full before an applicant can establish new eligibility under this chapter.

92.2(6) *Availability of funds.* Eligibility for IowaCare shall not be approved when the department has determined that there are insufficient funds available to pay for additional enrollment, in accordance with 441—92.14(249A,249J).

441—92.3(249A,249J) Application. Medicaid application policies in 441—76.1(249A) and 441—76.8(249A) apply to IowaCare except as follows:

92.3(1) An application for IowaCare may also be submitted on Comm. 239, IowaCare Application, or Form 470-4364, IowaCare Renewal Application. An applicant who submits an application on another form allowed under 441—76.1(249A) shall also sign Form 470-4194, IowaCare Premium Agreement.

92.3(2) A new application is required for each 12-month certification period.

441—92.4(249A,249J) Application processing. Department staff shall process IowaCare applications. The department shall base eligibility decisions primarily on information declared by the applicant. A face-to-face interview is not required.

92.4(1) *Verification.* Applicants seeking eligibility under 92.2(1)*"b"* shall provide verification of medical expenses as required under 92.5(5)*"b."* IowaCare applicants shall not be required to provide verification of income, household members, disability, social security number, age, HAWK-I premium, group health insurance, or pregnancy, unless the verification is specifically requested in writing.

a. The department shall notify the person in writing of any further verification requested. The person shall have five working days to supply the requested information. The local office may extend the deadline for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

b. Failure of the person to supply requested information or refusal by the person to authorize the department to secure the information from other sources shall serve as a basis for denial of an application or cancellation of IowaCare benefits.

92.4(2) *Screening for full Medicaid.* The department shall screen each application for eligibility under coverage groups listed in 441—75.1(249A). If the applicant is eligible under another coverage group, the IowaCare application shall be considered an application for that coverage group.

92.4(3) *Time limit for decision.* The department shall make a determination of approval or denial as soon as possible, but no later than three working days after the filing date of the application, unless:

a. One or more conditions listed in 441—subrule 76.3(1), 76.3(3), 76.3(4), or 76.3(6) exist; or

b. The application is being processed for Medicaid eligibility under a coverage group listed in 441—75.1(249A).

441—92.5(249A,249J) Determining income eligibility. The department shall determine the income of an applicant's household as of the date of decision. To be eligible, the household's income minus allowable deductions shall not exceed 200 percent of the federal poverty level for the household size.

92.5(1) *Household size.* The household size shall include the applicant and the applicant's dependent or unborn children and spouse living in the same home, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act. A person who is absent from the home shall not be included in the household size, unless the absence is temporary.

a. An applicant's spouse shall not be considered absent from the home when:

(1) The spouse's absence is due solely to a pattern of employment, including active duty in the uniformed services of the United States.

(2) The spouse 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.

b. The conditions described in 441—paragraph 75.53(4)*"b"* shall be applied to determine whether a person's absence is temporary.

92.5(2) *Self-declaration of income.* Applicants shall self-declare the household's future unearned and earned income based on their best estimate.

a. Applicants who receive income on a regular basis shall declare their household's monthly income as described at 92.5(3) and 92.5(4).

b. Applicants who are self-employed, receive their income on an irregular basis, or are not currently employed shall declare their household's anticipated yearly income as described in 92.5(3) and 92.5(4).

92.5(3) *Earned income.* All earned income as defined in this subrule that is received by a person included in the household size shall be counted except for the earnings of a child who is a full-time student as defined in 441—subparagraphs 75.54(1)*"b"*(1), (2), and (3). Earned income shall include income in the form of a salary, wages, tips, or profit from self-employment.

a. For income from salary, wages, or tips, earned income shall mean the total gross amount of income irrespective of the expenses of employment.

b. For self-employment income, earned income shall mean the net profit from self-employment, defined as gross income less the costs of producing the income.

c. 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 the net profit counted as earned income 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 verifies expenses in excess of 40 percent of the total gross income received, the net profit counted as earned income shall be determined in the same manner as specified at paragraph 92.5(3)*"b."*

92.5(4) *Unearned income.* Unearned income of all household members shall be counted unless exempted as income by:

a. 441—subrule 75.57(6), paragraph *"b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m," "p," "q," "r," "t," "u," "v," "w," "x," "y," "z,"* or *"aa"*; or

b. 441—subrule 75.57(7), paragraph *"a," "b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m,"* or *"q."*

92.5(5) *Deductions.* The department shall determine a household's countable income by deducting the following from the household's self-declared income:

a. Twenty percent of the household's self-declared earned income.

b. For women applying under 92.2(1)*"b,"* medical expenses incurred for a person included in the household size that are unpaid and not subject to payment by a third party. Verification of the unpaid expenses must be provided in order to receive the deduction. The medical expenses that can be deducted are:

(1) Health insurance premiums, deductibles, or coinsurance charges; and

(2) Medical and dental expenses.

92.5(6) *Disregard of changes.* A person found to be income-eligible upon application or recertification of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

92.5(7) *Unearned nonrecurring lump-sum income.* All unearned nonrecurring lump-sum income shall be disregarded.

92.5(8) *Earned lump-sum income.* Anticipated earned lump-sum income shall be prorated over the period for which the income is received.

441—92.6(249A,249J) Effective date. The department shall issue Form 470-4164, IowaCare Medical Card, to persons enrolled in the IowaCare program.

92.6(1) *Certification period.* IowaCare eligibility 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. The certification period shall continue for 12 consecutive months or, for women and newborns eligible under 92.2(1)*"b"* or *"c,"* until 60 days after the birth of the child.

92.6(2) *Retroactive eligibility.* IowaCare benefits shall also be available for the month preceding the month in which the application is filed if during that preceding month:

a. The applicant received Medicaid expansion services from a provider within the Medicaid expansion network; and

b. The applicant would have been eligible for IowaCare if application had been made.

92.6(3) *Care provided before eligibility.* No payment shall be made for medical care received before the effective date of eligibility.

441—92.7(249A,249J) Financial participation. In addition to the copayments required by 441—subrule 79.1(13), IowaCare members, with the exception of newborns eligible pursuant to 92.2(1)*"c,"* shall be assessed a sliding-scale monthly premium. No premium shall be assessed at the time of initial application for months of eligibility before and including the month of decision, including the retroactive month. A member shall be responsible for paying the premium for the first month after the month of decision and for the following three months, regardless of continued enrollment during the four-month period or during previous months, and for each month of continued enrollment after the required four months. If there is a break in enrollment of one month or more, a new four-month period of mandatory premiums shall be assessed, beginning with the month following the month of decision.

92.7(1) *Premium amount.* The monthly premium amount shall be established for a 12-month period beginning with the first month of eligibility, based on projected monthly income for the 12-month period.

a. The monthly premium amount is based on the household's countable monthly income as a percentage of the federal poverty level for a household of that size. Effective April 1, 2008, premium amounts based on this percentage are as follows:

When the household's income is at or below:	Each member's premium amount is:
100% of federal poverty level	$ 0
110% of federal poverty level	$43
120% of federal poverty level	$47
130% of federal poverty level	$52
140% of federal poverty level	$56
150% of federal poverty level	$60
160% of federal poverty level	$64
170% of federal poverty level	$69
180% of federal poverty level	$73
190% of federal poverty level	$77
200% of federal poverty level	$82

b. The listed premium amount is calculated based on the lowest income level in each 10 percent increment for a one-person household. Households with income at or below 100 percent of the poverty level are not subject to a premium. Premiums for households with income over 100 percent of the poverty level are 5 percent of the applicable income level. The department will update these amounts annually on April 1 using the latest federal poverty level guidelines.

c. The cost of premiums paid for HAWK-I shall be deducted from the premium assessed according to this subrule.

d. The monthly premium established for a 12-month certification period shall not be increased due to an increase in income or a change in household size.

e. The premium may be reduced prospectively during the 12-month certification period if the member declares a reduction in projected average monthly income or an increase in household size or is granted a hardship exemption.

92.7(2) *Billing and payment.* Form 470-4165, IowaCare Billing Statement, shall be used for billing and collection.

a. *Method of payment.* Members shall submit premium payments to the following address: Iowa Medicaid Enterprise, IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013.

b. *Due date.* When the department notifies the member of the amount of the premiums, the member shall pay any premiums due as follows:

(1) The premium for each month is due the last calendar day of the month the premium is to cover. EXCEPTION: The premiums for the months covered in the initial billing are due the last calendar day of the following month.

(2) If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend.

c. *Application of payment.* The department shall apply premium payments received to the oldest unpaid month forward. When premiums for all months have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

92.7(3) *Hardship exemption.* A member who submits a written statement indicating that payment of the monthly premium will be a financial hardship shall be exempted from premium payment for that month, except as provided in paragraph *"c."* If the statement is not postmarked by the premium due date, the member shall be obligated to pay the premium.

a. A partial payment submitted with a written statement indicating that full payment of the monthly premium will be a financial hardship that is postmarked or received on or before the end of the month for which the premium is due shall be considered a request for a hardship exemption. The exemption shall be granted for the balance owed for that month.

b. If the postmark is illegible, the date that the hardship declaration is initially received by the department or the department's designee shall be considered the date of the request.

c. A member shall not be exempted from premium payment for a month in which the member misrepresented the household's circumstances.

92.7(4) *Failure to pay premium.* If the member fails to pay the assessed premium or to declare a hardship by the date the premium is due, the department shall cancel IowaCare benefits effective the last day of the next calendar month. A member whose IowaCare benefits are canceled due to nonpayment of premiums must reapply to establish IowaCare eligibility.

92.7(5) *Refund of premium.* When a member's IowaCare coverage is canceled due to a circumstance listed in paragraph *"a,"* premiums paid for any period after the cancellation date shall be refunded.

a. The premium obligation is reduced to zero when a member's IowaCare coverage is canceled because the member:

(1) Is determined eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40);

(2) Has access to group health insurance coverage as defined in subrule 92.2(4);

(3) Reaches age 65;

(4) Dies; or

(5) No longer meets program requirements after the four mandatory premium months.

b. The amount of the refund shall be offset by any outstanding premiums owed.

c. Any excess premium received for an individual not receiving IowaCare benefits shall be refunded after two calendar months unless an application or reapplication is pending or upon the individual's request.

d. Any excess premium received for an IowaCare member shall be refunded after two calendar months of a zero premium or upon the member's request.

441—92.8(249A,249J) Benefits. Under IowaCare, payment will be made only for services and providers as specified in this rule. No payment will be made for any service provided elsewhere or by another provider.

92.8(1) *Provider network.* Except as provided in subrules 92.8(3) through 92.8(5), IowaCare members shall have medical assistance only for services provided to the member by:

a. The University of Iowa Hospitals and Clinics; or

b. Broadlawns Medical Center in Des Moines; or

c. A state mental health institute, exclusive of the units providing substance abuse treatment, services to gero-psychiatric patients, or treatment for sexually violent predators; or

d. Any physician, advanced registered nurse practitioner, or physician assistant who is part of a medical institution listed in this subrule. Physician assistants are able to render covered services as auxiliary personnel pursuant to 441—subrule 78.1(13).

92.8(2) *Covered services.* Services shall be limited to the services covered by the Iowa Medicaid program pursuant to 441—Chapter 78, 441—79.9(249A), and 441—Chapter 85, Division I. All conditions of service provision shall apply in the same manner as under the regular Iowa Medicaid program and pursuant to 441—Chapter 78, 441—79.3(249A), 441—79.5(249A), 441—79.6(249A), 441—79.8(249A) through 441—79.14(249A), and applicable provider manuals. These conditions include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

92.8(3) *Obstetric and newborn coverage.* IowaCare members who qualify under 92.2(1)*"b"* or *"c"* are also eligible for the services specified in paragraph *"a"* or *"b"* from the providers specified in paragraph *"c"* or *"d."*

a. Covered services for pregnant women shall be limited to:

(1) Inpatient hospital services when the diagnosis-related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.

(2) Obstetrical services provided in an outpatient hospital setting when the primary or secondary diagnosis code is V22 through V24.9.

(3) Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

b. Newborns will be eligible while hospitalized and for a period not to exceed 60 days from the date of birth.

(1) Inpatient hospital services shall be payable when the diagnosis-related group (DRG) submitted for payment is between 385 and 391.7.

(2) Services provided by a health care provider other than a hospital shall be covered as provided in subrule 92.8(2).

c. For persons who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, the services listed in this subrule are covered only when provided by the University of Iowa Hospitals and Clinics.

d. Persons who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain the services listed in this subrule from any provider that participates in Iowa Medicaid.

92.8(4) *Routine preventive medical examinations.* A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. IowaCare members who qualify under paragraph 92.2(1)*"b"* or *"c"* are eligible to receive routine preventive medical examinations from:

(1) Any provider specified under subrule 92.8(1), or

(2) Any physician, advanced registered nurse practitioner, or physician assistant who participates in Iowa Medicaid, including but not limited to providers available through a free clinic, a rural health clinic, or a federally qualified health center. Physician assistants are able to render covered services as auxiliary personnel pursuant to 441—subrule 78.1(13).

b. A provider that bills IowaCare for a routine preventive medical examination shall use diagnosis code V70 and evaluation and management CPT code 99202, 99203, 99204, 99212, 99213, or 99214, as appropriate to the level of service provided. Basic laboratory work may also be billed in association with the medical examination, as appropriate and necessary.

92.8(5) *Drugs for smoking cessation.* IowaCare members may obtain outpatient prescription drugs for smoking cessation that are related to another appropriately billed IowaCare service from any pharmacy participating in the Iowa Medicaid program.

441—92.9(249A,249J) Claims. Claims for Medicaid expansion services provided to IowaCare members shall be submitted to the Iowa Medicaid Enterprise, P.O. Box 150001, Des Moines, Iowa 50315, as required by 441—Chapter 80. To facilitate tracking of expenditures, clean claims for IowaCare services shall be submitted to the Iowa Medicaid enterprise within 20 days from ending date of service.

441—92.10(249A,249J) Reporting changes.

92.10(1) *Reporting requirements.* A member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member obtains other health insurance coverage.

92.10(2) *Untimely report.* When a change is not timely reported, any incorrect program expenditures shall be subject to recovery in accordance with 441—92.13(249A,249J).

92.10(3) *Effective date of change.* After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount 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); or

b. The certification has expired.

441—92.11(249A,249J) Reapplication. A new application is required when a member's 12-month certification period has expired or a member is seeking to regain eligibility after cancellation.

92.11(1) *Reapplication at least three days before end of certification period.* When a member submits an application before the last three working days of the member's current certification period, the department shall approve or deny the application by the last working day of the current certification period unless a condition described at 92.4(3)*"a"* or *"b"* applies.

92.11(2) *Reapplication within three days of end of certification period or later.* When a member submits an application during the last three working days of the member's current certification period or after the certification period ends, the department shall approve or deny the application as described at 92.4(3).

441—92.12(249A,249J) Terminating eligibility. IowaCare eligibility shall end when any of the following occur:

1. The certification period ends.
2. The member begins receiving medical assistance in a coverage group under 441—subrules 75.1(1) through 75.1(40).
3. The member does not pay premiums as required by 441—92.7(249A,249J).
4. The member no longer meets the nonfinancial eligibility requirements under 441—92.2(249A,249J).
5. The member is found to have been ineligible at the time the eligibility determination was made due to member misrepresentation or member or agency error.
6. The member dies.

441—92.13(249A,249J) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with 441—76.12(249A).

92.13(1) The department shall recover Medicaid funds expended on behalf of a member from the member's estate in accordance with 441—76.12(249A).

92.13(2) Any funds recovered from third parties, including Medicare, by a provider other than a state mental health institute shall be submitted to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

441—92.14(249A,249J) Discontinuance of the program. IowaCare is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expected to be expended before the end of the fiscal year, enrollment of new members into the program will be discontinued or limited to a reduced scope of services until funding is received for the next fiscal year.

92.14(1) *Suspension of enrollment.* To ensure equitable treatment, applications shall be approved on a first-come, first-served basis and enrollment will be suspended when the likely costs of caring for those already enrolled will exhaust the available funding during the year. "First-come, first-served" status is determined by the date the application is approved for eligibility and entered into the computer system.

92.14(2) *Enrollment for limited services.* Eligibility or payment for services received cannot be approved beyond the amount of funds available. Because funds are limited, applications may be approved for a reduced scope of services.

441—92.15(249A,249J) Right to appeal. Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. However, households will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program pursuant to 441—92.14(249A,249J).

These rules are intended to implement Iowa Code chapter 249J.

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CHAPTER 57
RESIDENTIAL CARE FACILITIES
[Prior to 7/15/87, Health Department[470] Ch 57]

481—57.1(135C) Definitions. For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words "shall" and "must" indicate those standards are mandatory. The use of the words "should" and "could" indicate those standards are recommended.

57.1(1) *"Accommodation"* means the provision of lodging, including sleeping, dining, and living areas.

57.1(2) *"Administrator"* means a person approved and certified by the department who administers, manages, supervises, and is in general administrative charge of a residential care facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

57.1(3) *"Alcoholic"* means a person in a state of dependency resulting from excessive or prolonged consumption of alcoholic beverages as defined in Iowa Code section 125.2.

57.1(4) *"Ambulatory"* means the condition of a person who immediately and without aid of another is physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

57.1(5) *"Basement"* means that part of a building where the finish floor is more than 30 inches below the finish grade of the building.

57.1(6) *"Board"* means the regular provision of meals.

57.1(7) *"Communicable disease"* means a disease caused by the presence of viruses or microbial agents within a person's body, which agents may be transmitted either directly or indirectly to other persons.

57.1(8) *"Department"* means the state department of inspections and appeals.

57.1(9) *"Distinct part "* means a clearly identifiable area or section within a health care facility, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

57.1(10) *"Drug addiction"* means a state of dependency, as medically determined, resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 204.

57.1(11) *"Medication"* means any drug including over-the-counter substances ordered and administered under the direction of the physician.

57.1(12) *"Nonambulatory"* means the condition of a person who immediately and without aid of another is not physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

57.1(13) *"Personal care"* means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are help in getting in and out of bed, assistance with personal hygiene and bathing, help with dressing and feeding, and supervision over medications which can be self-administered.

57.1(14) *"Program of care"* means all services being provided for a resident in a health care facility.

57.1(15) *"Qualified 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 having one year's experience working with the mentally retarded.

57.1(16) *"Rate"* means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules and regulations.

57.1(17) *"Responsible party"* means the person who signs or cosigns the admission agreement required in 57.14(135C) or the resident's guardian or conservator if one has been appointed. In the event that a resident has neither a guardian, conservator nor person who signed or cosigned the resident's admission agreement, the term "responsible party" shall include the resident's sponsoring agency, e.g., the department of social services, veteran's administration, religious groups, fraternal organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

57.1(18) *"Restraints"* means the measures taken to control a resident's physical activity for the resident's own protection or for the protection of others.

481—57.2(135C) Variances. Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual residential care facility. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

57.2(1) To request a variance, the licensee must:

a. Apply for variance in writing on a form provided by the department of inspections and appeals;

b. Cite the rule or rules from which a variance is desired;

c. State why compliance with the rule or rules cannot be accomplished;

d. Explain alternate arrangements or compensating circumstances which justify the variance;

e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

57.2(2) Upon receipt of a request for variance, the director of the department of inspections and appeals will:

a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;

b. If the request meets the above criteria, evaluate the alternate arrangements of compensating circumstances against the requirement of the rules;

c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;

d. Consult with the applicant if additional information is required.

57.2(3) Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

481—57.3(135C) Application for licensure.

57.3(1) Initial application and licensing. In order to obtain an initial residential care facility license for a residential care facility which is currently licensed the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 57 and 60;

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the facility drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door location;

e. Submit a photograph of the front and side elevation of the facility;

f. Submit the statutory fee for a residential care facility license;

g. Comply with all other local statutes and ordinances in existence at the time of licensure;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

57.3(2) In order to obtain an initial residential care facility license for a facility not currently licensed as a residential care facility, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 57 and 60. Exceptions noted in 481—subrule 60.3(2) shall not apply;

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the proposed opening date of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the residential care facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door locations;

e. Submit a photograph of the front and side of the residential care facility;

f. Submit the statutory fee for a residential care facility license;

g. Comply with all other local statutes and ordinances in existence at the time of licensure;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

57.3(3) Renewal application. In order to obtain a renewal of the residential care facility license, the applicant must:

a. Submit the completed application form 30 days prior to annual license renewal date of residential care facility license;

b. Submit the statutory license fee for a residential care facility with the application for renewal;

c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;

d. Submit appropriate changes in the résumé to reflect any changes in the resident care program or other services.

57.3(4) Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

481—57.4(135C) Special categories. Special variations and considerations may be granted a residential care facility which is operated for people who have special problems such as retardation, physical disabilities, have a physical or mental disability or a condition in common which can best be treated in a specialized environment under an approved program of care commensurate with the needs of the residents of the facility. Criteria for these specialized programs shall be established by the department based on the résumé of programs and services furnished by the facility and the numbers and qualifications of the administrator and staff providing these services in the facility.

57.4(1) Such a facility shall be provided with the kind of equipment, numbers of qualified staff, and operated in such fashion as to meet the requirements of the department.

57.4(2) On approval of the department, the state fire marshal, the department of social services, or other appropriate agencies, other variations from the established rules and regulations and standards for a licensed health care facility of that category may be made as is necessary to successfully implement the specialized program, providing that it does not endanger the health, safety, or welfare of any resident and that alternate means to effect the same degree of protection shall be used when such variances are permitted.

481—57.5(135C) General requirements.

57.5(1) The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

57.5(2) The license shall be valid only in the possession of the licensee to whom it is issued.

57.5(3) The posted license shall accurately reflect the current status of the residential care facility. (III)

57.5(4) Licenses expire one year after the date of issuance or as indicated on the license.

57.5(5) Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

481—57.6(135C) Notifications required by the department. The department shall be notified:

57.6(1) Within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents may be admitted until the minimum staffing requirements are achieved; (III)

57.6(2) Of any proposed change in the residential care facility's functional operation or addition or deletion of required services; (III)

57.6(3) Thirty days before addition, alteration, or new construction is begun in the residential care facility or on the premises; (III)

57.6(4) Thirty days in advance of closure of the residential care facility; (III)

57.6(5) Within two weeks of any change in administrator; (III)

57.6(6) When any change in the category of license is sought; (III)

57.6(7) Prior to the purchase, transfer, assignment, or lease of a residential care facility, the licensee shall:

a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)

b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease if completed; (III)

c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's residential care facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

57.6(8) Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a residential care facility, the department shall upon request send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

481—57.7(135C) Witness fees. Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

481—57.8(135C) Licenses for distinct parts.

57.8(1) Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

57.8(2) The following requirements shall be met for a separate licensing of a distinct part:

a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

c. The distinct part must be operationally and financially feasible;

d. A separate personal care staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry and dietary in common with each other.

481—57.9(135C) Administrator. Each residential care facility shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (III)

57.9(1) The administrator shall be at least 18 years of age and shall have a high school diploma or equivalent. (III) In addition, this person shall meet at least one of the following conditions:

a. Be a licensed nursing home administrator; or (III)

b. Have completed a one-year educational training program approved by the department for residential care facility administrators; or (III)

c. Have two years of supervised experience in a residential care facility, at least six months of which was in an administrative capacity. (III)

57.9(2) The administrator may act as an administrator for not more than two residential care facilities. (II)

a. The distance between the two facilities shall be no greater than 50 miles. (II)

b. The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)

c. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

57.9(3) The licensee may be the approved administrator providing the licensee meets the requirements set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

57.9(4) A provisional administrator may be appointed on a temporary basis by the residential care facility licensee to assume the administrative responsibilities for a residential care facility for a period not to exceed six months when, through no fault of its own, the home has lost its administrator and has not been able to replace the administrator provided the department has been notified prior to the date of the administrator's appointment. (III)

57.9(5) In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

a. Be knowledgeable of the operation of the facility; (III)

b. Have access to records concerned with the operation of the facility; (III)

c. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

d. Be at least 18 years of age; (III)

e. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)

f. Have had training to carry out assignments and take care of emergencies and sudden illnesses of residents. (III)

57.9(6) An administrator of only one facility shall be considered as a full-time employee. Full-time employment is defined as 40 hours per week. (III)

481—57.10(135C) Administration.

57.10(1) The licensee shall:

a. Assume the responsibility for the overall operation of the residential care facility; (III)

b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)

c. Establish written policies, which shall be available for review, for the operation of the residential care facility. (III)

57.10(2) The administrator shall:

a. Be responsible for the selection and direction of competent personnel who provide services for the resident care program; (III)

b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)

c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)

d. Make available the residential care facility payroll records for departmental review as needed. (III)

481—57.11(135C) General policies.

57.11(1) There shall be written personnel policies in facilities of more than 15 beds to include hours of work and attendance at educational programs. (III)

57.11(2) There shall be a written job description developed for each category of worker in facilities of more than 15 beds. The job description shall include title of job, job summary, age range, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

57.11(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

a. Employees shall have a physical examination and tuberculin test before employment. (I, II, III)

b. Employees shall have a physical examination at least every four years, including an assessment of tuberculosis status. (I, II, III)

57.11(4) Health certificates for all employees shall be available for review. (III)

57.11(5) Rescinded IAB 10/19/88, effective 11/23/88.

57.11(6) There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident, which includes the individuals to be contacted in case of emergency. (III)

57.11(7) The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

57.11(8) The residential care facility shall have established policies concerning the control, investigation, and prevention of infections within the facility. (III)

57.11(9) Each facility licensed as a residential care facility shall provide an organized continuous 24-hour program of care commensurate with the needs of the residents of the home and under the direction of an administrator whose combined training and supervisory experience is such as to ensure adequate and competent care. (III)

57.11(10) Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

57.11(11) Each facility shall have a written and implemented infection control program addressing the following:

a. Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)

b. Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

c. Dressings, soaks, or packs; (I, II, III)

d. Infection identification; (I, II, III)

e. Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

f. Sanitation techniques for resident care equipment; (I, II, III)

g. Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III)

h. Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Adminstration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

57.11(12) Aseptic techniques. If a resident needs any of the treatment or devices on the list below, written and implemented procedures regarding aseptic techniques shall be followed.

a. Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)

b. Urinary catheter, (I, II, III)

c. Respiratory suction, oxygen or humidification, (I, II, III)

d. Decubitus care, (I, II, III)

e. Tracheostomy, (I, II, III)

f. Nasogastric or gastrostomy tubes, (I, II, III)

g. Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

481—57.12(135C) Personnel.

57.12(1) *General qualifications.*

a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a residential care facility. (II)

b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a residential care facility. (II)

c. No person shall be allowed to provide services in a facility if the person has a disease;

(1) Which is transmissible through required workplace contact, (I, II, III)

(2) Which presents a significant risk of infecting others, (I, II, III)

(3) Which presents a substantial possibility of harming others, and (I, II, III)

(4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

d. Reserved.

e. Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

57.12(2) *Supervision and staffing.*

a. Staffing.

(1) In a facility that is licensed for more than one level of care, where the facility consists of a single building or of contiguous buildings, the department shall establish on an individual facility basis the numbers and qualifications of the staff required in a residential care facility, based on the needs of the residents in that facility.

(2) In a facility licensed only for residential care the facility shall provide the following minimum staffing ratios of personal care staff:

Days—1:25 or less (II, III)

Evenings—1:35 or less (II, III)

Nights—1:45 or less (II, III)

Additional staffing above the minimum ratio may be required by the department commensurate with the needs of individual residents.

b. Personnel in a residential care facility shall provide 24-hour coverage for residential care services. Personnel shall be up and dressed at all times in facilities over 15 beds. (II, III)

c. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. (II, III)

d. Physician's orders shall be implemented by qualified personnel. (II, III)

57.12(3) *Personnel histories.*

a. Each health care facility shall submit a form specified by the department of public safety to the department of public safety, and receive the results of a criminal history check and dependent adult abuse record check before any person is employed in a health care facility. The health care facility may submit a form specified by the department of human services to the department of human services to request a child abuse history check. For the purposes of this subrule, "employed in a facility" shall be defined as any individual who is paid, either by the health care facility or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors), to provide direct or indirect treatment or services to residents in a health care facility. Direct treatment or services include those provided through person-to-person contact. Indirect treatment or services include those provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance. Specifically excluded from the requirements of this subrule are individuals such as

building contractors, repair workers or others who are in a facility for a very limited purpose, are not in the facility on a regular basis, and who do not provide any treatment or services to the residents of the health care facility. (I, II, III)

b. A person who has a criminal record or founded dependent adult abuse report cannot be employed in a health care facility unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse report does not merit prohibition from employment. (I, II, III)

c. Each health care facility shall ask each person seeking employment in a facility "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of crime in this state or any other state?" The person shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The person shall indicate, by signature, that the person has been informed that the record checks will be conducted. (I, II, III)

d. If a person has a record of founded child abuse in Iowa or any other state, the person shall not be employed in a health care facility unless the department of human services has evaluated the crime or founded report and concluded that the report does not merit prohibition of employment. (I, II, III)

e. Proof of dependent adult abuse and criminal history checks may be kept in files maintained by the temporary employee agencies and contractors. Facilities may require temporary agencies and contractors to provide a copy of the results of the dependent adult abuse and criminal history checks. (I, II, III)

481—57.13(135C) Admission, transfer, and discharge.

57.13(1) *General admission policies.*

a. No resident shall be admitted to or retained in a residential care facility who is in need of greater services than the facility can provide. (II, III)

b. No residential care facility shall admit more residents than the number of beds for which it is licensed. (II, III)

c. There shall be no more beds erected than is stipulated on the license. (II, III)

d. There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

e. The admission of a resident to a residential care facility shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

f. The admission of a resident shall not grant the residential care facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the residential care facility as required by these rules. (III)

g. A residential care facility shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

h. Rescinded, effective 7/14/82.

i. Funds or properties received by the residential care facility, belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

j. Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

k. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity. (III)

l. Upon the verified petition of the county board of supervisors, the district court may appoint the administrator of a county care facility as conservator or guardian or both of a resident of such county care facility. Such administrator shall serve as conservator or guardian or both without fee. The administrator may establish either separate or common bank accounts for cash funds of such resident wards. (III)

57.13(2) *Discharge or transfer.*

a. Prior notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

b. Proper arrangements shall be made by the residential care facility for the welfare of the resident prior to the transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

c. The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such transfer or discharge. (II, III)

d. Advance notification by telephone will be made to the receiving facility prior to the transfer of any resident. (III)

e. When a resident is transferred or discharged, the appropriate record as set forth in 57.16(1) will accompany the resident. (II, III)

f. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

481—57.14(135C) Contracts. Each contract shall:

57.14(1) State the base rate or scale per day or per month, the services included, and the method of payment; (III)

57.14(2) Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the contract shall:

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in subsection 2; (III)

b. State the method of payment of additional charges; (III)

c. Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

d. State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc. (III)

57.14(3) Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the program assessment at the time of admission, which is determined in consultation with the administrator; (III)

57.14(4) Include the total fee to be charged initially to the specific resident; (III)

57.14(5) State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

a. Written notification to the resident, or the responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of such changes; (III)

b. Notification to the resident, or responsible party when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must be also given within a reasonable time, not to exceed one week, listing specifically the adjustments made. (III)

57.14(6) State the terms of agreement in regard to refund of all advance payments, in the event of transfer, death, voluntary, or involuntary discharge; (III)

57.14(7) State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall

contain a provision that the bed will be held at the request of the resident or the resident's responsible party.

a. The facility shall ask the resident or responsible party if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

b. The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

57.14(8) State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

57.14(9) State the conditions of voluntary discharge or transfer; (III)

57.14(10) Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)

57.14(11) Each party shall receive a copy of the signed contract. (III)

481—57.15(135C) Physical examinations.

57.15(1) Each resident in a residential care facility shall have a designated licensed physician, who may be called when needed. (III)

57.15(2) Each resident admitted to a residential care facility shall have had a physical examination prior to admission. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (III)

a. Each resident admitted to a residential care facility shall have had a physical examination prior to admission. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be a part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (III)

b. The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, tuberculosis status, physical examination, diagnosis, statement of chief complaints, and results of any diagnostic procedures. (III)

57.15(3) Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

57.15(4) Rescinded, effective 7/14/82.

57.15(5) The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

57.15(6) Each resident shall be visited by or shall visit the resident's physician at least once each year. The year period shall be measured from the date of admission and is not to include preadmission physicals. Any required physician task or visit in a residential care facility may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with the physician. (III)

57.15(7) Residents shall be admitted to a residential care facility only on a written order signed by a physician certifying that the individual being admitted requires no more than personal care and supervision but does not require nursing care. (III)

This rule is intended to implement Iowa Code section 135C.23(2).

481—57.16(135C) Records.

57.16(1) *Resident record.* The licensee shall keep a permanent record on all residents admitted to a residential care facility with all entries current, dated, and signed. (III) The record shall include:

a. Name and previous address of resident; (III)

b. Birth date, sex, and marital status of resident; (III)

c. Church affiliation; (III)

d. Physician's name, telephone number, and address; (III)

e. Dentist's name, telephone number, and address; (III)

f. Name, address, and telephone number of next of kin or legal representative; (III)

g. Name, address, and telephone number of person to be notified in case of emergency; (III)

h. Mortician's name, telephone number, and address; (III)

i. Pharmacist's name, telephone number, and address; (III)

j. Physical examination and medical history; (III)

k. Certification by the physician that the resident requires no more than personal care and supervision, but does not require nursing care; (III)

l. Physician's orders for medication, treatments, and diet in writing and signed by the physician quarterly; (III)

m. A notation of yearly or other visits to physician or other professional services; (III)

n. Any change in the resident's condition; (II, III)

o. If the physician has certified that the resident is capable of taking prescribed medications, the resident shall be required to keep the administrator advised of current medications, treatments, and diet. The administrator shall keep a listing of medications, treatments, and diet prescribed by the physician for each resident; (III)

p. If the physician has certified that the resident is not capable of taking prescribed medication, it must be administered by a qualified person of the facility. A qualified person shall be defined as either a registered or licensed practical nurse or an individual who has completed the state-approved training course in medication administration; (II)

q. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication; (II, III)

r. A notation describing condition on admission, transfer, and discharge; (III)

s. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)

t. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)

u. Disposition of valuables. (III)

57.16(2) *Incident record.*

a. Each residential care facility shall maintain an incident record report and shall have available incident report forms. (III)

b. Report of incidents shall be in detail on a printed incident report form. (III)

c. The person in charge at the time of the incident shall oversee the preparation and sign the incident report. (III)

d. The report shall cover all accidents whether there is apparent injury or where hidden injury may have occurred. (III)

e. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)

f. A copy of the incident report shall be kept on file in the facility. (III)

57.16(3) *Retention of records.*

a. Records shall be retained in the facility for five years following termination of services. (III)

b. Records shall be retained within the facility upon change of ownership. (III)

c. Rescinded, effective 7/14/82.

d. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

57.16(4) *Reports to the department.* The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

57.16(5) *Personnel record.*

a. An employment record shall be kept for each employee consisting of the following information: Name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, date and reason for discharge or resignation. (III)

b. The personnel records shall be made available for review upon request by the department. (III)

481—57.17(135C) Resident care and personal services.

57.17(1) Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

57.17(2) Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

57.17(3) Residents shall have clean clothing as needed to present a neat appearance, be free of odors, and to be comfortable. Clothing shall be appropriate to their activities and to the weather. (III)

57.17(4) Rescinded, effective 7/14/82.

57.17(5) Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

57.17(6) Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

57.17(7) Rescinded, effective 7/14/82.

57.17(8) Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

57.17(9) Residents shall be required to bathe at least twice a week. (II, III)

57.17(10) Nonambulatory residents.

a. All nonambulatory residents shall be housed on the grade level floor. (II)

b. These provisions in paragraph *"a"* above relating to nonambulatory residents are not applicable if the facility has a suitably sized elevator.

481—57.18 Rescinded, effective 7/14/82.

481—57.19(135C) Drugs.

57.19(1) *Drug storage.*

a. Residents who have been certified in writing by the physician as capable of taking their own medications, may retain these medications in their bedroom but locked storage must be provided. (III)

b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

(1) A cabinet with a lock shall be provided which can be used for storage of drugs, solutions, and prescriptions; (III)

(2) A bathroom shall not be used for drug storage; (III)

(3) The drug storage cabinet shall be kept locked when not in use; (III)

(4) The drug storage cabinet key shall be in the possession of the employee charged with the responsibility of administering medications; (II)

(5) Schedule II drugs, as defined by Iowa Code chapter 204, shall be kept in a locked box within the locked medication cabinet; (II, III)

(6) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items; (III)

(7) Drugs for external use shall be stored separately from drugs for internal use; (III)

(8) All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons; (I, II)

(9) The drug cabinet shall have a work counter. Both the counter and cabinet shall be well-lighted; (III)

(10) Running water shall be available in the room in which the medicine cabinet is located or in an adjacent room; (III)

(11) Inspection of drug storage condition shall be made by the administrator and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician's order, and drugs improperly stored. (III)

(12) Double-locked storage of Schedule II drugs shall not be required under single-unit package drug distribution systems in which the quantity stored does not exceed a three-day supply and a missing dose can be readily detected. (II)

c. Bulk supplies of prescription drugs shall not be kept in a residential care facility unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

57.19(2) *Drug safeguards.*

a. All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

b. Medication containers having soiled, damaged, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

c. The medication for each resident shall be kept or stored in the original containers. (II, III)

d. When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

e. Unused prescription drugs prescribed for residents who have died shall be destroyed by the person in charge with a witness and notation made on the resident's record, or, if a unit dose system is used, such drugs shall be returned to the supplying pharmacist. (III)

f. Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

g. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

h. Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

i. There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by a responsible person with a witness and notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

j. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The personal physician of the resident, in conjunction with the pharmacist, shall institute these policies and provide procedures for review and endorsement. (II, III)

k. No resident shall be allowed to keep possession of any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

l. No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

m. Each facility shall establish a policy in conjunction with a licensed pharmacist to govern distributing prescribed medication to residents who are on leave from a facility. (III)

(1) Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 57.19(2)*"a,"* non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration.

(2) Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

(3) Medication distributed as above may be issued only by facility personnel responsible for administering medication.

57.19(3) *Drug administration.*

a. A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

b. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

c. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

d. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved residential aide course, nurse aide course, nurse aide training and testing program or nurse aide competency examination;

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

e. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

f. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph *"d"* of this subrule do not apply to this individual.

g. Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day that they are administered, (II) unless the unit dose system is used.

h. Injectable medications shall be administered by a qualified nurse or physician.

i. Residents certified by their physician as capable of injecting their own insulin may do so. Insulin may be administered pursuant to *"h"* above or as otherwise authorized by the resident's physician. Authorization by the physician shall:

(1) Be in writing,

(2) Be maintained in the resident's record,

(3) Be renewed quarterly,

(4) Include the name of the individual authorized to administer the insulin,

(5) Include documentation by the physician that the authorized person is qualified to administer insulin to that resident.

j. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

k. The unit dose system may be used by the facility.

l. In a freestanding residential care facility licensed for 15 or fewer beds, a person who has successfully completed a state-approved medication manager course may administer medications.

481—57.20(135C) Dental services.

57.20(1) The residential care facility personnel shall assist residents to obtain regular and emergency dental services. (III)

57.20(2) Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)

57.20(3) Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)

57.20(4) All dental reports or progress notes shall be included in the clinical record. (III)

57.20(5) Personal care staff shall assist the resident in carrying out dentist's recommendations. (III)

57.20(6) Dentists shall be asked to participate in the in-service program of the facility. (III)

481—57.21(135C) Dietary.

57.21(1) *Dietary staffing.*

a. In facilities licensed for over 15 beds, persons in charge of meal planning and food preparation shall complete the home study course on sanitation and food preparation offered by the department. (III)

b. In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

c. There shall be written work schedules and time schedules covering each type of job in the food service department. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area in facilities over 15 beds. (III)

57.21(2) *Nutrition and menu planning.*

a. Menus shall be planned and followed to meet nutritional needs of residents in accordance with the physician's orders. (II)

b. Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. (II) Recommended daily dietary allowances are:

(1) Milk - two or more cups served as beverage or used in cooking;

(2) Meat group - two or more servings of meat, fish, poultry, eggs, cheese or equivalent; at least four to five ounces edible portion per day;

(3) Vegetable and fruit group - four or more servings (two cups). This shall include a citrus fruit or other fruit and vegetable important for vitamin C daily, a dark green or deep yellow vegetable for vitamin A at least every other day, and other fruits and vegetables, including potatoes;

(4) Bread and cereal group - four or more servings of whole-grain, enriched or restored;

(5) Foods other than those listed will usually be included to meet daily energy requirements (calories) to add to the total nutrients and variety of meals.

c. At least three meals or their equivalent shall be served daily, at regular hours. (II)

(1) There shall be no more than a 14-hour span between substantial evening meal and breakfast. (II, III)

(2) To the extent medically possible, bedtime nourishments shall be offered routinely to all residents. Special nourishments shall be available when ordered by physician. (II, III)

d. Menus shall include a variety of foods prepared in various ways. The same menu shall not be repeated on the same day of the following week. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

g. A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

57.21(3) *Dietary storage, food preparation, and service.*

a. All food and drink shall be clean, wholesome, free from spoilage, and safe for human consumption. (II, III)

b. The use of foods from salvaged, damaged, or unlabeled containers shall be prohibited. (III)

c. All perishable or potentially hazardous food shall be stored at safe temperatures of 45°F (7°C) or below, or 140°F (60°C) or above. (III)

d. No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (III)

e. Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a two-day period shall be maintained on the premises. Minimum food portion requirements for a low-cost plan shall conform to information supplied by the nutrition section of the department of health. (II, III)

f. Table service shall be attractive. Dishes shall be free of cracks, chips, and stains. (III)

g. If family-style service is used, all leftover prepared food that has been on the table shall be properly handled. (III)

h. Poisonous compounds shall not be kept in food storage or preparation areas. (II)

57.21(4) *Sanitation in food preparation area.*

a. "Food Service Sanitation Manual", revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C., shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with food service sanitation.

b. Residents shall not be allowed in the food preparation area. (III)

c. In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)

d. All foods, while being stored, prepared, displayed, served, or transported shall be protected against contamination from dust, flies, rodents, and other vermin. (II, III)

e. Food shall be protected from unclean utensils and worn surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, and overhead leakage. (II, III)

f. All appliances and work areas shall be kept clean. (III)

g. There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds. (III)

h. A schedule for duties to be performed daily shall be posted in each food area. (III)

i. All cooking equipment in facilities of 15 or more beds shall be provided with a properly sized exhaust system and hood to eliminate excess heat, moisture, and odors from the kitchen. (III)

j. Spillage and breakage shall be cleaned up immediately. (III)

k. All garbage not mechanically disposed of shall be kept in nonabsorbent, cleanable containers pending disposal. All filled containers shall be covered and stored in a sanitary manner. (III)

l. The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff. (III)

m. The walls, ceilings, and floors of all rooms in which food is prepared and served shall be in good repair, smooth, washable, and shall be kept clean. (III)

n. There shall be no washing, ironing, sorting or folding of laundry in the food service area. Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)

o. Ice shall be stored and handled in such a manner as to prevent contamination. Ice scoops should be sanitized daily and kept in a clean container. (III)

p. There shall be no animals or birds in the food preparation area. (III)

q. No dishes or cooking utensils shall be towel dried. (III)

r. In facilities over 15 beds, a mechanical dishwasher is required. (III)

s. If there is a dishwashing machine, it must provide a wash temperature of 140°F (60°C) to 160°F (71°C) and a rinse temperature of 170°F (76°C) to 180°F (82°C). In a freestanding residential care facility licensed for 15 or fewer beds, a wash and rinse temperature of 140°F (60°C) to 160°F (71°C) shall be acceptable. (III)

t. A three-compartment pot and pan sink with 110°F (43°C) to 115°F (46°C) water for washing, a compartment for rinsing with water at 170°F (76°C) to 180°F (82°C) for sanitizing with space for air drying, or a two-compartment sink with access to a mechanical dishwasher for sanitizing all utensils shall be provided. (III)

u. All dishes, silverware, and cooking utensils shall be stored above the floor in a sanitary manner, in a clean, dry place protected from flies, splashes, dust, and other contaminants. (III)

v. Procedures for washing and handling dishes shall be followed in order to protect the welfare of the residents and employees. Persons handling dirty dishes shall not handle clean dishes without washing their hands. (III)

w. Dishes, silverware, and cooking utensils shall be properly cleaned by prerinsing or scraping, washing, sanitizing, and air-drying. (III)

57.21(5) *Hygiene of food service personnel.*

a. Food service personnel shall be free of communicable diseases and practice hygienic food-handling techniques. In the event food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. Personnel recovering from a diagnosed intestinal infection shall submit a report from their physician showing freedom from infection before returning to work in the food service department. (II, III)

b. Employees shall wear clean, washable uniforms that are not used for duties outside the food service area. (III)

c. Hairnets shall be worn by all food service personnel. Individuals with beards shall provide for total enclosure of facial hair. (III)

d. Clean aprons and hairnets shall be available for use by other personnel in emergency situations. (III)

e. Persons handling food shall be knowledgeable of good hand-washing techniques. A hand-wash sink shall be provided in or adjacent to the food service area. Continuous on-the-job training on sanitation shall be encouraged. (III)

f. The use of tobacco shall be prohibited in the kitchen. (III)

57.21(6) *Food and drink.* All food and drink consumed within the facility shall be clean and wholesome and comply with local ordinances and applicable provisions of state and federal laws. (II, III)

481—57.22(135C) Service plan.

57.22(1) Prior to admission of a resident, the administrator or the administrator's designee shall develop a written and organized orientation plan. The plan shall be designed to assist the resident in adapting to the facility and to assist the facility staff in becoming knowledgeable of the resident and the resident's needs. (III)

57.22(2) Within 30 days of admission, the administrator or the administrator's designee shall, in conjunction with the resident, other facility staff or any organization that works with or serves the resident, develop a written, individualized, and integrated program of ongoing services for the resident. (III)

a. The program shall be planned and implemented to address the resident's priorities and assessed needs, such as living, rehabilitation, activity, behavioral, emotional, mental health and social, and shall

take into consideration the resident's personal goals and preferences, including the resident's preferred living situation. (III)

b. The service plan shall include specific goals and objectives with regular documentation of each. (III)

c. The service plan shall be reviewed at least quarterly, or more often as necessary. (III)

57.22(3) Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change, and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's family members or responsible party. (III)

481—57.23(135C) Resident activities program.

57.23(1) Each residential care facility shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

a. The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

b. The program shall include individual goals for each resident. (III)

c. The activity program shall include both group and individual activities. (III)

d. No resident shall be forced to participate in the activity program. (III)

57.23(2) *Coordination of activities program.*

a. Each residential care facility with over 15 beds shall employ a person to direct the activities program. (III)

[1]*b.* [2] Staffing for the activity program shall be provided on the minimum basis of 45 minutes per licensed bed per week. (II, III)

c. The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

d. The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

e. There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

57.23(3) *Duties of activity coordinator.* The activity coordinator shall:

a. Have access to all residents' records excluding financial records; (III)

b. Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

c. Keep all necessary records including:

(1) Attendance; (III)

(2) Record individual resident progress notes at least every three months; (III)

(3) Monthly calendars, prepared in advance. (III)

d. Coordinate the activity program with all other services in the facility; (III)

e. Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

57.23(4) *Supplies, equipment, and storage.*

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc. (III)

b. Storage shall be provided for recreational equipment and supplies. (III)

c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

[1] Emergency, pursuant to Iowa Code section 17A.5(2)*"b"*(2).

[2] Objection filed 2/14/79, see insert IAC 3/7/79.

481—57.24(135C) Resident advocate committee. Each facility shall have a resident advocate committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for resident advocate committees promulgated by the department of elder affairs. (II)

57.24(1) Role of committee in complaint investigations.

a. The department shall notify the facility's resident advocate committee of a complaint from the public. The department shall not disclose the name of a complainant.

b. The department may refer complaints to the resident advocate committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department of elder affairs. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation or the investigation.

c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the resident advocate committee and the department of elder affairs of its findings, including any citations and fines issued.

d. Results of all complaint investigations addressed by the resident advocate committee shall be forwarded to the department within ten days of completion of the investigation.

57.24(2) The resident advocate committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

57.24(3) When requested, names, addresses and telephone numbers of family members shall be given to the resident advocate committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the family member's name, address or telephone number given to the resident advocate committee.

This rule is intended to implement Iowa Code section 135C.25.

481—57.25(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

57.25(1) *Fire safety.*

a. All residential care facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

57.25(2) *Safety duties of administrator.* The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

a. The plan shall be posted. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

57.25(3) *Resident safety.*

a. Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when under direct supervision. (II, III)

b. Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

c. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

d. Smoking shall be permitted only in posted areas. (II, III)

e. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (II, III)

57.25(4) *Restraints.*

a. Rescinded, effective 7/14/82.

b. Residents shall not be kept behind locked doors;

c. Temporary seclusion of residents shall be used only in an emergency to prevent injury to the resident or to others pending transfer to appropriate placement;

d. A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room;

e. Divided doors shall be of such type that when the upper half is closed the lower section shall close.

481—57.26(135C) Housekeeping.

57.26(1) Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

57.26(2) Each resident unit shall be cleaned on a routine schedule. (III)

57.26(3) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

57.26(4) A hallway or corridor shall not be used for storage of equipment. (III)

57.26(5) All odors shall be kept under control by cleanliness and proper ventilation. (III)

57.26(6) Clothing worn by personnel shall be clean and washable. (III)

57.26(7) Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

57.26(8) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

57.26(9) Polishes used on floors shall provide a nonslip finish. (III)

57.26(10) Throw or scatter rugs shall not be permitted. (III)

57.26(11) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

57.26(12) Residents shall not have access to storage areas for all cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials. (II, III)

57.26(13) Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

57.26(14) Personal possessions of residents which may constitute hazards to themselves or to others shall be removed and stored. (III)

481—57.27(135C) Maintenance.

57.27(1) Each facility shall establish a maintenance program to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and ensure sanitary practices throughout the facility. In facilities over 15 beds, this program shall be established in writing and available for review by the department. (III)

57.27(2) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

57.27(3) Draperies and furniture shall be clean and in good repair. (III)

57.27(4) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

57.27(5) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the national electric code. (III)

57.27(6) All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

57.27(7) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. (III)

57.27(8) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

57.27(9) The facility shall be kept free of flies, other insects, and rodents. (III)

57.27(10) Janitor closet.

a. Facilities shall be provided with storage for cleaning equipment, supplies, and utensils. (III)

b. Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

c. In facilities licensed for over 15 beds, a janitor's closet shall be provided. It shall be equipped with water for filling scrub pails and a janitor's sink for emptying scrub pails. (III)

481—57.28(135C) Laundry.

57.28(1) All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

57.28(2) Except for related activities, the laundry room shall not be used for other purposes. (III)

57.28(3) Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

57.28(4) Residents' personal laundry shall be marked with an identification. (III)

57.28(5) Bed linens, towels, and washcloths shall be clean and stain-free. (III)

57.28(6) If laundry is done in the facility, the following shall be provided:

a. A clean, dry, well-lighted area to accommodate a washer and dryer of adequate size to serve the needs of the facility. (III)

b. In facilities of over 15 beds, the laundry room shall be divided into separate areas, one for sorting soiled linen and one for sorting and folding clean linen. (III)

481—57.29(135C) Garbage and waste disposal.

57.29(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

57.29(2) All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

57.29(3) All containers shall be thoroughly cleaned each time the containers are emptied. (III)

57.29(4) All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

57.29(5) Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

481—57.30(135C) Buildings, furnishings, and equipment.

57.30(1) *Buildings—general requirements.*

a. For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than seven feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within seven feet of the floor shall be protected by screen guards of not more than one-fourth inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates except closets used for the storage of residents' clothing. (III)

j. All stairways in resident-occupied areas shall have substantial handrails on both sides. (III)

k. Each open stairway shall have protective barriers. (III)

l. Screens of 16 mesh per square inch shall be provided at all openings. (III)

m. Screen doors shall swing outward and be self-closing. At the discretion of the state fire marshal, screens for fire doors may swing in. (III)

n. All resident rooms shall have a door. (III)

o. All rooms in resident-occupied areas shall have general lighting switched at the entrance to each room. (III)

57.30(2) *Furnishings and equipment.*

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a home-like atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

d. Night lights shall be provided in corridors, at stairways, attendant's stations and residents' bedrooms, and hazardous areas with no less than one foot-candle throughout the area at all times. (III)

57.30(3) *Dining and living rooms.*

a. Every facility shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 57.30(3)*"e"* are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment.

f. Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably furnished. (III)

(3) When space is provided to be used only for activities and recreational purposes, the area shall be at least 15 square feet per licensed bed. At least 50 percent of the required area must be in one room. (III)

g. Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) When space is provided to be used only for dining, the area shall total at least 15 square feet per licensed bed. (III)

57.30(4) *Bedrooms.*

a. Each resident shall be provided with a standard, single, or twin bed, substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. (III)

b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)

c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)

d. There shall be a comfortable chair, either a rocking chair or arm chair, per resident bed. The resident's personal wishes shall be considered. (III)

e. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)

g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

h. There shall be a wardrobe or closet in each resident's room. Minimum clear dimensions shall be 1′ 10″ deep by 1′ 8″ wide with full hanging space and provide a clothes rod and shelf. In a multiple bedroom, closet or wardrobe space shall be assigned each resident sufficient for the resident's needs. (III)

i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)

j. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)

k. Reading lamps shall be provided each resident in the resident's room. (III)

l. Each room shall have sufficient accessible mirrors to serve residents' needs. (III)

m. Usable floor space of a room shall be no less than eight feet in any major dimension. (III)

n. Bedrooms shall have a minimum of 80 square feet of usable floor space per bed. (III)

o. There shall be no more than four residents per room. (III)

p. Each resident room shall be provided with light and ventilation by means of a window or windows with an area equal to one-eighth of the total floor area. The windows shall be openable. (III)

57.30(5) *Bath and toilet facilities.*

a. Provision shall be made for bars to hold individual towels and washcloths. (III)

b. All lavatories shall have paper towel dispensers and an available supply of soap. (III)

c. Minimum numbers of toilet and bath facilities shall be one lavatory, one toilet for each 10 residents, and one tub or shower for each 15 residents or fraction thereof. (III)

d. There shall be a minimum of one bathroom with tub or shower, toilet stool and lavatory on each floor in multistory buildings for facilities licensed for over 15 beds. Separate toilets for the sexes shall be provided. (III)

e. Grab bars shall be provided at all toilet stools, tubs, and showers. Grab bars, accessories, and anchorage shall have sufficient strength to sustain a deadweight of 250 pounds for five minutes. (III)

f. Each toilet room shall have a door. (III)

g. All toilet, bath, and shower facilities shall be supplied with adequate safety devices appropriate to the needs of the individual residents. Raised toilet seats shall be available for residents who are aged or infirm. (III)

h. Toilet and bath facilities shall have an aggregate outside window area of at least four square feet. Facilities having a system of mechanical ventilation are exempt from this regulation. (III)

i. Every facility shall provide a toilet and lavatory with grab bars for the public and staff. (III)

57.30(6) *Heating.* A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

57.30(7) *Water supply.*

a. Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)

b. Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)

c. A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)

d. The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)

e. Hot and cold running water under pressure shall be available in the facility. (III)

f. Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department. (III)

57.30(8) *Sewage system.*

a. Sewage shall be collected and disposed of in a manner approved by the department. Disposal into a municipal system will be considered as meeting this requirement. (III)

b. Private sewage systems shall conform to the rules and regulations of the department of environmental quality, state health department, and the natural resources council. (III)

c. Every facility shall have an interior plumbing system complete with flushing device. (III)

57.30(9) *Attendant's station.* In facilities over 15 beds, an attendant's station with a minimum of 40 square feet shall be provided which is centrally located in the resident area and shall have a well-lighted desk with the necessary equipment for the keeping of required records and supplies. (III)

481—57.31(135C) Family and employee accommodations.

57.31(1) Children under 14 years of age shall not be allowed into the service areas. (III)

57.31(2) The residents' bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)

57.31(3) In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

57.31(4) In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

57.31(5) In all health care facilities, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

481—57.32(135C) Animals. No animals shall be allowed within the facility except with written approval of the department and under controlled conditions. (III)

481—57.33(135C) Environment and grounds.

57.33(1) A residential care facility shall be constructed in a neighborhood free from excessive noise, dirt, polluted, or odorous air, or similar disturbances. (III)

57.33(2) There shall be an area available for outdoor activities calculated at 25 square feet per licensed bed. Open air porches may be included in meeting such requirements. (III)

481—57.34(135C) Supplies.

57.34(1) *Linen supplies.*

a. There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom of odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

57.34(2) *First aid kit.* A first aid emergency kit shall be available on each floor in every facility. (II, III)

57.34(3) *General supplies.*

a. All equipment shall be properly cleaned and sanitized before use by another resident. (III)

b. Clean and sanitary storage shall be provided for equipment and supplies. (III)

481—57.35(135C) Residents' rights in general.

57.35(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 57.35(2) to 57.35(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

57.35(2) Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

a. Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

b. As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

57.35(3) Policies and procedures regarding the use of chemical and physical restraints shall define the use of restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

57.35(4) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

57.35(5) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

57.35(6) Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies. (II)

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

c. A statement shall be signed by the resident, or the resident's responsible party, if applicable, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party. In the case of a mentally retarded resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

e. All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English speaking, deaf or blind residents of changes. (II)

57.35(7) Each resident or responsible party shall be fully informed in a contract as required in rule 57.14(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges not covered by the facility's basic per diem rate. (II)

57.35(8) Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the department of health and human services protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or mentally retarded individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

a. The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either, shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

b. The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

c. If the physician determines or in the case of a confused or mentally retarded resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

d. Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

57.35(9) In residential care facilities which are also county care facilities, policies and procedures shall address the admission and retention of persons with histories of dangerous and disturbing behavior. For the purpose of this subrule, persons with histories of dangerous or disturbing behavior are those persons who have been committed for evaluation and found to be seriously mentally impaired pursuant to Iowa Code section 229.13 or 812.1 within six months of the request for admission to the facility. In addition to establishing the criteria for admission and retention of persons so defined, the policies and procedures shall provide for:

a. Reasonable precautions to prevent the resident from harming self, other residents, or employees of the facility.

b. Treatment of persons with mental illness as defined in Iowa Code section 229.1(1) which is provided in accordance with the individualized health care plan.

c. Ongoing and documented staff training on individualized health care planning for persons with mental illness.

481—57.36(135C) Involuntary discharge or transfer.

57.36(1) A facility shall not involuntarily discharge or transfer a resident from a facility except: for medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), except as prohibited by Title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k and by reason of action pursuant to Iowa Code chapter 229. (I, II)

a. "Medical reasons" for transfer or discharge are based on the resident's needs and are determined and documented in the resident's record by the attending physician. Transfer or discharge may be required to provide a different level of care. (II)

b. "Welfare" of a resident or that of other residents refers to their social, emotional, or physical well-being. A resident might be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with other residents' needs and rights). Evidence that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall be in writing and shall include specific information to support this determination. (II)

c. Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. The 30-day requirement shall not apply in any of the following instances:

(1) If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) If the transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

d. The notice required by paragraph *"c"* shall contain all of the following information:

(1) The stated reason for the proposed transfer or discharge. (II)

(2) The effective date of the proposed transfer or discharge. (II)

(3) A statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as "department") within seven days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department of inspections and appeals designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." (II)

e. A request for a hearing made under 57.36(1)*"d"*(3) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

f. The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, responsible party, and Iowa department of elder affairs long-term care ombudsman of record, not later than five full business days after receipt of the request. This notice shall also inform the licensee, resident or responsible party that they have a right to appear at the hearing in person or be represented by their attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department of elder affairs long-term care ombudsman shall have the right to appear at the hearing.

g. The hearing shall be heard by a department of inspections and appeals designee pursuant to Iowa Code chapter 17A. (The hearing shall be public unless the resident or representative requests in writing that it be closed.) The licensee or designee shall have the opportunity to present to the representative of the department any oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and responsible party shall also have an opportunity to present to the representative of the department any oral testimony or written material to show just cause why a transfer or discharge should not be made. In a determination

as to whether a transfer or discharge is authorized, the burden of proof rests on the party requesting the transfer or discharge.

h. Based upon all testimony and material submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department of elder affairs long-term care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision.

i. A copy of the notice required by paragraph *"c"* shall be personally delivered to the resident and a copy placed in the resident's record. A copy shall also be transmitted to the department, the resident's responsible party, physician, the person or agency responsible for the resident's placement, maintenance, and care in the facility, and the department of elder affairs long-term care ombudsman.

j. If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

k. The involuntary transfer or discharge shall be discussed with the resident, the resident's responsible party, and the person or agency responsible for the resident's placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's record. (II)

l. The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident's record. (II)

(1) Counseling shall be provided by a qualified individual who meets one of the following criteria:

1. Has a bachelor's or master's degree in social work from an accredited college. (II)

2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with a public or private agency. (II)

3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)

4. Is a licensed psychologist or psychiatrist. (II)

5. Is any other person of the resident's choice. (II)

(2) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be discharged or transferred. (II)

(3) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

m. In the case of an emergency transfer or discharge as outlined in 57.36(1)*"c"*(1), the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident's file and it must contain all the information required by subparagraphs (1) and (2) of 57.36(1)*"d."* In addition, the notice must contain a statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals within 7

days after receiving this notice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." A hearing requested pursuant to this subrule shall be held in accordance with paragraphs *"f," "g,"* and *"h."* (II)

n. Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department of inspections and appeals. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

57.36(2) Intrafacility transfer:

a. Residents shall not be relocated from room to room within a licensed health care facility arbitrarily. (I, II) Involuntary relocation may occur only in the following situations, and the situation shall be documented in the resident's record.

(1) Incompatibility with or disturbing to other roommates, as documented in the resident's record.

(2) For the welfare of the resident or other residents of the facility.

(3) For medical, nursing or psychosocial reasons, as documented in the resident's record, as judged by the attending physician, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.

(4) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex.

(5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

b. Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or responsible party include:

(1) Change from private pay status to Title XIX, except as outlined in 57.36(2)*"a"*(5). (II)

(2) As punishment or behavior modification (except as specified in 57.36(2)*"a"*(1)). (II)

(3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph *"a,"* the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or responsible party. (II)

d. If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately, or as soon as possible, of the condition requiring emergency relocation and the notification shall be documented. (II)

481—57.37(135C) Residents' rights. Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise the resident's rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

57.37(1) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

57.37(2) The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

a. Designation of an employee responsible for handling grievances and recommendations. (II)
b. A method of investigating and assessing the validity of a grievance or recommendation. (II)
c. Methods of resolving grievances. (II)
d. Methods of recording grievances and actions taken. (II)

57.37(3) The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, and resident advocate committee members and the text of Iowa Code section 135C.46 to provide to residents a further course of redress. (II)

481—57.38(135C) Financial affairs—management. Each resident, who has not been assigned a guardian or conservator by the court, may manage the resident's own personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

57.38(1) The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

57.38(2) An employee shall be designated in writing to be responsible for resident accounts. (II)

57.38(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code subsection 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or mentally retarded resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

57.38(4) If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

57.38(5) A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

57.38(6) A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

481—57.39(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical and physical restraints, except in an emergency for the shortest amount of time necessary to protect the resident from injury to the resident or to others, pending the immediate transfer to an appropriate facility. The decision to use restraints on an emergency basis shall be made by the designated charge person who shall promptly report the action taken to the physician and the reasons for using restraints shall be documented in the resident's record. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

57.39(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

57.39(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

57.39(3) Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff. (II)

57.39(4) Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain that separation until the abuse investigation is completed. (I, II)

57.39(5) Suspected abuse reports. The department shall investigate all complaints of dependent adult abuse which are alleged to have happened in a health care facility. The department shall inform the department of human services of the results of all evaluations and dispositions of dependent adult abuse investigations.

57.39(6) Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

481—57.40(135C) Resident records. Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

57.40(1) The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

57.40(2) Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

57.40(3) The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

481—57.41(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (II)

57.41(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

57.41(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

57.41(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

57.41(4) Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

57.41(5) Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply under emergency conditions. (II)

481—57.42(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

57.42(1) Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

57.42(2) Residents who perform work for the facility must receive remuneration unless the work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

481—57.43(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

57.43(1) Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

57.43(2) Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

a. The resident refuses to see the visitor(s). (II)

b. The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)

c. The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

57.43(3) Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

57.43(4) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

57.43(5) Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

57.43(6) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

57.43(7) Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified mental retardation professional, or facility administrator for refusing permission. (II)

57.43(8) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

481—57.44(135C) Resident activities. Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified mental retardation professional as appropriate in the resident's resident record. (II)

57.44(1) Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

57.44(2) All residents shall have the freedom to refuse to participate in these activities. (II)

481—57.45(135C) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

57.45(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

57.45(2) Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

57.45(3) Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart.

The facility shall be responsible for secure storage of the items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

57.45(4) A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

57.45(5) A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

481—57.46(135C) Family visits. Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room, if available. (II)

57.46(1) The facility shall provide for needed privacy in visits between spouses. (II)

57.46(2) Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why such an arrangement would have an adverse effect on the health of the resident. (II)

57.46(3) Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an agreement would have an adverse effect on the health of the resident. (II)

481—57.47(135C) Choice of physician. Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility. (II)

481—57.48(135C) Incompetent residents.

57.48(1) Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

57.48(2) The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

481—57.49(135C) County care facilities. In addition to Chapter 57 licensing rules, county care facilities licensed as residential care facilities must also comply with department of human services rules, 441—Chapter 37. Violations of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

481—57.50(135C) Another business or activity in a facility. A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs *"a"* through *"j"* of this rule. (I, II, III)

57.50(1) The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

a. Health and safety risks for residents;

b. Compatibility of the proposed business or activity with the facility program;

c. Noise created by the proposed business or activity;

d. Odors created by the proposed business or activity;

e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;

f. Use of the facility's corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;

g. Proposed staffing for the business or activity;

h. Sharing of services and staff between the proposed business or activity and the facility;

i. Facility layout and design; and

j. Parking area utilized by the business or activity.

57.50(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

57.50(3) A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 60. (I, II, III)

481—57.51(135C) Respite care services. Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A residential care facility which chooses to provide respite care services must meet the following requirements related to respite services and must be licensed as a residential care facility.

57.51(1) A residential care facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

57.51(2) Rule 481—57.36(135C), regarding involuntary discharge or transfer rights, does not apply to residents who are being cared for under a respite care contract.

57.51(3) Pursuant to rule 481—57.14(135C), the facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements under 481—57.14(135C), except the requirements under subrule 57.14(7).

57.51(4) Respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.6(1), 135C.14, 135C.23(2), 135C.25, 135C.36, 227.4, 235B.1(6), and 235B.1(11).

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◊ Two or more ARCs

1 Effective date of 470—57.15(2) *"a"* and *"b"* delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAB 6/4/86.

2 See IAB, Inspections and Appeals Department.

3 Effective date of 481—57.12(2) *"a,"* last paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held July 8, 1993.

OBJECTION

At its February 13 meeting the Administrative Rules Review Committee voted the following objection: [Subrules 57.23(2)*"b,"* 58.26(2)*"b,"* 59.31(2)*"b,"* 63.21(3)"*b,"* published IAB 12/13/78]

The committee objects to the amendments to 470* IAC 57.23(2)*"b,"* 58.26(2)*"b,"* 59.31(2)*"b"* and 63.21(3)*"b,"* which strike the phrase "Twenty-five percent of the staffing may be provided by qualified volunteers. The time shall be spent in working with the organized program activity.", on the grounds these provisions are unreasonable. It is the understanding of the committee these deletions in effect require facilities to employ a person to coordinate recreation activities. It is the feeling of the committee this would result in higher per bed costs without demonstrably improving the services rendered to the patient. Volunteers have always played a major role in health care institutions, and no evidence has been submitted indicating a decline in that role or in public interest in donating time and energy.

These amendments appear in the 12-13-78 IAB, and have been filed under the emergency provisions of chapter 17A, 1979 Code.

*Chapter 57 transferred to Inspections and Appeals[481], IAC 7/15/87.

CHAPTER 58
NURSING FACILITIES
[Prior to 7/15/87, Health Department[470] Ch 58]

481—58.1(135C) Definitions. For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words "shall" and "must" indicates those standards are mandatory. The use of the words "should" and "could" indicates those standards are recommended.

"Accommodation" means the provision of lodging, including sleeping, dining, and living areas.

"Administrator" means a person licensed pursuant to Iowa Code chapter 147 who administers, manages, supervises, and is in general administrative charge of a nursing facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

"Alcoholic" means a person in a state of dependency resulting from excessive or prolonged consumption of alcoholic beverages as defined in Iowa Code section 125.2.

"Ambulatory" means the condition of a person who immediately and without aid of another is physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

"Basement" means that part of a building where the finish floor is more than 30 inches below the finish grade.

"Board" means the regular provision of meals.

"Chairfast" means capable of maintaining a sitting position but lacking the capacity of bearing own weight, even with the aid of a mechanical device or another individual.

"Communicable disease" means a disease caused by the presence of viruses or microbial agents within a person's body, which agents may be transmitted either directly or indirectly to other persons.

"Department" means the state department of inspections and appeals.

"Distinct part" means a clearly identifiable area or section within a health care facility, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

"Drug addiction" means a state of dependency, as medically determined, resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 124.

"Medication" means any drug including over-the-counter substances ordered and administered under the direction of the physician.

"Nonambulatory" means the condition of a person who immediately and without aid of another is not physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

"Nourishing snack" is defined as a verbal offering of items, single or in combination, from the basic food groups. Adequacy of the "nourishing snack" will be determined both by resident interviews and by evaluation of the overall nutritional status of residents in the facility.

"Person directed care environment" means the provision of care and services provided in a facility that promotes decision making and choices by the resident, enhances the primary caregiver's capacity to respond to each resident's needs, and promotes a homelike environment. Examples of a person directed care environment include, but are not limited to, the Green House concept, the Eden alternative, service houses and neighborhoods.

"Personal care" means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are assistance in getting in and out of bed, assistance with personal hygiene and bathing, assistance with dressing, meal assistance, and supervision over medications which can be self-administered.

"Potentially hazardous food" means a food that is natural or synthetic and that requires temperature control because it is in a form capable of supporting the rapid and progressive growth of infectious or toxigenic microorganisms, the growth and toxin production of clostridium botulinum, or in raw shell eggs, the growth of salmonella enteritidis. Potentially hazardous food includes an animal food (a food of animal origin) that is raw or heat-treated; a food of plant origin that is heat-treated or consists of raw

seed sprouts; cut melons; and garlic and oil mixtures that are not acidified or otherwise modified at a food processing plant in a way that results in mixtures that do not support growth of bacteria.

"Program of care" means all services being provided for a resident in a health care facility.

"Qualified 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 having one year's experience working with the mentally retarded.

"Qualified nurse" means a registered nurse or a licensed practical nurse, as defined in Iowa Code chapter 152.

"Rate" means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules and regulations.

"Responsible party" means the person who signs or cosigns the admission agreement required in 58.13(135C) or the resident's guardian or conservator if one has been appointed. In the event that a resident does not have a guardian, conservator or other person signing the admission agreement, the term "responsible party" shall include the resident's sponsoring agency, e.g., the department of human services, the U.S. Department of Veterans Affairs, religious groups, fraternal organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

"Restraints" means any chemical, manual method or physical or mechanical device, material, or equipment attached to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

"Substantial evening meal" is defined as an offering of three or more menu items at one time, one of which includes a high protein such as meat, fish, eggs or cheese. The meal would represent no less than 20 percent of the day's total nutritional requirements.

481—58.2(135C) Variances. Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual nursing facility. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

58.2(1) To request a variance, the licensee must:

a. Apply for variance in writing on a form provided by the department;

b. Cite the rule or rules from which a variance is desired;

c. State why compliance with the rule or rules cannot be accomplished;

d. Explain alternate arrangements or compensating circumstances which justify the variance;

e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

58.2(2) Upon receipt of a request for variance, the director of inspections and appeals will:

a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;

b. If the request meets the above criteria, evaluate the alternate arrangements or compensating circumstances against the requirement of the rules;

c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;

d. Consult with the applicant if additional information is required.

58.2(3) Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

481—58.3(135C) Application for licensure.

58.3(1) Initial application and licensing. In order to obtain an initial nursing facility license, for a nursing facility which is currently licensed, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Applicable exceptions found in rule 481—61.2(135C) shall apply based on the construction date of the facility.

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the nursing facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door location;

e. Submit a photograph of the front and side elevation of the nursing facility;

f. Submit the statutory fee for a nursing facility license;

g. Meet the requirements of a nursing facility for which licensure application is made;

h. Comply with all other local statutes and ordinances in existence at the time of licensure;

i. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

58.3(2) In order to obtain an initial nursing facility license for a facility not currently licensed as a nursing facility, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Exceptions noted in 481—subrule 61.1(2) shall not apply;

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the nursing facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door locations;

e. Submit a photograph of the front and side elevation of the nursing facility;

f. Submit the statutory fee for a nursing facility license;

g. Comply with all other local statutes and ordinances in existence at the time of licensure;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

58.3(3) *Renewal application.* In order to obtain a renewal of the nursing facility license, the applicant must:

a. Submit the completed application form 30 days prior to annual license renewal date of nursing facility license;

b. Submit the statutory license fee for a nursing facility with the application for renewal;

c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;

d. Submit appropriate changes in the résumé to reflect any changes in the resident care program or other services.

58.3(4) Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

481—58.4(135C) General requirements.

58.4(1) The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

58.4(2) The license shall be valid only in the possession of the licensee to whom it is issued.

58.4(3) The posted license shall accurately reflect the current status of the nursing facility. (III)

58.4(4) Licenses expire one year after the date of issuance or as indicated on the license.

58.4(5) No nursing facility shall be licensed for more beds than have been approved by the health facilities construction review committee.

58.4(6) Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

481—58.5(135C) Notifications required by the department. The department shall be notified:

58.5(1) Within 48 hours, by letter, of any reduction or loss of nursing or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

58.5(2) Of any proposed change in the nursing facility's functional operation or addition or deletion of required services; (III)

58.5(3) Thirty days before addition, alteration, or new construction is begun in the nursing facility or on the premises; (III)

58.5(4) Thirty days in advance of closure of the nursing facility; (III)

58.5(5) Within two weeks of any change in administrator; (III)

58.5(6) When any change in the category of license is sought; (III)

58.5(7) Prior to the purchase, transfer, assignment, or lease of a nursing facility, the licensee shall:

a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)

b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)

c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's nursing facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

58.5(8) Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a nursing facility, the department shall upon request send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

481—58.6(135C) Witness fees. Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

481—58.7(135C) Licenses for distinct parts.

58.7(1) Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

58.7(2) The following requirements shall be met for a separate licensing of a distinct part:

a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

c. A distinct part must be operationally and financially feasible;

d. A separate staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry, and dietary in common with each other.

481—58.8(135C) Administrator.

58.8(1) Each nursing facility shall have one person in charge, duly licensed as a nursing home administrator or acting in a provisional capacity. (III)

58.8(2) A licensed administrator may act as an administrator for not more than two nursing facilities.

a. The distance between the two facilities shall be no greater than 50 miles. (II)

b. The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)

c. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

58.8(3) The licensee may be the licensed nursing home administrator providing the licensee meets the requirements as set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

58.8(4) A provisional administrator may be appointed on a temporary basis by the nursing facility licensee to assume the administrative duties when the facility, through no fault of its own, has lost its administrator and has been unable to replace the administrator provided that no facility licensed under Iowa Code chapter 135C shall be permitted to have a provisional administrator for more than 6 months in any 12-month period and further provided that:

a. The department has been notified prior to the date of the administrator's appointment; (III)

b. The board of examiners for nursing home administrators has approved the administrator's appointment and has confirmed such appointment in writing to the department. (III)

58.8(5) In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

a. Be knowledgeable of the operation of the facility; (III)

b. Have access to records concerned with the operation of the facility; (III)

c. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

d. Be at least 18 years of age; (III)

e. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)

f. Have had training to carry out assignments and take care of emergencies and sudden illness of residents. (III)

58.8(6) A licensed administrator in charge of two facilities shall employ an individual designated as a full-time assistant administrator for each facility. (III)

58.8(7) An administrator of only one facility shall be considered as a full-time employee. Full-time employment is defined as 40 hours per week. (III)

481—58.9(135C) Administration.

58.9(1) The licensee shall:

a. Assume the responsibility for the overall operation of the nursing facility; (III)

b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)

c. Establish written policies, which shall be available for review, for the operation of the nursing facility. (III)

58.9(2) The administrator shall:

a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program; (III)

b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)

c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)

d. Make available the nursing facility payroll records for departmental review as needed; (III)

e. Be required to maintain a staffing pattern of all departments. These records must be maintained for six months and are to be made available for departmental review. (III)

481—58.10(135C) General policies.

58.10(1) There shall be written personnel policies in facilities of more than 15 beds to include hours of work, and attendance at educational programs. (III)

58.10(2) There shall be a written job description developed for each category of worker. The job description shall include title of job, job summary, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

a. Employees shall have a physical examination and tuberculin test before employment; (I, II, III)

b. Employees shall have a physical examination at least every four years, including an assessment of tuberculosis status. (I, II, III)

58.10(4) Health certificates for all employees shall be available for review. (III)

58.10(5) Rescinded IAB 10/19/88, effective 11/23/88.

58.10(6) There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident which includes the individual to be contacted in case of emergency. (III)

58.10(7) The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

58.10(8) Infection control program. Each facility shall have a written and implemented infection control and exposure control program with policies and procedures based on the guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. (I, II, III) CDC guidelines are available at http://www.cdc.gov/ncidod/dhqp/index.html.

58.10(9) Infection control committee. Each facility shall establish an infection control committee of representative professional staff responsible for overall infection control in the facility. (III)

a. The committee shall annually review and revise the infection control policies and procedures to monitor effectiveness and suggest improvement. (III)

b. The committee shall meet at least quarterly, submit reports to the administrator, and maintain minutes in sufficient detail to document its proceedings and actions. (III)

c. The committee shall monitor the health aspect and the environment of the facility. (III)

58.10(10) There shall be written policies for resident care programs and services as outlined in these rules. (III)

58.10(11) Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

481—58.11(135C) Personnel.

58.11(1) *General qualifications.*

a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a nursing facility. (II)

b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a nursing facility. (II)

c. No person shall be allowed to provide services in a facility if the person has a disease:

(1) Which is transmissible through required workplace contact, (I, II, III)

(2) Which presents a significant risk of infecting others, (I, II, III)

(3) Which presents a substantial possibility of harming others, and (I, II, III)

(4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

d. Reserved.

e. Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

f. Persons employed in all departments, except the nursing department of a nursing facility shall be qualified through formal training or through prior experience to perform the type of work for which they have been employed. Prior experience means at least 240 hours of full-time employment in a field related to their duties. Persons may be hired in laundry, housekeeping, activities and dietary without experience or training if the facility institutes a formal in-service training program to fit the job description in question and documents such as having taken place within 30 days after the initial hiring of such untrained employees. (III)

g. Rescinded, effective 7/14/82.

h. The health services supervisor shall be a qualified nurse as defined in these regulations. (II)

i. Those persons employed as nurse's aides, orderlies, or attendants in a nursing facility who have not completed the state-approved 75-hour nurse's aide program shall be required to participate in a structured on-the-job training program of 20 hours' duration to be conducted prior to any resident contact, except that contact required by the training program. This educational program shall be in addition to facility orientation. Each individual shall demonstrate competencies covered by the curriculum. This shall be observed and documented by an R.N. and maintained in the personnel file. No aide shall work independently until this is accomplished, nor shall the aide's hours count toward meeting the minimum hours of nursing care required by the department. The curriculum shall be approved by the department. An aide who has completed the state-approved 75-hour course may model skills to be learned.

Further, such personnel shall be enrolled in a state-approved 75-hour nurse's aide program to be completed no later than six months from the date of employment. If the state-approved 75-hour program has been completed prior to employment, the on-the-job training program requirement is waived. The 20-hour course is in addition to the 75-hour course and is not a substitute in whole or in part. The 75-hour program, approved by the department, may be provided by the facility or academic institution.

Newly hired aides who have completed the state-approved 75-hour course shall demonstrate competencies taught in the 20-hour course upon hire. This shall be observed and documented by an R.N. and maintained in the personnel file.

All personnel administering medications must have completed the state-approved training program in medication administration. (II)

j. There shall be an organized ongoing in-service educational and training program planned in advance for all personnel in all departments. (II, III)

k. Nurse aides, orderlies or attendants in a nursing facility who have received training other than the Iowa state-approved program, must pass a challenge examination approved by the department of inspections and appeals. Evidence of prior formal training in a nursing aide, orderly, attendant, or other comparable program must be presented to the facility or institution conducting the challenge examination before the examination is given. The approved facility or institution, following department of inspections and appeals guidelines, shall make the determination of who is qualified to take the examination. Documentation of the challenge examinations administered shall be maintained.

58.11(2) *Nursing supervision and staffing.*

a. Rescinded IAB 8/7/91, effective 7/19/91.

b. Where only part-time nurses are employed, one nurse shall be designated health service supervisor. (III)

c. A qualified nurse shall be employed to relieve the supervising nurses, including charge nurses, on holidays, vacation, sick leave, days off, absences or emergencies. Pertinent information for contacting such relief person shall be posted at the nurse's station. (III)

d. When the health service supervisor serves as the administrator of a facility 50 beds and over, a qualified nurse must be employed to relieve the health service supervisor of nursing responsibilities. (III)

e. The department may establish on an individual facility basis the numbers and qualifications of the staff required in the facility using as its criteria the services being offered and the needs of the residents. (III)

f. Additional staffing, above the minimum ratio, may be required by the department commensurate with the needs of the individual residents. (III)

g. The minimum hours of resident care personnel required for residents needing intermediate nursing care shall be 2.0 hours per resident day computed on a seven-day week. A minimum of 20 percent of this time shall be provided by qualified nurses. If the maximum medical assistance rate is reduced below the 74th percentile, the requirement will return to 1.7 hours per resident per day computed on a seven-day week. A minimum of 20 percent of this time shall be provided by qualified nurses. (II, III)

h. The health service supervisor's hours worked per week shall be included in computing the 20 percent requirement.

i. A nursing facility of 75 beds or more shall have a qualified nurse on duty 24 hours per day, seven days a week. (II, III)

j. In facilities under 75 beds, if the health service supervisor is a licensed practical nurse, the facility shall employ a registered nurse, for at least four hours each week for consultation, who must be on duty at the same time as the health service supervisor. (II, III)

(1) This shall be an on-site consultation and documentation shall be made of the visit. (III)

(2) The registered nurse-consultant shall have responsibilities clearly outlined in a written agreement with the facility. (III)

(3) Consultation shall include but not be limited to the following: counseling the health service supervisor in the management of the health services; (III) reviewing and evaluating the health services in determining that the needs of the residents are met; (II, III) conducting a review of medications at least monthly if the facility does not employ a registered nurse part-time. (II, III)

k. Facilities with 75 or more beds must employ a health service supervisor who is a registered nurse. (II)

l. There shall be at least two people who shall be capable of rendering nursing service, awake, dressed, and on duty at all times. (II)

m. Physician's orders shall be implemented by qualified personnel. (II, III)

58.11(3) *Personnel histories.*

a. Each health care facility shall submit a form specified by the department of public safety to the department of public safety, and receive the results of a criminal history check and dependent adult abuse record check before any person is employed in a health care facility. The health care facility shall submit a form specified by the department of human services to the department of human services to request a child abuse history check. For the purposes of this subrule, "employed in a facility" shall be defined as any individual who is paid, either by the health care facility or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors), to provide direct or indirect treatment or services to residents in a health care facility. Direct treatment or services include those provided through person-to-person contact. Indirect treatment or services include those provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance. Specifically excluded from the requirements of this subrule are individuals such as building contractors, repair workers or others who are in a facility for a very limited purpose, are not in the facility on a regular basis, and do not provide any treatment or services to the residents of the health care facility. (I, II, III)

b. A person who has a criminal record or founded dependent adult abuse report cannot be employed in a health care facility unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse report does not merit prohibition from employment. (I, II, III)

c. Each health care facility shall ask each person seeking employment in a facility "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of crime in this state or any other state?" The person shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The person shall indicate, by signature, that the person has been informed that the record checks will be conducted. (I, II, III)

d. If a person has a record of founded child abuse in Iowa or any other state, the person shall not be employed in a health care facility unless the department of human services has evaluated the crime or founded report and concluded that the report does not merit prohibition of employment. (I, II, III)

e. Proof of dependent adult abuse and criminal history checks may be kept in files maintained by the temporary employee agencies and contractors. Facilities may require temporary agencies and contractors to provide a copy of the results of the dependent adult abuse and criminal history checks. (I, II, III)

481—58.12(135C) Admission, transfer, and discharge.

58.12(1) *General admission policies.*

a. No resident shall be admitted or retained in a nursing facility who is in need of greater services than the facility can provide. (II, III)

b. No nursing facility shall admit more residents than the number of beds for which it is licensed, except guest rooms for visitors. (II, III)

c. There shall be no more beds erected than is stipulated on the license. (II, III)

d. There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

e. The admission of a resident to a nursing facility shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

f. The admission of a resident shall not grant the nursing facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the facility as required by these rules. (III)

g. A nursing facility shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

h. Rescinded, effective 7/14/82.

i. Funds or properties received by the nursing facility belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

j. Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

k. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity.

l. Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A, the facility shall ask the resident or the resident's personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a potential veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services.

If a resident is eligible for benefits through the United States Department of Veterans Affairs or other third-party payor, the facility first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II, III)

58.12(2) *Discharge or transfer.*

a. Prior notification shall be made to the resident, as well as the resident's next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

b. Proper arrangements shall be made by the nursing facility for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

c. The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such a discharge or transfer. (II, III)

d. Advance notification will be made to the receiving facility prior to the transfer of any resident. (III)

e. When a resident is transferred or discharged, the appropriate record as set forth in 58.15(2)*"k"* of these rules will accompany the resident. (II, III)

f. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

481—58.13(135C) Contracts. Each contract shall:

58.13(1) State the base rate or scale per day or per month, the services included, and the method of payment; (III)

58.13(2) Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. Furthermore, the contract shall: (III)

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in 58.13(3); (III)

b. State the method of payment of additional charges; (III)

c. Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

d. State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.; (III)

58.13(3) Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the nursing assessment at the time of admission, which is determined in consultation with the administrator; (III)

58.13(4) Include the total fee to be charged initially to the specific resident; (III)

58.13(5) State the conditions whereby the facility may make adjustments to the facility's overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

a. Written notification to the resident, or responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to effective date of such changes; (III)

b. Notification to the resident, or responsible party when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

58.13(6) State the terms of agreement in regard to refund of all advance payments in the event of transfer, death, voluntary or involuntary discharge; (III)

58.13(7) State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party.

a. The facility shall ask the resident or responsible party if the resident wants the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

b. The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

58.13(8) State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

58.13(9) State the conditions of voluntary discharge or transfer; (III)

58.13(10) Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)

58.13(11) Each party shall receive a copy of the signed contract. (III)

481—58.14(135C) Medical services.

58.14(1) Each resident in a nursing facility shall designate a licensed physician who may be called when needed. Professional management of a resident's care shall be the responsibility of the hospice program when:

a. The resident is terminally ill, and

b. The resident has elected to receive hospice services under the federal Medicare program from a Medicare-certified hospice program, and

c. The facility and the hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of hospice care.

58.14(2) Each resident admitted to a nursing facility shall have had a physical examination prior to admission. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be made part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (III)

58.14(3) Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

58.14(4) Rescinded, effective 7/14/82.

58.14(5) The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

58.14(6) A schedule listing the names and telephone numbers of the physicians shall be posted in each nursing station. (III)

58.14(7) Residents shall be admitted to a nursing facility only on a written order signed by a physician certifying that the individual being admitted requires no greater degree of nursing care than the facility is licensed to provide. (III)

58.14(8) Each resident shall be visited by or shall visit the resident's physician at least twice a year. The year period shall be measured from the date of admission and is not to include preadmission physicals. Notwithstanding the provisions of 42 CFR 483.40, any required physician task or visit in a nursing facility may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with a physician, as outlined in Table 1. (III)

In dually certified skilled nursing/nursing facilities, the advanced registered nurse practitioner, clinical nurse specialist, and physician assistant must follow the skilled nursing facility requirements for services for skilled nursing facility stays. For nursing facility stays in skilled nursing/nursing facilities, any required physician task or visit may be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant working in collaboration with the physician.

Nurse practitioners, clinical nurse specialists, and physician assistants may perform other tasks that are not reserved to the physician such as visits outside the normal schedule needed to address new symptoms or other changes in medical status.

Table 1: Authority for non-physician practitioners to perform visits, sign orders, and sign certifications/recertifications when permitted by state law*

	Initial Comprehensive Visit/Orders	Other Required Visits[1]	Other Medically Necessary Visits and Orders[2]	Certification/ Recertification
Skilled Nursing Facilities				
Nurse practitioner and clinical nurse specialist employed by the facility	May not perform/May not sign	May perform	May perform and sign	May not sign
Nurse practitioner and clinical nurse specialist not a facility employee	May not perform/May not sign	May perform	May perform and sign	May sign subject to state requirements
Physician assistant regardless of employer	May not perform/May not sign	May perform	May perform and sign	May not sign
Nursing Facilities				
Nurse practitioner, clinical nurse specialist, and physician assistant employed by the facility	May not perform/May not sign	May not perform	May perform and sign	May sign subject to state requirements
Nurse practitioner, clinical nurse specialist, and physician assistant not a facility employee	May perform/May sign	May perform	May perform and sign	May sign subject to state requirements

*As permitted by state law governing the scope and practice of nurse practitioners, clinical nurse specialists, and physician assistants.

[1] Other required visits include the skilled nursing resident monthly visits that may be alternated between physician and advanced registered nurse practitioners, clinical nurse specialists, or physician assistants after the initial comprehensive visit is completed.

[2] Medically necessary visits may be performed prior to the initial comprehensive visit.

481—58.15(135C) Records.

58.15(1) *Resident admission record.* The licensee shall keep a permanent record on all residents admitted to a nursing facility with all entries current, dated, and signed. This shall be a part of the resident clinical record. (III) The admission record form shall include:

a. Name and previous address of resident; (III)

b. Birth date, sex, and marital status of resident; (III)

c. Church affiliation; (III)

d. Physician's name, telephone number, and address; (III)

e. Dentist's name, telephone number, and address; (III)

f. Name, address, and telephone number of next of kin or legal representative; (III)

g. Name, address, and telephone number of person to be notified in case of emergency; (III)

h. Mortician's name, telephone number, and address; (III)

i. Pharmacist's name, telephone number, and address. (III)

58.15(2) *Resident clinical record.* There shall be a separate clinical record for each resident admitted to a nursing facility with all entries current, dated, and signed. (III) The resident clinical record shall include:

a. Admission record; (III)

b. Admission diagnosis; (III)

c. Physical examination: The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, tuberculosis status, physical examination, diagnosis, statement of chief complaints, estimation of restoration potential and results of any diagnostic procedures. The report of the physical examination shall be signed by the physician. (III)

d. Physician's certification that the resident requires no greater degree of nursing care than the facility is licensed to provide; (III)

e. Physician's orders for medication, treatment, and diet in writing and signed by the physician quarterly; (III)

f. Progress notes.

(1) Physician shall enter a progress note at the time of each visit; (III)

(2) Other professionals, i.e., dentists, social workers, physical therapists, pharmacists, and others shall enter a progress note at the time of each visit; (III)

g. All laboratory, X-ray, and other diagnostic reports; (III)

h. Nurse's record including:

(1) Admitting notes including time and mode of transportation; room assignment; disposition of valuables; symptoms and complaints; general condition; vital signs; and weight; (II, III)

(2) Routine notes including physician's visits; telephone calls to and from the physician; unusual incidents and accidents; change of condition; social interaction; and P.R.N. medications administered including time and reason administered, and resident's reaction; (II, III)

(3) Discharge or transfer notes including time and mode of transportation; resident's general condition; instructions given to resident or legal representative; list of medications and disposition; and completion of transfer form for continuity of care; (II, III)

(4) Death notes including notification of physician and family to include time, disposition of body, resident's personal possessions and medications; and complete and accurate notes of resident's vital signs and symptoms preceding death; (III)

i. Medication record.

(1) An accurate record of all medications administered shall be maintained for each resident. (II, III)

(2) Schedule II drug records shall be kept in accordance with state and federal laws; (II, III)

j. Death record. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)

k. Transfer form.

(1) The transfer form shall include identification data from the admission record, name of transferring institution, name of receiving institution, and date of transfer; (III)

(2) The nurse's report shall include resident attitudes, behavior, interests, functional abilities (activities of daily living), unusual treatments, nursing care, problems, likes and dislikes, nutrition, current medications (when last given), and condition on transfer; (III)

(3) The physician's report shall include reason for transfer, medications, treatment, diet, activities, significant laboratory and X-ray findings, and diagnosis and prognosis; (III)

l. Consultation reports shall indicate services rendered by allied health professionals in the facility or in health-centered agencies such as dentists, physical therapists, podiatrists, oculists, and others. (III)

58.15(3) *Resident personal record.* Personal records may be kept as a separate file by the facility.

a. Personal records may include factual information regarding personal statistics, family and responsible relative resources, financial status, and other confidential information.

b. Personal records shall be accessible to professional staff involved in planning for services to meet the needs of the resident. (III)

c. When the resident's records are closed, the information shall become a part of the final record. (III)

d. Personal records shall include a duplicate copy of the contract(s). (III)

58.15(4) *Incident record.*

a. Each nursing facility shall maintain an incident record report and shall have available incident report forms. (III)

b. Report of incidents shall be in detail on a printed incident report form. (III)

c. The person in charge at the time of the incident shall prepare and sign the report. (III)

d. The report shall cover all accidents where there is apparent injury or where hidden injury may have occurred. (III)

e. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)

f. A copy of the incident report shall be kept on file in the facility. (III)

58.15(5) *Retention of records.*

a. Records shall be retained in the facility for five years following termination of services. (III)

b. Records shall be retained within the facility upon change of ownership. (III)

c. Rescinded, effective 7/14/82.

d. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

58.15(6) *Reports to the department.* The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

58.15(7) *Personnel record.*

a. An employment record shall be kept for each employee, consisting of the following information: name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, criminal history and dependent adult abuse background checks, and date and reason for discharge or resignation. (III)

b. The personnel records shall be made available for review upon request by the department. (III)

481—58.16(135C) Resident care and personal services.

58.16(1) Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

58.16(2) Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

58.16(3) Residents shall have clean clothing as needed to present a neat appearance, to be free of odors, and to be comfortable. Clothing shall be based on resident choice and shall be appropriate to residents' activities and to the weather. (III)

58.16(4) Rescinded, effective 7/14/82.

58.16(5) Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

58.16(6) Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

58.16(7) Rescinded, effective 7/14/82.

58.16(8) Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

58.16(9) Except for those who request differently, residents who are not bedfast shall be fully dressed each day to maintain self-esteem and promote the residents' normal lifestyles. (III)

58.16(10) Residents shall receive a bath of their choice, based on the facility's accommodations, as needed to maintain proper hygiene. (II, III)

481—58.17 Rescinded, effective 7/14/82.

481—58.18(135C) Nursing care.

58.18(1) Individual health care plans shall be based on resident treatment decisions, the nature of the illness or disability, treatment, and care prescribed. Goals shall be developed by each discipline providing service, treatment, and care. These plans shall be in writing, revised as necessary, and kept current. They shall be made available to all those rendering the services and for review by the department. (III)

58.18(2) Residents shall be protected against hazards to themselves and others or the environment. (II, III)

58.18(3) The facility shall provide resident and family education as an integral part of restorative and supportive care. (III)

58.18(4) The facility shall provide prompt response from qualified staff for the resident's use of the nurse call system. (II, III) (Prompt response being considered as no longer than 15 minutes.)

481—58.19(135C) Required nursing services for residents. The program plan for nursing facilities shall have the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:

58.19(1) *Activities of daily living.*

a. Bathing; (II, III)

b. Daily oral hygiene (denture care); (II, III)

c. Routine shampoo; (II, III)

d. Nail care; (III)

e. Shaving; (III)

f. Daily care and application of prostheses (glasses, hearing aids, glass eyes, limb prosthetics, braces, or other assistive devices); (II, III)

g. Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III)

h. Daily routine range of motion; (II, III)

i. Mobility (assistance with wheelchair, mechanical lift, or other means of locomotion); (I, II, III)

j. Elimination.

(1) Assistance to and from the bathroom and perineal care; (II, III)

(2) Bedpan assistance; (II, III)

(3) Care for incontinent residents; (II, III)

(4) Bowel and bladder training programs including in-dwelling catheter care (i.e., insertion and irrigation), enema and suppository administration, and monitoring and recording of intake and output, including solid waste; (I, II, III)

k. Colostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)

l. Ileostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)

m. All linens necessary; (III)

n. Nutrition and meal service.

(1) Regular, therapeutic, modified diets, and snacks; (I, II, III)

(2) Mealtime preparation of resident; (II, III)

(3) Assistance to and from meals; (II, III)

(4) In-room meal service or tray service; (II, III)

(5) Assistance with food preparation and meal assistance including total assistance if needed; (II, III)

(6) Assistance with adaptive devices; (II, III)

(7) Enteral nutrition (to be performed by a registered nurse or licensed practical nurse only); (I, II, III)

o. Promote initiation of self-care for elements of resident care; (II, III)

p. Oral suctioning (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse). (I, II)

58.19(2) *Medication and treatment.*

a. Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I, II)

b. Wound care; (I, II)

c. Blood glucose monitoring; (I, II)

d. Vital signs, blood pressure, and weights; (I, II)

e. Ambulation and transfer; (II, III)

f. Provision of restraints; (I, II)

g. Administration of oxygen (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II)

h. Provision of all treatments; (I, II, III)

i. Provision of emergency medical care, including arranging for transportation, in accordance with written policies and procedures of the facility; (I, II, III)

j. Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III)

481—58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:

58.20(1) Direct the implementation of the physician's orders; (I, II)

58.20(2) Plan for and direct the nursing care, services, treatments, procedures, and other services in order that each resident's needs and choices, where practicable, are met; (II, III)

58.20(3) Review the health care needs and choices, where practicable, of each resident admitted to the facility and assist the attending physician in planning for the resident's care; (II, III)

58.20(4) Develop and implement a written health care plan in cooperation with, to the extent practicable, the resident, the resident's family or the resident's legal representative, and others in accordance with instructions of the attending physician as follows:

a. The written health care plan, based on the assessment and reassessment of the resident's health needs and choices, where practicable, is personalized for the individual resident and indicates care to be given, goals to be accomplished, and methods, approaches, and modifications necessary to achieve best results; (III)

b. The health service supervisor is responsible for preparing, reviewing, supervising the implementation, and revising the written health care plan; (III)

c. The health care plan is readily available for use by all personnel caring for the resident; (III)

58.20(5) Initiate preventative and restorative nursing procedures for each resident so as to achieve and maintain the highest possible degree of function, self-care, and independence based on resident choice, where practicable; (II, III)

58.20(6) Supervise health services personnel to ensure they perform the following restorative measures in their daily care of residents:

a. Maintaining good bodily alignment and proper positioning; (II, III)

b. Making every effort to keep the resident active except when contraindicated by physician's orders, and encouraging residents to achieve independence in activities of daily living by teaching self-care, transfer, and ambulation activities; (III)

c. Assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests as necessary; (III)

d. Assisting residents to carry out prescribed therapy exercises between visits of the therapist; (III)

e. Assisting residents with routine range of motion exercises; (III)

58.20(7) Plan and conduct nursing staff orientation and in-service programs and provide for training of nurse's aides; (III)

58.20(8) Plan with the resident and the resident's physician and family and health-related agencies for the care of the resident upon discharge; (III)

58.20(9) Designate a responsible person to be in charge during absences; (III)

58.20(10) Be responsible for all assignments and work schedules for all health services personnel to ensure that the health needs of the residents are met; (III)

58.20(11) Ensure that all nurse's notes are descriptive of the care rendered including the resident's response; (III)

58.20(12) Visit each resident routinely to be knowledgeable of the resident's current condition; (III)

58.20(13) Evaluate in writing the performance of each individual on the health care staff on at least an annual basis. This evaluation shall be available for review in the facility to the department; (III)

58.20(14) Keep the administrator informed of the resident's status; (III)

58.20(15) Teach and coordinate rehabilitative health care including activities of daily living, promotion and maintenance of optimal physical and mental functioning; (III)

58.20(16) Supervise serving of meals to ensure that individuals unable to assist themselves are promptly fed and that special eating adaptive devices are available as needed; (II, III)

58.20(17) Make available a nursing procedure manual which shall include all procedures practiced in the facility; (III)

58.20(18) Participate with the administrator in the formulation of written policies and procedures for resident services; (III)

58.20(19) The person in charge shall immediately notify the family of any accident, injury, or adverse change in the resident's condition requiring physician's notification. (III)

481—58.21(135C) Drugs, storage, and handling.

58.21(1) Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

a. A cabinet with a lock, convenient to nursing service, shall be provided and used for storage of all drugs, solutions, and prescriptions; (III)

b. The drug storage cabinet shall be kept locked when not in use; (III)

c. The medication cabinet key shall be in the possession of the person directly responsible for issuing medications; (II, III)

d. Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a three-day supply and a missing dose can be readily detected. (II)

58.21(2) Drugs for external use shall be stored separately from drugs for internal use. (III)

58.21(3) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items. A method for locking these medications shall be provided. (III)

58.21(4) All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

58.21(5) All flammable materials shall be specially stored and handled in accordance with applicable local and state fire regulations. (II)

58.21(6) A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

a. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

b. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

c. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved nurse aide course, nurse aide training and testing program or nurse aide competency examination.

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

d. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

(4) Successfully complete a department-approved nurse aide competency evaluation.

e. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph *"c"* of this subrule do not apply to this individual.

58.21(7) Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day that they are administered, (II) unless the unit dose system is used.

58.21(8) An accurate written record of medications administered shall be made by the individual administering the medication. (III)

58.21(9) Records shall be kept of all Schedule II drug medications received and dispensed in accordance with the controlled drug and substance Act. (III)

58.21(10) Any unusual resident reaction shall be reported to the physician at once. (II)

58.21(11) A policy shall be established by the facility in conjunction with a licensed pharmacist to govern the distribution of prescribed medications to residents who are on leave from the facility. (III)

a. Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 58.21(14)*"a,"* non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration.

b. Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

c. Medication distributed as above may be issued only by a nurse responsible for administering medication. (I, II, III)

58.21(12) Emergency medications. A nursing facility shall provide emergency medications pursuant to the following requirements: (III)

a. Prescription drugs as well as nonprescription items must be prescribed or approved by the physician, in consultation with the pharmacist, who provides emergency service to the facility; (III)

b. The emergency medications shall be stored in an accessible place; (III)

c. A list of the emergency medications and quantities of each item shall be maintained by the facility; (III)

d. The container holding the emergency medications shall be closed with a seal which may be broken when drugs are required in an emergency or for inspection; (III)

e. Any item removed from the emergency medications shall be replaced within 48 hours; (III)

f. A permanent record shall be kept of each time the emergency medications are used; (III)

g. The emergency medications shall be inspected by a pharmacist at least once every three months to determine the stability of items. (III)

58.21(13) Drug handling.

a. Bulk supplies of prescription drugs shall not be kept in a nursing facility unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

b. Inspection of drug storage condition shall be made by the health service supervisor and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the nurse and pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician's order, and drugs improperly stored. (III)

c. If the facility permits licensed nurses to dilute or reconstitute drugs at the nursing station, distinctive supplementary labels shall be available for the purpose. The notation on the label shall be so made as to be indelible. (III)

d. Dilution and reconstitution of drugs and their labeling shall be done by the pharmacist whenever possible. If not possible, the following shall be carried out only by the licensed nurse:

(1) Specific directions for dilution or reconstitution and expiration date should accompany the drug; (III)

(2) A distinctive supplementary label shall be affixed to the drug container when diluted or reconstituted by the nurse for other than immediate use. (III) The label shall bear the following: resident's name, dosage and strength per unit/volume, nurse's name, expiration date, and date and time of dilution. (III)

58.21(14) Drug safeguards.

a. All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

b. Medication containers having soiled, damaged, illegible or makeshift labels, or medication samples shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

c. There shall be no medications or any solution in unlabeled containers. (II, III)

d. The medications of each resident shall be kept or stored in the originally received containers. (II, III)

e. Labels on containers shall be clearly legible and firmly affixed. No label shall be superimposed on another label of a drug container. (II, III)

f. When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

g. Unused prescription drugs prescribed for residents who are deceased shall be returned to the supplying pharmacist. (III)

h. Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

i. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

j. Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

k. There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by the responsible nurse with a witness and a notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

l. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The physician, in consultation with the pharmacist serving the home, shall institute policies and provide procedures for review and endorsement of stop orders on drugs. This policy shall be conveniently located for personnel administering medications. (II, III)

m. No resident shall be allowed to keep possession of any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

n. Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedroom, but locked storage must be provided. (II)

o. No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

p. A qualified nurse shall:

(1) Establish a medication schedule system which identifies the time and dosage of each medication prescribed for each resident, is based on the resident's desired routine, and is approved by the resident's physician. (II, III)

(2) Establish a medication record containing the information specified above needed to monitor each resident's drug regimen. (II, III)

q. Telephone orders shall be taken by a qualified nurse. Orders shall be written into the resident's record and signed by the person receiving the order. Telephone orders shall be submitted to the physician for signature within 48 hours. (III)

r. A pharmacy operating in connection with a nursing facility shall comply with the provisions of the pharmacy law requiring registration of pharmacies and the regulations of the Iowa board of pharmacy examiners. (III)

s. In a nursing facility with a pharmacy or drug supply, service shall be under the personal supervision of a pharmacist licensed to practice in the state of Iowa. (III)

58.21(15) Drug administration.

a. Injectable medications shall not be administered by anyone other than a qualified nurse or physician. In the case of a resident who has been certified by the resident's physician as capable of taking the resident's own insulin, the resident may inject the resident's own insulin. (II)

b. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

c. The health service supervisor shall be responsible for the supervision and direction of all personnel administering medications. (II)

481—58.22(135C) Rehabilitative services. Rehabilitative services shall be provided to maintain function or improve the resident's ability to carry out the activities of daily living.

58.22(1) *Physical therapy services.*

a. Each facility shall have a written agreement with a licensed physical therapist to provide physical therapy services. (III)

b. Physical therapy shall be rendered only by a physical therapist licensed to practice in the state of Iowa. All personnel assisting with the physical therapy of residents must be under the direction of a licensed physical therapist. (II, III)

c. The licensed physical therapist shall:

(1) Evaluate the resident and prepare a physical therapy treatment plan conforming to the medical orders and goals; (III)

(2) Consult with other personnel in the facility who are providing resident care and plan with them for the integration of a physical therapy treatment program into the overall health care plan; (III)

(3) Instruct the nursing personnel responsible for administering selected restorative procedures between treatments; (III)

(4) Present programs in the facility's in-service education programs. (III)

d. Treatment records in the resident's medical chart shall include:

(1) The physician's prescription for treatment; (III)

(2) An initial evaluation note by the physical therapist; (III)

(3) The physical therapy care plan defining clearly the long-term and short-term goals and outlining the current treatment program; (III)

(4) Notes of the treatments given and changes in the resident's condition; (III)

(5) A complete discharge summary to include recommendations for nursing staff and family. (III)

e. There shall be adequate facilities, space, appropriate equipment, and storage areas as are essential to the treatment or examinations of residents. (III)

58.22(2) *Other rehabilitative services.*

a. The facility shall arrange for specialized and supportive rehabilitative services when such services are ordered by a physician. (III) These may include audiology and occupational therapy.

b. Audiology services shall be under the direction of a person licensed in the state of Iowa by the board of speech pathology and audiology. (II, III)

c. Occupational therapy services shall be under the direction of a qualified occupational therapist who is currently registered by the American Occupational Therapy Association. (II, III)

d. The appropriate professional shall:

(1) Develop the treatment plan and administer or direct treatment in accordance with the physician's prescription and rehabilitation goals; (III)

(2) Consult with other personnel within the facility who are providing resident care and plan with them for the integration of a treatment program into the overall health care plan. (III)

481—58.23(135C) Dental, diagnostic, and other services.

58.23(1) *Dental services.*

a. The nursing facility personnel shall assist residents to obtain regular and emergency dental services. (III)

b. Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)

c. Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)

d. All dental reports or progress notes shall be included in the clinical record. (III)

e. Nursing personnel shall assist the resident in carrying out dentist's recommendations. (III)

f. Dentists shall be asked to participate in the in-service program of the facility. (III)

58.23(2) *Diagnostic services.*

a. The nursing facility shall make provisions for promptly securing required clinical laboratory, X-ray, and other diagnostic services. (III)

b. All diagnostic services shall be provided only on the written, signed order of a physician. (III)

c. Agreements shall be made with the local hospital laboratory or independent laboratory to perform specific diagnostic tests when they are required. (III)

d. Transportation arrangements for residents shall be made, when necessary, to and from the source of service. (III)

e. Copies of all diagnostic reports shall be requested by the facility and included in the resident's clinical record. (III)

f. The physician ordering the specific diagnostic service shall be promptly notified of the results. (III)

g. Simple tests such as customarily done by nursing personnel for diabetic residents may be performed in the facility. (III)

58.23(3) *Other services.*

a. The nursing facility shall assist residents to obtain such supportive services as requested by the physician. (III)

b. Transportation arrangements shall be made when necessary. (III)

c. Services could include the need for prosthetic devices, glasses, hearing aids, and other necessary items. (III)

481—58.24(135C) Dietary.

58.24(1) *Organization of dietetic services.* The facility shall meet the needs of the residents and provide the services listed in this standard. If the service is contracted out, the contractor shall meet the same standard. A written agreement shall be formulated between the facility and the contractor and shall convey to the department the right to inspect the food service facilities of the contractor. (III)

a. There shall be written policies and procedures for dietetic services that include staffing, nutrition, menu planning, therapeutic diets, preparation, service, ordering, receiving, storage, sanitation, and staff hygiene. The policies and procedures shall be made available for use by dietetic services. (III)

b. There shall be written job descriptions for each position in dietetic services. The job descriptions shall be made available for use by dietetic services. (III)

58.24(2) *Dietary staffing.*

a. The facility shall employ a qualified dietary supervisor who:

(1) Is a qualified dietitian as defined in 58.24(2)*"e"*; or

(2) Is a graduate of a dietetic technician training program approved by the American Dietetic Association; or

(3) Is a certified dietary manager certified by the certifying board for dietary managers of the Dietary Managers Association (DMA) and maintains that credential through 45 hours of DMA-approved continuing education; or

(4) Has completed a DMA-approved course curriculum necessary to take the certification examination required to become a certified dietary manager; or

(5) Has documented evidence of at least two years' satisfactory work experience in food service supervision and who is in an approved dietary manager association program and will successfully complete the program within 12 months of the date of enrollment; or

(6) Has completed or is in the final 90-hour training course approved by the department. (II, III)

b. The supervisor shall have overall supervisory responsibility for dietetic services and shall be employed for a sufficient number of hours to complete management responsibilities that include:

(1) Participating in regular conferences with consultant dietitian, administrator and other department heads; (III)

(2) Writing menus with consultation from the dietitian and seeing that current menus are posted and followed and that menu changes are recorded; (III)

(3) Establishing and maintaining standards for food preparation and service; (II, III)

(4) Participating in selection, orientation, and in-service training of dietary personnel; (II, III)

(5) Supervising activities of dietary personnel; (II, III)

(6) Maintaining up-to-date records of residents identified by name, location and diet order; (III)

(7) Visiting residents to learn individual needs and communicating with other members of the health care team regarding nutritional needs of residents when necessary; (II, III)

(8) Keeping records of repairs of equipment in dietetic services. (III)

c. The facility shall employ sufficient supportive personnel to carry out the following functions:

(1) Preparing and serving adequate amounts of food that are handled in a manner to be bacteriologically safe; (II, III)

(2) Washing and sanitizing dishes, pots, pans and equipment at temperatures required by procedures described elsewhere; (II, III)

(3) Serving of therapeutic diets as prescribed by the physician and following the planned menu. (II, III)

d. The facility may assign simultaneous duties in the kitchen and laundry, housekeeping, or nursing service to appropriately trained personnel. Proper sanitary and personal hygiene procedures shall be followed as outlined under the rules pertaining to staff hygiene. (II, III)

e. If the dietetic service supervisor is not a licensed dietitian, a consultant dietitian is required. The consultant dietitian shall be licensed by the state of Iowa pursuant to Iowa Code chapter 152A.

f. Consultants' visits shall be scheduled to be of sufficient duration and at a time convenient to:

(1) Record, in the resident's medical record, any observations, assessments and information pertinent to medical nutrition therapy; (I, II, III)

(2) Work with residents and staff on resident care plans; (III)

(3) Consult with the administrator and others on developing and implementing policies and procedures; (III)

(4) Write or approve general and therapeutic menus; (III)

(5) Work with the dietetic supervisor on developing procedures, recipes and other management tools; (III)

(6) Present planned in-service training and staff development for food service employees and others. Documentation of consultation shall be available for review in the facility by the department. (III)

g. In facilities licensed for more than 15 beds, dietetic services shall be available for a minimum of a 12-hour span extending from the time of preparation of breakfast through supper. (III)

58.24(3) *Nutrition and menu planning.*

a. Menus shall be planned and followed to meet the nutritional needs of each resident in accordance with the physician's orders and in consideration of the resident's choices and preferences. (II, III)

b. Menus shall be planned to provide 100 percent of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. A current copy of the Simplified Diet Manual published by Blackwell Publishing, Ames, Iowa, shall be available and used in the planning and serving of all meals. (II)

c. At least three meals or their equivalent shall be served daily, at regular hours comparable to normal mealtimes in the community. (II)

(1) There shall be no more than a 14-hour span between a substantial evening meal and breakfast except as provided in subparagraph (3) below. (II, III)

(2) The facility shall offer snacks at bedtime daily. (II, III)

(3) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast of the following day. The current resident group must agree to this meal span and a nourishing snack must be served. (II)

d. Menus shall include a variety of foods prepared in various ways. The same menu shall not be repeated on the same day of the following week. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by department personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded. (III)

g. A file of tested recipes adjusted to the number of people to be served in the facility shall be maintained. (III)

h. Alternate foods shall be offered to residents who refuse the food served. (II, III)

58.24(4) *Therapeutic diets.*

a. Therapeutic diets shall be prescribed by the attending physician. A current therapeutic diet manual shall be readily available to attending physicians, nurses and dietetic service personnel. This manual shall be used as a guide for writing menus for therapeutic diets. A licensed dietitian shall be

responsible for writing and approving the therapeutic menu and reviewing procedures for preparation and service of food. (III)

b. Personnel responsible for planning, preparing and serving therapeutic diets shall receive instructions on those diets. (III)

58.24(5) *Food preparation and service.*

a. Methods used to prepare foods shall be those which conserve nutritive value and flavor and meet the taste preferences of the residents. (III)

b. Foods shall be attractively served. (III)

c. Foods shall be cut up, chopped, ground or blended to meet individual needs. (II, III)

d. Self-help devices shall be provided as needed. (II, III)

e. Table service shall be attractive. (III)

f. Plasticware, china and glassware that are unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze shall be discarded. (III)

g. All food that is transported through public corridors shall be covered. (III)

h. All potentially hazardous food or beverages capable of supporting rapid and progressive growth of microorganisms that can cause food infections or food intoxication shall be maintained at temperatures of 41°F or below or at 140°F or above at all times, except during necessary periods of preparation. Frozen food shall be maintained frozen. (I, II, III)

i. Potentially hazardous food that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165°F for 15 seconds. (I, II, III)

j. Food must be reheated to 165°F within no more than two hours after the heating process begins. (I, II, III)

k. Cooked potentially hazardous food shall be cooled:

(1) Within two hours, from 140°F to 70°F; and

(2) Within four hours, from 70°F to 41°F or less. (I, II, III)

58.24(6) *Dietary ordering, receiving, and storage.*

a. All food and beverages shall be of wholesome quality and procured from sources approved or considered satisfactory by federal, state and local authorities. Food or beverages from unlabeled, rusty, leaking, broken or damaged containers shall not be served. (I, II, III)

b. A minimum of at least a one-week supply of staple foods and a three-day supply of perishable foods shall be maintained on the premises to meet the planned menu needs until the next food delivery. Supplies shall be appropriate to meet the requirements of the menu. (III)

c. All milk shall be pasteurized. (III)

d. Milk may be served in individual, single-use containers. Milk may be served from refrigerated bulk milk dispensers or from the original container. Milk served from a refrigerated bulk milk dispenser shall be dispensed directly into the glass or other container from which the resident drinks. (II, III)

e. Records which show amount and kind of food purchased shall be retained for three months and shall be made available to the department upon request. (III)

f. Dry or staple items shall be stored at least six inches (15 cm) above the floor in a ventilated room, not subject to sewage or wastewater backflow, and protected from condensation, leakage, rodents or vermin in accordance with the Food Code, 1999 edition. (III)

g. Pesticides, other toxic substances and drugs shall not be stored in the food preparation or storage areas used for food or food preparation equipment and utensils. Soaps, detergents, cleaning compounds or similar substances shall not be stored in food storage rooms or areas. (II)

h. Food storage areas shall be clean at all times. (III)

i. There shall be a reliable thermometer in each refrigerator, freezer and in storerooms used for food. (III)

j. Foods held in refrigerated or other storage areas shall be appropriately covered. Food that was prepared and not served shall be stored appropriately, clearly identifiable and dated. (III)

58.24(7) *Sanitation in food preparation area.*

a. Unless otherwise indicated in this chapter or 481—Chapter 61, the sanitary provisions as indicated in Chapters 3, 4 and 7 of the 1999 Food Code, U.S. Public Health Service, Food and Drug Administration, Washington, DC 20204, shall apply.

b. Residents may be allowed in the food preparation area. (III)

c. The food preparation area may be used as a dining area for residents, staff or food service personnel. (III)

d. All food service areas shall be kept clean, free from litter and rubbish, and protected from rodents, animals, roaches, flies and other insects. (II, III)

e. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair, and shall be free from breaks, corrosion, cracks and chipped areas. (II, III)

f. There shall be effective written procedures established for cleaning all work and serving areas. (III)

g. A schedule of cleaning duties to be performed daily shall be posted. (III)

h. An exhaust system and hood shall be clean, operational and maintained in good repair. (III)

i. Spillage and breakage shall be cleaned up immediately and disposed of in a sanitary manner. (III)

j. Wastes from the food service that are not disposed of by mechanical means shall be kept in leakproof, nonabsorbent, tightly closed containers when not in immediate use and shall be disposed of frequently. (III)

k. The food service area shall be located so it will not be used as a passageway by residents, guests or non-food service staff. (III)

l. The walls, ceilings and floors of all rooms in which food is prepared and served shall be in good repair, smooth, washable, and shall be kept clean. Walls and floors in wet areas should be moisture-resistant. (III)

m. Ice shall be stored and handled in such a manner as to prevent contamination. Ice scoops should be sanitized daily and kept in a clean container. (III)

n. There shall be no animals or birds in the food preparation area. (III)

o. All utensils used for eating, drinking, and preparing and serving food and drink shall be cleaned and disinfected or discarded after each use. (III)

p. If utensils are washed and rinsed in an automatic dishmachine, one of the following methods shall be used:

(1) When a conventional dishmachine is utilized, the utensils shall be washed in a minimum of 140°F using soap or detergent and sanitized in a hot water rinse of not less than 170°F. (II, III)

(2) When a chemical dishmachine is utilized, the utensils shall be washed in a minimum of 120°F using soap or detergent and sanitized using a chemical sanitizer that is automatically dispensed by the machine and is in a concentration equivalent to 50 parts per million (ppm) available chloride. (II, III)

q. If utensils are washed and rinsed in a three-compartment sink, the utensils shall be thoroughly washed in hot water at a minimum temperature of 110°F using soap or detergent, rinsed in hot water to remove soap or detergent, and sanitized by one of the following methods:

(1) Immersion for at least 30 seconds in clean water at 180°F; (II, III)

(2) Immersion in water containing bactericidal chemical at a minimum concentration as recommended by the manufacturer. (II, III)

r. After sanitation, the utensils shall be allowed to drain and dry in racks or baskets on nonabsorbent surfaces. Drying cloths shall not be used. (III)

s. Procedures for washing and handling dishes shall be followed in order to protect the welfare of the residents and employees. Persons handling dirty dishes shall not handle clean dishes without first washing their hands. (III)

t. A mop and mop pail shall be provided for exclusive use in kitchen and food storage areas. (III)

58.24(8) *Hygiene of food service personnel.*

a. Personnel, if involved in dietetic services, shall be trained in basic food sanitation techniques, shall be clean and wear clean clothing, including a cap or a hairnet sufficient to contain, cover and restrain

hair. Beards, mustaches and sideburns that are not closely cropped and neatly trimmed shall be covered. (III)

b. Personnel shall be excluded from duty when affected by skin infections or communicable diseases in accordance with the facility's infection control policies. (II, III)

c. Employee street clothing stored in the food service area shall be in a closed area. (III)

d. Food preparation sinks shall not be used for hand washing. Separate hand-washing facilities with soap, hot and cold running water, and single-use towels shall be used properly. (II, III)

e. The use of tobacco shall be prohibited in the food preparation area. (III)

58.24(9) *Paid nutritional assistants.* A paid nutritional assistant means an individual who meets the requirements of this subrule and who is an employee of the facility or an employee of a temporary employment agency employed by the facility. A facility may use an individual working in the facility as a paid nutritional assistant only if that individual has successfully completed a state-approved training program for paid nutritional assistants. (I, II, III)

a. *Training program requirements.*

(1) A state-approved training program for paid nutritional assistants must include, at a minimum, eight hours of training in the following areas:

1. Feeding techniques.
2. Assistance with feeding and hydration.
3. Communication and interpersonal skills.
4. Appropriate responses to resident behavior.
5. Safety and emergency procedures, including the Heimlich maneuver.
6. Infection control.
7. Resident rights.
8. Recognizing changes in residents that are inconsistent with their normal behavior and reporting these changes to the supervisory nurse.

(2) In addition to the training program requirements specified above, the training program must include at least four hours of classroom study, two hours of supervised laboratory work, and two hours of supervised clinical experience.

(3) A facility that offers a paid nutritional assistant training program must provide sufficient supplies in order to teach the objectives of the course.

(4) All paid nutritional assistant training program instructors shall be registered nurses. Other qualified health care professionals may assist the instructor in teaching the classroom portion and clinical or laboratory experiences. The ratio of students to instructor shall not exceed ten students per instructor in the clinical setting.

(5) Each individual enrolled in a paid nutritional assistant training program shall complete a 50-question multiple choice written test and must obtain a score of 80 percent or higher. In addition, the individual must successfully perform the feeding of a resident in a clinical setting. A registered nurse shall conduct the final competency determination.

(6) If an individual does not pass either the written test or competency demonstration, the individual may retest the failed portion a second time. If the individual does not pass either the written test or competency demonstration portion the second time, the individual shall not be allowed to retest.

b. *Program approval.* A facility or other entity may not offer or teach a paid nutritional assistant training program until the department has approved the program. Individuals trained in a program not approved by the department will not be allowed to function as paid nutritional assistants.

(1) A facility or other institution offering a paid nutritional assistant training program must provide the following information about the training program to the department before offering the program or teaching paid nutritional assistants:

1. Policies and procedures for program administration.
2. Qualifications of the instructors.
3. Maintenance of program records, including attendance records.
4. Criteria for determining competency.
5. Program costs and refund policies.

6. Lesson plans, including the objectives to be taught, skills demonstrations, assignments, quizzes, and classroom, laboratory and clinical hours.

(2) The facility or other institution offering a paid nutritional assistant training program must submit the materials specified above for department review. The department shall, within ten days of receipt of the material, advise the facility or institution whether the program is approved, or request additional information to assist the department in determining whether the curriculum meets the requirements for a paid nutritional assistant training program. Before approving any paid nutritional assistant training program, the department shall determine whether the curriculum meets the requirements specified in this subrule. The department shall maintain a list of facilities and institutions eligible to provide paid nutritional assistant training. (I, II, III)

(3) A facility shall maintain a record of all individuals who have successfully completed the required training program and are used by the facility as paid nutritional assistants. The individual shall complete the training program with a demonstration of knowledge and competency skills necessary to serve as a paid nutritional assistant. (I, II, III)

(4) Upon successful completion of the training program, the facility or other institution providing the training shall, within ten calendar days, provide the individual with a signed and dated certificate of completion. A facility that employs paid nutritional assistants shall maintain on file copies of the completed certificate and skills checklist for each individual who has successfully completed the training program. (I, II, III)

c. Working restrictions.

(1) A paid nutritional assistant must work under the supervision of a registered nurse or a licensed practical nurse. In an emergency, a paid nutritional assistant must call a supervisory nurse for help on the resident call system. (I, II, III)

(2) A facility must ensure that a paid nutritional assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube, parenteral or intravenous feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. (I, II, III)

481—58.25(135C) Social services program.

58.25(1) The administrator or designee shall be responsible for developing a written, organized orientation program for all residents. (III)

58.25(2) The program shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the medical or health care, recovery, and rehabilitation of the individual. (III)

58.25(3) The social services plan, including specific goals and regular evaluation of progress, shall be incorporated into the overall plan of care. (III)

481—58.26(135C) Resident activities program.

58.26(1) *Organized activities.* Each nursing facility shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

a. The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

b. The program shall include individual goals for each resident. (III)

c. The program shall include both group and individual activities. (III)

d. No resident shall be forced to participate in the activity program. (III)

e. The activity program shall include suitable activities for those residents unable to leave their rooms. (III)

f. The program shall be incorporated into the overall health plan and shall be designed to meet the goals as written in the plan.

58.26(2) *Coordination of activities program.*

a. Each nursing facility shall employ a person to direct the activities program. (III)

[1]*b.* [2]Staffing for the activity program shall be provided on the minimum basis of 35 minutes per licensed bed per week. (II, III)

c. The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

d. The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

e. There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

58.26(3) *Duties of activity coordinator.* The activity coordinator shall:

a. Have access to all residents' records excluding financial records; (III)

b. Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

c. Keep all necessary records including:

(1) Attendance; (III)

(2) Individual resident progress notes recorded at regular intervals (at least quarterly). A copy of these notes shall be placed in the resident's clinical record; (III)

(3) Monthly calendars, prepared in advance. (III)

d. Coordinate the activity program with all other services in the facility; (III)

e. Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

58.26(4) *Supplies, equipment, and storage.*

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III) These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc.

b. Storage shall be provided for recreational equipment and supplies. (III)

c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

[1] Emergency, pursuant to Iowa Code section 17A.5(2)*"b"*(2).

[2] Objection filed 2/14/79, see insert IAC 3/7/79 following Ch 57.

481—58.27(135C) Resident advocate committee. Each facility shall have a resident advocate committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for resident advocate committees promulgated by the department of elder affairs. (II)

58.27(1) Role of committee in complaint investigations.

a. The department shall notify the facility's resident advocate committee of a complaint from the public. The department shall not disclose the name of a complainant.

b. The department may refer complaints to the resident advocate committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department of elder affairs. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation or the investigation.

c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the resident advocate committee and the department of elder affairs of its findings, including any citations and fines issued.

d. Results of all complaint investigations addressed by the resident advocate committee shall be forwarded to the department within ten days of completion of the investigation.

58.27(2) The resident advocate committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

58.27(3) When requested, names, addresses and telephone numbers of family members shall be given to the resident advocate committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the family member's name, address or telephone number given to the resident advocate committee.

This rule is intended to implement Iowa Code section 135C.25.

481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

58.28(1) *Fire safety.*

a. All nursing facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

58.28(2) *Safety duties of administrator.* The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

a. The plan shall be posted. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

58.28(3) *Resident safety.*

a. Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when the resident is under direct supervision. (II, III)

b. Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

c. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

d. Smoking shall be permitted only in posted areas. (II, III)

e. Each resident shall receive adequate supervision to ensure against hazard from self, others, or elements in the environment. (II, III)

481—58.29(135C) Resident care.

58.29(1) There shall be a readily available supply of self-help and ambulation devices such as wheelchairs, walkers, and such other devices maintained in good repair that will meet the current needs of all residents. (III)

58.29(2) The facility shall ensure that each ambulatory resident has well-fitting shoes to provide support and prevent slipping. (III)

58.29(3) Equipment for personal care shall be maintained in a safe and sanitary condition. (II, III)

58.29(4) The expiration date for sterile equipment shall be exhibited on its wrappings. (III)

58.29(5) Residents who have been known to wander shall be provided with appropriate means of identification. (II, III)

58.29(6) Electric heating pads, blankets, or sheets shall be used only on the written order of a physician, when allowed by the Life Safety Code or applicable state or local fire regulations. (II, III)

481—58.30 Rescinded, effective 7/14/82.

481—58.31(135C) Housekeeping.

58.31(1) Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

58.31(2) Each resident unit shall be cleaned on a routine schedule. (III)

58.31(3) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

58.31(4) A hallway or corridor shall not be used for storage of equipment. (III)

58.31(5) All odors shall be kept under control by cleanliness and proper ventilation. (III)

58.31(6) Clothing worn by personnel shall be clean and washable. (III)

58.31(7) Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

58.31(8) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

58.31(9) Polishes used on floors shall provide a nonslip finish. (III)

58.31(10) *Throw or scatter rugs shall not be permitted. (III)

*Objection, see filed rules (Ch 58) published IAC Supp. 9/7/77, 10/5/77.

58.31(11) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

58.31(12) Residents shall not have access to storage areas for all cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials. (II, III)

58.31(13) Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

58.31(14) Definite procedures shall be established for training housekeeping personnel. (III)

58.31(15) Rescinded IAB 12/6/06, effective 1/10/07.

58.31(16) There shall be provisions for the cleaning and storage of housekeeping equipment and supplies for each nursing unit. (III)

58.31(17) Bathtubs, shower stalls, or lavatories shall not be used for laundering, cleaning of utensils and mops, or for storage. (III)

58.31(18) Bedside utensils shall be stored in enclosed cabinets. (III)

58.31(19) Kitchen sinks shall not be used for the cleaning of mops, soaking of laundry, cleaning of bedside utensils, nursing utensils, or dumping of wastewater. (III)

58.31(20) Personal possessions of residents which may constitute hazards to themselves or others shall be removed and stored. (III)

481—58.32(135C) Maintenance.

58.32(1) Each facility shall establish a maintenance program in writing to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. (III)

58.32(2) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

58.32(3) Draperies and furniture shall be clean and in good repair. (III)

58.32(4) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

58.32(5) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the national electrical code. (III)

58.32(6) All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

58.32(7) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. Documentation of these inspections shall be available for review. (III)

58.32(8) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

58.32(9) The facility shall be kept free of flies, other insects, and rodents. (III)

58.32(10) Maintenance personnel.

a. A written program shall be established for the orientation of maintenance personnel. (III)

b. Maintenance personnel shall:

(1) Follow established written maintenance programs; (III)
(2) Be provided with appropriate, well-constructed, and properly maintained equipment. (III)

481—58.33(135C) Laundry.

58.33(1) All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

58.33(2) Except for related activities, the laundry room shall not be used for other purposes. (III)

58.33(3) Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

58.33(4) Residents' personal laundry shall be marked with an identification. (III)

58.33(5) Bed linens, towels, and washcloths shall be clean and stain-free. (III)

481—58.34(135C) Garbage and waste disposal.

58.34(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

58.34(2) All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

58.34(3) All containers shall be thoroughly cleaned each time the containers are emptied. (III)

58.34(4) All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

58.34(5) Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

481—58.35(135C) Buildings, furnishings, and equipment.

58.35(1) *Buildings—general requirements.*

a. For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than seven feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within seven feet of the floor shall be protected by screen guards of not more than one-half-inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates, except closets used for the storage of residents' clothing. (III)

58.35(2) *Furnishings and equipment.*

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a home-like atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

58.35(3) *Dining and living rooms.*

a. Every facility shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 58.35(3)*"e"* are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment. (III)

f. Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably provided with parlor furniture, television and radio receivers in good working order, recreational material such as games, puzzles, and cards, and reading material such as current newspapers and magazines. Furnishings and equipment of the room should be such as to allow group activities. (III)

(3) Card tables or game tables shall be made available. The tables should be of a height to allow a person seated in a wheelchair to partake in the games or card playing. (III)

(4) Chairs of proper height and appropriate to their use shall be provided for seating residents at game tables and card tables. (III)

g. Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) Dining tables and chairs shall be provided. (III)

(3) Dining tables should be so constructed that a person seated in a wheelchair can dine comfortably. (III)

(4) Tables shall be of sturdy construction with smooth, durable, nonpermeable tops that can be cleaned with a detergent sanitizing solution. (III)

(5) Dining chairs shall be sturdy and comfortable. Some arm chairs should be provided for ease of movement for some residents. (III)

(6) Residents shall be encouraged to eat in the dining room. (III)

58.35(4) *Bedrooms.*

a. Each resident shall be provided with a standard, single, or twin bed that is substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. Seventy-five percent of the beds shall have a spring with an adjustable head and foot section. A resident shall have the right to sleep in a chair per the resident's request and to have the bed removed from the room to allow for additional space. (III)

b. Each bed shall be equipped with the following: casters or glides unless a low bed and mattress are being used for fall precautions; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; clean, comfortable pillows of average size; and moisture-proof covers and sheets as necessary to keep the mattress and pillows dry and clean. (III)

c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)

d. There shall be a comfortable chair, either a rocking chair or armchair, per resident bed. The resident's personal wishes shall be considered. (III)

e. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)

g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

h. Clothing shall be hung in closets or wardrobes available in each room. (III)

i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)

j. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)

k. Reading lamps shall be provided each resident in the resident's room. (III)

l. Each room shall have sufficient accessible mirrors to serve the resident's needs. Mirrors are not required if the room is located in a CCDI unit and the mirrors cause concern for the resident. (III)

m. Sturdy, adjustable overbed tables shall be provided for each resident who is unable to eat in the dining room. (III)

n. Each resident bedroom shall have a door. The door shall be the swing type and shall not swing into the corridor. (III)

58.35(5) *Heating.* A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

58.35(6) *Water supply.*

a. Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)

b. Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)

c. A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)

d. The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)

e. Hot and cold running water under pressure shall be available in the facility. (III)

f. Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department of health. (III)

58.35(7) *Nonambulatory residents.*

a. All nonambulatory residents shall be housed on the grade level floor. (II, III)

b. These provisions in *"a"* above relating to nonambulatory residents are not applicable if the facility has a suitably sized elevator.

481—58.36(135C) Family and employee accommodations.

58.36(1) Children under 14 years of age shall not be allowed into the service areas. (III)

58.36(2) The residents' bedrooms shall not be occupied by employees or family members of the licensee. (III)

58.36(3) In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

58.36(4) In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

58.36(5) In all health care facilities, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

481—58.37(135C) Animals. Animals may be permitted within the facility with prior approval of the department and under controlled conditions. (III)

481—58.38(135C) Supplies.

58.38(1) *Linen supplies.*

a. There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

58.38(2) *First-aid kit.* A first-aid emergency kit shall be available on each floor in every facility. (II, III)

58.38(3) *Supplies and equipment for nursing services.*

a. All nursing care equipment shall be properly sanitized or sterilized before use by another resident. (II)

b. There shall be disposable or one-time use items available with provisions for proper disposal to prevent reuse except as allowed by 58.10(8)*"h,"* 481—paragraph 59.12(10)*"h,"* or 481—paragraph 64.12(14)*"h."* (I, II, III)

c. Convenient, safe storage shall be provided for bath and toilet supplies, bathroom scales, mechanical lifts, and shower chairs. (III)

d. Sanitary and protective storage shall be provided for all equipment and supplies. (III)

e. All items that must be sterilized shall be autoclaved unless sterile disposable items are furnished which are promptly disposed of after a single use. (III)

f. Supplies and equipment for nursing and personal care sufficient in quantities to meet the needs of the residents shall be provided and, as a minimum, include the following: (III)

Bath basins
Soap containers
Denture cups
Emesis basins
Mouthwash cups
Bedpans
Urinals
Enema equipment
Commodes
Quart graduate measure
Thermometer for measurement of bath water temperature
Oral thermometer
Rectal thermometer
Basins for sterilizing thermometers
Basins for irrigations
Asepto syringes
Sphygmomanometer
Paper towels
Paper handkerchiefs
Insulin syringes
2 cc hypodermic syringes
Rectal tubes
Catheters and catheterization equipment
Douche nozzle
Oxygen therapy equipment
Naso-gastric feeding equipment
Wheelchairs
Moisture-proof draw sheets
Moisture-proof pillow covers
Moisture-proof mattress covers
Foot tubs
Metal pitcher
Disinfectant solutions
Alcohol
Lubricating jelly
Skin lotion
Applicators
Tongue blades
Toilet paper
Rubber gloves or disposable gloves
Scales for nonambulatory patients
Tourniquet
Suction machine

Weight scales	Medicine dispensing containers
Hypodermic needles	Bandages
Stethoscope	Adhesive
Ice caps	Portable linen hampers
Hot water bottles	Denture identification equipment
	Tracheotomy care equipment

481—58.39(135C) Residents' rights in general.

58.39(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 58.39(2) to 58.39(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

58.39(2) Policies and procedures shall address the admission and retention of persons with histories of dangerous or disturbing behavior. For the purposes of the subrule, persons with histories of dangerous or disturbing behavior are those persons who have been found to be seriously mentally impaired pursuant to Iowa Code section 229.13 or 812.1 within six months of the request for admission to the facility. In addition to establishing the criteria for admission and retention of persons so defined, the policies and procedures shall provide for:

a. Reasonable precautions to prevent the resident from harming self, other residents, or employees of the facility.

b. Treatment of persons with mental illness as defined in Iowa Code section 229.1(1) and which is provided in accordance with the individualized health care plan.

c. Ongoing and documented staff training on individualized health care planning for persons with mental illness.

58.39(3) Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

a. Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

b. As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

58.39(4) Policies and procedures regarding the use of chemical and physical restraints shall define the use of said restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

58.39(5) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

58.39(6) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

58.39(7) Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies. (II)

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

c. A statement shall be signed by the resident, or the resident's responsible party, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party, if applicable. In the case of a mentally retarded resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

e. All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English speaking, deaf, or blind residents of such changes. (II)

58.39(8) Each resident or responsible party shall be fully informed in a contract as required in rule 58.13(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges including any charges for services not covered under the Title XIX program or not covered by the facility's basic per diem rate. (II)

58.39(9) Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the U.S. Department of Health and Human Services protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or mentally retarded individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

a. The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either, shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

b. The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

c. If the physician determines or in the case of a confused or mentally retarded resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

d. The resident's plan of care shall be based on the physician's orders. It shall be developed upon admission by appropriate facility staff and shall include participation by the resident if capable. Residents shall be advised of alternative courses of care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives shall be elicited and honored if feasible.

e. Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the

possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

This rule is intended to implement Iowa Code section 135C.23(2).

481—58.40(135C) Involuntary discharge or transfer.

58.40(1) A facility shall not involuntarily discharge or transfer a resident from a facility except: for medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), except as prohibited by Title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k by reason of action pursuant to Iowa Code chapter 229; by reason of negative action by the Iowa department of social services; and by reason of negative action by the professional standards review organization. A resident shall not be transferred or discharged solely because the cost of the resident's care is being paid under Iowa Code chapter 249A, or because the resident's source of payment is changing from private support to payment under chapter 249A. (I, II)

a. "Medical reasons" for transfer or discharge are based on the resident's needs and are determined and documented in the resident's record by the attending physician. Transfer or discharge may be required to provide a different level of care. In the case of transfer or discharge for the reason that the resident's condition has improved such that the resident no longer needs the level of care being provided by the facility, the determination that such medical reason exists is the exclusive province of the professional standards review organization or utilization review process in effect for residents whose care is paid in full or in part by Title XIX. (II)

b. "Welfare" of a resident or that of other residents refers to their social, emotional, or physical well-being. A resident might be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with the resident's needs and rights). Evidence that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall be in writing and shall include specific information to support this determination.

c. Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. The 30-day requirement shall not apply in any of the following instances:

(1) If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) If the transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility.

(3) If the discharge or transfer is the result of a final, nonappealable decision by the department of social services or the professional standards review organization.

d. The notice required by paragraph *"c"* shall contain all of the following information:

(1) The stated reason for the proposed transfer or discharge. (II)

(2) The effective date of the proposed transfer or discharge. (II)

(3) A statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department of inspections and appeals designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing.

To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." (II)

e. A request for a hearing made under 58.40(1)*"d"*(3) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

f. The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, responsible party, and Iowa department of elder affairs long-term care ombudsman of record not later than five full business days after receipt of request. This notice shall also inform the licensee, resident or responsible party that they have a right to appear at the hearing in person or be represented by their attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department of elder affairs long-term care ombudsman shall have the right to appear at the hearing.

g. The hearing shall be heard by a department of inspections and appeals designee pursuant to Iowa Code chapter 17A. (The hearing shall be public unless the resident or representative requests in writing that it be closed.) The licensee or designee shall have the opportunity to present to the representative of the department any oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and responsible party shall also have an opportunity to present to the representative of the department any oral testimony or written material to show just cause why a transfer or discharge should not be made. In a determination as to whether a transfer or discharge is authorized, the burden of proof rests on the party requesting the transfer or discharge.

h. Based upon all testimony and materials submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department of elder affairs long-term care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision.

i. A copy of the notice required by paragraph *"c"* shall be personally delivered to the resident and a copy placed in the resident's record. A copy shall also be transmitted to the department, the resident's responsible party, physician, the person or agency responsible for the resident's placement, maintenance, and care in the facility, and the department of elder affairs long-term care ombudsman.

j. If the basis for an involuntary transfer or discharge is the result of a negative action by the Iowa department of human services or the professional standards review organization (Iowa Foundation for Medical Care), appeals shall be filed with those agencies as appropriate. Continued payment shall be consistent with rules of those agencies.

k. If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

l. The involuntary transfer or discharge shall be discussed with the resident, the resident's responsible party, and the person or agency responsible for the resident's placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion

and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made part of the resident's record. (II)

m. The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident's record. (II)

(1) Counseling shall be provided by a qualified individual who meets one of the following criteria:

1. Has a bachelor's or master's degree in social work from an accredited college. (II)

2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with a public or private agency. (II)

3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)

4. Is a licensed psychologist or psychiatrist. (II)

5. Is any other person of the resident's choice. (II)

(2) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be transferred or discharged. (II)

(3) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

n. In the case of an emergency transfer or discharge as outlined in 58.40(1)*"c"*(1), the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident's file and it must contain all the information required by 58.40(1)*"d"*(1) and (2). In addition, the notice must contain a statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals within 7 days after receiving this notice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." A hearing requested pursuant to this subrule shall be held in accordance with paragraphs *"f," "g,"* and *"h."* (II)

o. Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department of inspections and appeals. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

58.40(2) Intrafacility transfer:

a. Residents shall not be relocated from room to room within a licensed health care facility arbitrarily. (I, II) Involuntary relocation may occur only in the following situations and such situation shall be documented in the resident's record.

(1) Incompatibility with or disturbing to other roommates, as documented in the resident's record.

(2) For the welfare of the resident or other residents of the facility.

(3) For medical, nursing or psychosocial reasons, as documented in the resident's record, as judged by the attending physician, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.

(4) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex.

(5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

b. Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident, or responsible party include:

(1) Change from private pay status to Title XIX, except as outlined in 58.40(2)*"a"*(5). (II)

(2) As punishment or behavior modification, except as specified in 58.40(2)*"a"*(1). (II)

(3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph *"a,"* the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or responsible party. (II)

d. If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately or as soon as possible of the condition requiring emergency relocation and such notification shall be documented. (II)

481—58.41(135C) Residents' rights. Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

58.41(1) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

58.41(2) The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

a. Designation of an employee responsible for handling grievances and recommendations. (II)

b. A method of investigating and assessing the validity of a grievance or recommendation. (II)

c. Methods of resolving grievances. (II)

d. Methods of recording grievances and actions taken. (II)

58.41(3) The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, and resident advocate committee members and the text of Iowa Code section 135C.46 to provide to residents a further course of redress. (II)

481—58.42(135C) Financial affairs—management. Each resident who has not been assigned a guardian or conservator by the court may manage the resident's own personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

58.42(1) The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

58.42(2) An employee shall be designated in writing to be responsible for resident accounts. (II)

58.42(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or mentally retarded resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

58.42(4) If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge that the resident has seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

58.42(5) A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

58.42(6) A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report

findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of a mentally retarded individual when ordered in writing by a physician and authorized by a designated qualified mental retardation professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

58.43(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

58.43(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

58.43(3) Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff. (II)

58.43(4) Physicians' orders are required to utilize all types of physical restraints and shall be renewed at least quarterly. (II) Physical restraints are defined as the following:

Type I—the equipment used to promote the safety of the individual but is not applied directly to their person. Examples: divided doors and totally enclosed cribs.

Type II—the application of a device to the body to promote safety of the individual. Examples: vest devices, soft-tie devices, hand socks, geriatric chairs.

Type III—the application of a device to any part of the body which will inhibit the movement of that part of the body only. Examples: wrist, ankle or leg restraints and waist straps.

58.43(5) Physical restraints are not to be used to limit resident mobility for the convenience of staff and must comply with life safety requirements. If a resident's behavior is such that it may result in injury to the resident or others and any form of physical restraint is utilized, it should be in conjunction with a treatment procedure(s) designed to modify the behavioral problems for which the resident is restrained, or as a last resort, after failure of attempted therapy. (I, II)

58.43(6) Each time a Type II or III restraint is used documentation on the nurse's progress record shall be made which includes type of restraint and reasons for the restraint and length of time resident was restrained. The documentation of the use of Type III restraint shall also include the time of position change. (II)

58.43(7) Each facility shall implement written policies and procedures governing the use of restraints which clearly delineate at least the following:

a. Physicians' orders shall indicate the specific reasons for the use of restraints. (II)

b. Their use is temporary and the resident will not be restrained for an indefinite amount of time. (I, II)

c. A qualified nurse shall make the decision for the use of a Type II or Type III restraint for which there shall be a physician's order. (II)

d. A resident placed in a Type II or III restraint shall be checked at least every 30 minutes by appropriately trained staff. No form of restraint shall be used or applied in such a manner as to cause injury or the potential for injury and provide a minimum of discomfort to resident restrained. (I, II)

e. Reorders are issued only after the attending physician reviews the resident's condition. (II)

f. Their use is not employed as punishment, for the convenience of the staff, or as a substitute for supervision or program. (I, II)

g. The opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which Type II and Type III restraints are employed, except when resident is sleeping. However, when resident awakens, this shall be provided. This shall be documented each time. A check sheet may serve this purpose. (I, II)

h. Locked restraints or leather restraints shall not be permitted except in life-threatening situations. Straight jackets and secluding residents behind locked doors shall not be employed. (I, II)

i. Nursing assessment of the resident's need for continued application of a Type III restraint shall be made every 12 hours and documented on the nurse's progress record. Documentation shall include the type of restraint, reason for the restraint and the circumstances. Nursing assessment of the resident's need for continued application of either a Type I or Type II restraint and nursing evaluation of the resident's physical and mental condition shall be made every 30 days and documented on the nurse's progress record. (II)

j. A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room. (II)

k. Divided doors shall be of the type that when the upper half is closed the lower section shall close. (II)

l. Methods of restraint shall permit rapid removal of the resident in the event of fire or other emergency. (I, II)

m. The facility shall provide orientation and ongoing education programs in the proper use of restraints.

58.43(8) In the case of a mentally retarded individual who participates in a behavior modification program involving use of restraints or aversive stimuli, the program shall be conducted only with the informed consent of the individual's parent or responsible party. Where restraints are employed, an individualized program shall be developed by the interdisciplinary team with specific methodologies for monitoring its progress. (II)

a. The resident's responsible party shall receive a written account of the proposed plan of the use of restraints or aversive stimuli and have an opportunity to discuss the proposal with a representative(s) of the treatment team. (II)

b. The responsible party must consent in writing prior to the use of the procedure. Consent may also be withdrawn in writing. (II)

58.43(9) Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain that separation until the abuse investigation is completed. (I, II)

58.43(10) Suspected abuse reports. The department shall investigate all complaints of dependent adult abuse which are alleged to have happened in a health care facility. The department shall inform the department of human services of the results of all evaluations and dispositions of dependent adult abuse investigations.

58.43(11) Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

This rule is intended to implement Iowa Code sections 135C.14, 235B.3(1), and 235B.3(11).

481—58.44(135C) Resident records. Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

58.44(1) The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

58.44(2) Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs

of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

58.44(3) The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

481—58.45(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (II)

58.45(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

58.45(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

58.45(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

58.45(4) Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

58.45(5) Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply in emergency conditions. (II)

481—58.46(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

58.46(1) Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

58.46(2) If the plan of care requires activities for therapeutic or training reasons, the plan for these activities shall be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time limited and reviewed at least quarterly. (II)

58.46(3) Residents who perform work for the facility must receive remuneration unless the work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

481—58.47(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

58.47(1) Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

58.47(2) Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

a. The resident refuses to see the visitor(s). (II)

b. The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)

c. The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

58.47(3) Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

58.47(4) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

58.47(5) Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

58.47(6) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

58.47(7) Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified mental retardation professional or facility administrator for refusing permission. (II)

58.47(8) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

481—58.48(135C) Resident activities. Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified mental retardation professional as appropriate in the resident's record. (II)

58.48(1) Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

58.48(2) All residents shall have the freedom to refuse to participate in these activities. (II)

481—58.49(135C) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

58.49(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

58.49(2) Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

58.49(3) Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of the items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

58.49(4) A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

58.49(5) A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

481—58.50(135C) Family visits. Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room if available. (II)

58.50(1) The facility shall provide for needed privacy in visits between spouses. (II)

58.50(2) Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why an arrangement would have an adverse effect on the health of the resident. (II)

58.50(3) Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an agreement would have an adverse effect on the health of the resident. (II)

481—58.51(135C) Choice of physician and pharmacy. Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility.

A facility shall not require the repackaging of medications dispensed by the Veterans Administration or an institution operated by the Veterans Administration for the purpose of making the drug distribution system compatible with the system used by the facility. (II)

481—58.52(135C) Incompetent resident.

58.52(1) Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

58.52(2) The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

481—58.53(135C) County care facilities. In addition to Chapter 58 licensing rules, county care facilities licensed as nursing facilities must also comply with department of human services rules, 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

481—58.54(73GA,ch 1016) Special unit or facility dedicated to the care of persons with chronic confusion or a dementing illness (CCDI unit or facility).

58.54(1) A nursing facility which chooses to care for residents in a distinct part shall obtain a license for a CCDI unit or facility. In the case of a distinct part, this license will be in addition to its ICF license. The license shall state the number of beds in the unit or facility. (III)

a. Application for this category of care shall be submitted on a form provided by the department. (III)

b. Plans to modify the physical environment shall be submitted to the department. The plans shall be reviewed based on the requirements of 481—Chapter 61. (III)

58.54(2) A statement of philosophy shall be developed for each unit or facility which states the beliefs upon which decisions will be made regarding the CCDI unit or facility. Objectives shall be developed for each CCDI unit or facility as a whole. The objectives shall be stated in terms of expected results. (II, III)

58.54(3) A résumé of the program of care shall be submitted to the department for approval at least 60 days before a separate CCDI unit or facility is opened. A new résumé of the program of care shall be submitted when services are substantially changed. (II, III)

The résumé of the program of care shall:

a. Describe the population to be served; (II, III)

b. State philosophy and objectives; (II, III)

c. List admission and discharge criteria; (II, III)

d. Include a copy of the floor plan; (II, III)

e. List the titles of policies and procedures developed for the unit or facility; (II, III)

f. Propose a staffing pattern; (II, III)

g. Set out a plan for specialized staff training; (II, III)

h. State visitor, volunteer, and safety policies; (II, III)

i. Describe programs for activities, social services and families; (II, III) and

j. Describe the interdisciplinary care planning team. (II, III)

58.54(4) Separate written policies and procedures shall be implemented in each CCDI unit or facility. There shall be:

a. Admission and discharge policies and procedures which state the criteria to be used to admit residents and the evaluation process which will be used. These policies shall require a statement from the attending physician agreeing to the placement before a resident can be moved into a CCDI unit or facility. (II, III)

b. Safety policies and procedures which state the actions to be taken by staff in the event of a fire, natural disaster, emergency medical or catastrophic event. Safety procedures shall also explain steps to be taken when a resident is discovered to be missing from the unit or facility and when hazardous cleaning materials or potentially dangerous mechanical equipment is being used in the unit or facility. The facility shall identify its method for security of the unit or facility and the manner in which the effectiveness of the security system will be monitored. (II, III)

c. Program and service policies and procedures which explain programs and services offered in the unit or facility including the rationale. (III)

d. Policies and procedures concerning staff which state minimum numbers, types and qualifications of staff in the unit or facility. (II, III)

e. Policies about visiting which suggest times and ensure the residents' rights to free access to visitors. (II, III)

f. Quality assurance policies and procedures which list the process and criteria which will be used to monitor and to respond to risks specific to the residents. This shall include, but not be limited to, drug use, restraint use, infections, incidents and acute behavioral events. (II, III)

58.54(5) Preadmission assessment of physical, mental, social and behavioral status shall be completed to determine whether the applicant meets admission criteria. This assessment shall be completed by a registered nurse and a staff social worker or social work consultant and shall become part of the permanent record upon admission of the resident. (II, III)

58.54(6) All staff working in a CCDI unit or facility shall have training appropriate to the needs of the residents. (II, III)

a. Upon assignment to the unit or facility, everyone working in the unit or facility shall be oriented to the needs of people with chronic confusion or dementing illnesses. They shall have special training appropriate to their job description within 30 days of assignment to the unit or facility. (II, III) The orientation shall be at least six hours. The following topics shall be covered:

(1) Explanation of the disease or disorder; (II, III)

(2) Symptoms and behaviors of memory-impaired people; (II, III)

(3) Progression of the disease; (II, III)

(4) Communication with CCDI residents; (II, III)

(5) Adjustment to care facility residency by the CCDI unit or facility residents and their families; (II, III)

(6) Inappropriate and problem behavior of CCDI unit or facility residents and how to deal with it; (II, III)

(7) Activities of daily living for CCDI residents; (II, III)

(8) Handling combative behavior; (II, III) and

(9) Stress reduction for staff and residents. (II, III)

b. Licensed nurses, certified aides, certified medication aides, social services personnel, housekeeping and activity personnel shall have a minimum of six hours of in-service training annually. This training shall be related to the needs of CCDI residents. The six-hour training shall count toward the required annual in-service training. (II, III)

58.54(7) There shall be at least one nursing staff person on a CCDI unit at all times. (I, II, III)

58.54(8) The CCDI unit or facility license may be revoked, suspended or denied pursuant to Iowa Code chapter 135C and Iowa Administrative Code 481—Chapter 50.

This rule is intended to implement 1990 Iowa Acts, chapter 1016.

481—58.55(135C) Another business or activity in a facility. A facility is allowed to have another business or activity in a health care facility or in the physical structure of the facility, if the other business or activity meets the requirements of applicable state and federal laws, administrative rules, and federal regulations.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs *"a"* through *"f"* of subrule 58.55(1). (I, II, III)

58.55(1) The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

a. Health and safety risks for residents;

b. Noise created by the proposed business or activity;

c. Odors created by the proposed business or activity;

d. Use of the facility's corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;

e. Proposed staffing for the business or activity; and

f. Sharing of services and staff between the proposed business or activity and the facility.

58.55(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

58.55(3) A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 61. (I, II, III)

481—58.56(135C) Respite care services. Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A nursing facility which chooses to provide respite care services must meet the following requirements related to respite services and must be licensed as a nursing facility.

58.56(1) A nursing facility certified as a Medicaid nursing facility or Medicare skilled nursing facility must meet all Medicaid and Medicare requirements including CFR 483.12, admission, transfer and discharge rights.

58.56(2) A nursing facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

58.56(3) Rule 481—58.40(135C) regarding involuntary discharge or transfer rights, does not apply to residents who are being cared for under a respite care contract.

58.56(4) Pursuant to rule 481—58.13(135C), the facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements under 481—58.13(135C), except the requirements under subrule 58.13(7).

58.56(5) Respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.6(1), 135C.14, 135C.25, 135C.32, 135C.36 and 227.4 and 1990 Iowa Acts, chapter 1016.

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[2] See IAB, Inspections and Appeals Department.

CHAPTER 63
RESIDENTIAL CARE FACILITIES FOR THE MENTALLY RETARDED

[Prior to 7/15/87, Health Department[470] Ch 63]

481—63.1(135C) Definitions. For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words "shall" and "must" indicate those standards are mandatory. The use of the words "should" and "could" indicate those standards are recommended.

63.1(1) *"Accommodation"* means the provision of lodging, including sleeping, dining, and living areas.

63.1(2) *"Administrator"* means a person who administers, manages, supervises, and is in general administrative charge of a residential care facility for the mentally retarded, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

63.1(3) *"Alcoholic"* means a person in a state of dependency resulting from excessive or prolonged consumption of alcoholic beverages as defined in Iowa Code section 125.2.

63.1(4) *"Ambulatory"* means a person who immediately and without aid of another, is physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

63.1(5) *"Basement"* means that part of a building where the finish floor is more than 30 inches below the finish grade.

63.1(6) *"Board"* means the regular provision of meals.

63.1(7) *"Communicable disease"* means a disease caused by the presence of virus or microbial agents within a person's body, which agents may be transmitted either directly or indirectly to other persons.

63.1(8) *"Department"* means the state department of inspections and appeals.

63.1(9) *"Distinct part"* means a clearly identifiable area or section within a residential care facility for the mentally retarded, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

63.1(10) *"Drug addiction"* means a state of dependency, as medically determined, resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 124.

63.1(11) *"Interdisciplinary team"* means persons drawn from, or representing such of the professions, disciplines, or services required for the care of the resident.

63.1(12) *"Medication"* means any drug including over-the-counter substances ordered and administered under the direction of the physician.

63.1(13) *"Nonambulatory"* means a person who immediately and without the aid of another is not physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

63.1(14) *"Personal care"* means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are help in getting in and out of bed, assistance with personal hygiene and bathing, help with dressing and feeding, and supervision over medications which can be self-administered.

63.1(15) *"Program of care"* means all services being provided for a resident in a health care facility.

63.1(16) *"Qualified 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 having one year's experience working with the mentally retarded.

63.1(17) *"Rate"* means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these regulations.

63.1(18) *"Responsible party"* means the person who signs or cosigns the admission agreement required in 63.14(135C) or the resident's guardian or conservator if one has been appointed. In the event that a resident has neither a guardian, conservator nor person who signed or cosigned the resident's admission agreement, the term "responsible party" shall include the resident's sponsoring agency, e.g.,

the department of social services, Veterans Administration, religious groups, fraternal organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

63.1(19) *"Restraints"* means the measures taken to control a resident's physical activity for the resident's own protection or for the protection of others.

481—63.2(135C) Variances. Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual residential care facility for the mentally retarded. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

63.2(1) To request a variance, the licensee must:

a. Apply for variance in writing, on a form provided by the department;

b. Cite the rule or rules from which a variance is desired;

c. State why compliance with the rule or rules cannot be accomplished;

d. Explain alternate arrangement or compensating circumstances which justify the variance;

e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

63.2(2) Upon receipt of a request for variance, the director of the department of inspections and appeals will:

a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;

b. If the request meets the above criteria, evaluate the alternate arrangements or compensating circumstances against the requirement of the rules;

c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;

d. Consult with the applicant if additional information is required.

63.2(3) Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

481—63.3(135C) Application for licensure.

63.3(1) Initial application and licensing. In order to obtain an initial residential care facility for the mentally retarded license, for a residential care facility for the mentally retarded which is currently licensed, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 60 and 63;

b. Submit a letter of intent and a written résumé of the resident care program and other services provided which reflect the services indicated in individualized programs of care for each resident for departmental review and approval;

c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the facility drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which each room will be put and window and door location;

e. Submit a photograph of the front and side elevation of the facility;

f. Submit the statutory fee for a residential care facility for the mentally retarded for which licensure application is made;

g. Comply with all other local statutes and ordinances in existence at the time of licensure;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

63.3(2) In order to obtain an initial residential care facility for the mentally retarded license for a facility not currently licensed as a residential care facility for the mentally retarded, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 60 and 63 (exceptions noted in 60.3(2) shall not apply);

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the proposed opening date of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the residential care facility for the mentally retarded, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which the room will be put and window and door locations;

e. Submit a photograph of the front and side elevation of the residential care facility for the mentally retarded;

f. Submit the statutory fee for a residential care facility for the mentally retarded;

g. Comply with all other local statutes and ordinances in existence at the time of licensure;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

63.3(3) Renewal application. In order to obtain a renewal of the residential care facility for the mentally retarded license, the applicant must:

a. Submit the completed application form 30 days prior to annual license renewal date of residential care facility for the mentally retarded license;

b. Submit the statutory license fee for a residential care facility for the mentally retarded with the application for renewal;

c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;

d. Submit appropriate changes in the résumé to reflect any changes in the resident care program and other services.

63.3(4) Deemed status.

a. The department shall recognize, in lieu of its own inspection, the comparable inspection and inspection findings of the Accreditation Council for Service for Mentally Retarded and Other Developmentally Disabled Persons (AC—MR/DD), if the department is given copies of all requested materials relating to the comparable inspection process, is notified of the scheduled comparable inspection not less than 30 days in advance of the inspection, and is given the opportunity to monitor the comparable inspection. The department may verify the findings of 10 percent of the comparable inspections, selected annually on a random basis, in order to ensure compliance with minimum residential care standards established pursuant to this chapter.

b. The above accreditation will be accepted in lieu of the department's yearly licensure inspection for each year of the AC—MR/DD accreditation period up to two years.

63.3(5) Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

This rule is intended to implement Iowa Code sections 135C.6(1) and 135C.9.

481—63.4(135C) General requirements.

63.4(1) The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

63.4(2) The license shall be valid only in the possession of the licensee to whom it is issued.

63.4(3) The posted license shall accurately reflect the current status of the residential care facility for the mentally retarded. (III)

63.4(4) Licenses expire one year after the date of issuance, or as indicated on the license.

63.4(5) Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

481—63.5(135C) Notifications required by the department. The department shall be notified:

63.5(1) Within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

63.5(2) Of any proposed change in the residential care facility for the mentally retarded's functional operation or addition or deletion of required services; (III)

63.5(3) Thirty days before addition, alteration, or new construction is begun in the residential care facility for the mentally retarded, or on the premises; (III)

63.5(4) Thirty days in advance of closure of the residential care facility for the mentally retarded; (III)

63.5(5) Within two weeks of any change in administrator; (III)

63.5(6) When any change in the category of license is sought; (III)

63.5(7) Prior to the purchase, transfer, assignment, or lease of a residential care facility for the mentally retarded the licensee shall:

a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)

b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)

c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's residential care facility for the mentally retarded to the named prospective purchaser, transferee, assignee, or lessee; (III)

63.5(8) Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a residential care facility for the mentally retarded, the department shall upon request, send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

481—63.6(135C) Witness fees. Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

481—63.7(135C) Licenses for distinct parts.

63.7(1) Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

63.7(2) The following requirements shall be met for a separate licensing of a distinct part:

a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

c. A distinct part must be operationally and financially feasible;

d. A separate staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry, and dietary in common with each other.

481—63.8(135C) Administrator. Each residential care facility for the mentally retarded shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (III)

63.8(1) The administrator shall be at least 18 years of age and shall have a high school diploma or equivalent. (III) In addition this person shall meet at least one of the following conditions:

a. Be a licensed nursing home administrator who is also a qualified mental retardation professional; (III) or

b. Be a qualified mental retardation professional with at least one year of experience in an administrative capacity in a health care facility; (III) or

c. Have completed a one-year educational training program approved by the department for residential care facility for the mentally retarded. (III)

63.8(2) The administrator may act as an administrator for not more than two residential care facilities for the mentally retarded. (II)

a. The distance between the two facilities shall be no greater than 50 miles. (II)

b. The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)

c. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

63.8(3) The licensee may be the approved administrator providing the licensee meets the requirements as set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

63.8(4) A provisional administrator may be appointed on a temporary basis by the residential care facility for the mentally retarded licensee to assume the administrative responsibilities for a residential care facility for the mentally retarded for a period not to exceed six months when, through no fault of its own, the home has lost its administrator and has not been able to replace the administrator, provided the department has been notified prior to the date of the administrator's appointment. (III)

63.8(5) In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

a. Be knowledgeable of the operation of the facility; (III)

b. Have access to records concerned with the operation of the facility; (III)

c. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

d. Be at least 18 years of age; (III)

e. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)

f. Have had training to carry out assignments and take care of emergencies and sudden illnesses of residents. (III)

63.8(6) The licensee shall:

a. Assume the responsibility for the overall operation of the residential care facility for the mentally retarded; (III)

b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)

c. Establish written policies, which shall be available for review, for the operation of the residential care facility for the mentally retarded. (III)

63.8(7) The administrator shall:

a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program; (III)

b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)

c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)

d. Make available the residential care facility for the mentally retarded payroll records for departmental review as needed. (III)

481—63.9(135C) General policies.

63.9(1) There shall be written personnel policies in facilities of more than 15 beds to include hours of work, and attendance at educational programs. (III)

63.9(2) There shall be a written job description developed for each category of worker in facilities. The job description shall include title of job, job summary, age range, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

63.9(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

a. Employees shall have a physical examination and tuberculin test before employment. (I, II, III)

b. Employees shall have a physical examination at least every four years, including an assessment of tuberculosis status. (I, II, III)

63.9(4) Health certificates for all employees shall be available for review. (III)

63.9(5) Rescinded IAB 10/19/88, effective 11/23/88.

63.9(6) There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident which includes the individual to be contacted in case of emergency. (III)

63.9(7) The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

63.9(8) The residential care facility for the mentally retarded shall have established policies concerning the control, investigation, and prevention of infections within the facility. (III)

63.9(9) Each facility licensed as a residential care facility for the mentally retarded shall provide an organized continuous 24-hour program of care commensurate with the needs of the residents of the home and under the direction of an administrator whose combined training and supervisory experience is such as to ensure adequate and competent care. (III)

63.9(10) Each facility shall have a written and implemented infection control program addressing the following:

a. Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)

b. Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

c. Dressings, soaks, or packs; (I, II, III)

d. Infection identification; (I, II, III)

e. Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

f. Sanitation techniques for resident care equipment; (I, II, III)

g. Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III)

h. Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Administration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

63.9(11) Aseptic techniques. If a resident needs any of the treatments or devices on the list below, written and implemented procedures regarding aseptic techniques shall be followed.

a. Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)

b. Urinary catheter, (I, II, III)

c. Respiratory suction, oxygen or humidification, (I, II, III)

d. Decubitus care, (I, II, III)

e. Tracheostomy, (I, II, III)

f. Nasogastric or gastrostomy tubes, (I, II, III)

g. Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

63.9(12) Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

481—63.10 Rescinded, effective 7/14/82.

481—63.11(135C) Personnel.

63.11(1) *General qualifications.*

a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a residential care facility for the mentally retarded. (II)

b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a residential care facility for the mentally retarded. (II)

c. No person shall be allowed to provide services in a facility if the person has a disease:

(1) Which is transmissible through required workplace contact, (I, II, III)

(2) Which presents a significant risk of infecting others, (I, II, III)

(3) Which presents a substantial possibility of harming others, and (I, II, III)

(4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

d. Reserved.

e. Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

63.11(2) *Supervision and staffing.*

a. The department shall establish on an individual facility basis the numbers and qualifications of the staff required in a residential care facility for the mentally retarded, using as its criteria the services being offered as indicated on the résumé program of care and, as required for individual care plans, the needs of the resident. (II, III)

b. Personnel in a residential care facility for the mentally retarded shall provide 24-hour coverage for residential care services for the mentally retarded. Personnel shall be up and dressed at all times in facilities over 15 beds. In facilities with 15 or less beds, personnel shall be up and dressed when residents are awake. (II, III)

c. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. (II, III)

d. Physician's orders shall be implemented by qualified personnel. (II, III)

63.11(3) *Personnel histories.*

a. Each health care facility shall submit a form specified by the department of public safety to the department of public safety, and receive the results of a criminal history check and dependent adult abuse record check before any person is employed in a health care facility. The health care facility may submit a form specified by the department of human services to the department of human services to request a child abuse history check. For the purposes of this subrule, "employed in a facility" shall be defined as any individual who is paid, either by the health care facility or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors), to provide direct or indirect treatment or services to residents in a health care facility. Direct treatment or services include those provided through person-to-person contact. Indirect treatment or services include those provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance. Specifically excluded from the requirements of this subrule are individuals such as building contractors, repair workers or others who are in a facility for a very limited purpose, are not in the facility on a regular basis, and who do not provide any treatment or services to the residents of the health care facility. (I, II, III)

b. A person who has a criminal record or founded dependent adult abuse report cannot be employed in a health care facility unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse report does not merit prohibition from employment. (I, II, III)

c. Each health care facility shall ask each person seeking employment in a facility "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of crime in this state or any other state?" The person shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The person shall indicate, by signature, that the person has been informed that the record checks will be conducted. (I, II, III)

d. If a person has a record of founded child abuse in Iowa or any other state, the person shall not be employed in a health care facility unless the department of human services has evaluated the crime or founded report and concluded that the report does not merit prohibition of employment. (I, II, III)

e. Proof of dependent adult abuse and criminal history checks may be kept in files maintained by the temporary employee agencies and contractors. Facilities may require temporary agencies and contractors to provide a copy of the results of the dependent adult abuse and criminal history checks. (I, II, III)

481—63.12(135C) Resident care and personal services.

63.12(1) Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

63.12(2) Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

63.12(3) Residents shall have clean clothing as needed to present a neat appearance, be free of odors, and to be comfortable. Clothing shall be appropriate to their activities and to the weather. (III)

63.12(4) Rescinded, effective 7/14/82.

63.12(5) Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

63.12(6) Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

63.12(7) Rescinded, effective 7/14/82.

63.12(8) Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

63.12(9) Residents shall be required to bathe at least twice a week. (II, III)

481—63.13(135C) Admission, transfer, and discharge.

63.13(1) *General admission policies.*

a. No resident shall be admitted or retained in a residential care facility for the mentally retarded who is in need of greater services than the facility can provide. (II, III)

b. No residential care facility for the mentally retarded shall admit more residents than the number of beds for which it is licensed. (II, III)

c. There shall be no more beds erected than is stipulated on the license. (II, III)

d. There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

e. The admission of a resident to a residential care facility for the mentally retarded shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

f. The admission of a resident shall not grant the residential care facility for the mentally retarded the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the residential care facility for the mentally retarded as required by these rules. (III)

g. A residential care facility for the mentally retarded shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value

or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

h. Rescinded, effective 7/14/82.

i. Funds or properties received by the residential care facility for the mentally retarded, belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

j. Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

k. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity. (III)

l. Upon the verified petition of the county board of supervisors, the district court may appoint the administrator of a county care facility as conservator or guardian or both of a resident of such county care facility. Such administrator shall serve as conservator or guardian or both without fee. The administrator may establish either separate or common bank accounts for cash funds of such resident wards. (III)

63.13(2) *Discharge or transfer.*

a. Prior notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

b. Proper arrangements shall be made by the residential care facility for the mentally retarded for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

c. The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such transfer or discharge. (II, III)

d. Advance notification by telephone will be made to the receiving facility prior to the transfer of any resident. (III)

e. When a resident is transferred or discharged, the appropriate record as set forth in 63.17(1) of these rules will accompany the resident. (II, III)

f. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

481—63.14(135C) Contracts. Each party shall receive a copy of the signed contract. Each contract for residents shall:

63.14(1) State the base rate or scale per day or per month, the services included, and the method of payment; (III)

63.14(2) Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the contract shall:

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in subrule 63.14(2); (III)

b. State the method of payment of additional charges; (III)

c. Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

d. State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc. (III)

63.14(3) Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on a preadmission evaluation assessment which is determined in consultation with the administrator; (III)

63.14(4) Include the total fee to be charged initially to the resident; (III)

63.14(5) State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

a. Written notification to the resident or responsible party, when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to effective date of such changes; (III)

b. Notification to the resident or responsible party, when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

63.14(6) State the terms of agreement in regard to refund of all advance payments in the event of transfer, death, voluntary or involuntary discharge; (III)

63.14(7) State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party:

a. The facility shall ask the resident or responsible party if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented; (II)

b. The facility shall reserve the bed when requested for as long as the resident can ensure payment in accordance with the contract; (II)

63.14(8) State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

63.14(9) State the conditions of voluntary discharge or transfer; (III)

63.14(10) Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (III)

481—63.15(135C) Physical examinations.

63.15(1) Each resident in a residential care facility for the mentally retarded shall have a designated licensed physician, who may be called when needed. (III)

63.15(2) Each resident admitted to a residential care facility for the mentally retarded shall have had a physical examination prior to admission. If the resident is admitted directly from another health care facility, a copy of the admission physical and discharge summary may be part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be part of the resident's record. (III)

a. Each resident admitted to a residential care facility shall have had a physical examination prior to admission. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be a part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (III)

b. The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, tuberculosis status, physical examination, diagnosis, statement of chief complaints, and results of any diagnostic procedures. (III)

63.15(3) Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

63.15(4) Rescinded, effective 7/14/82.

63.15(5) The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

63.15(6) Each resident shall be visited by or shall visit the resident's physician at least annually. The year period shall be measured from the date of admission and is not to include preadmission physicals. Any required physician task or visit in a residential care facility for the mentally retarded may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with the physician. (III)

63.15(7) Residents shall be admitted to a residential care facility for the mentally retarded only on a written order signed by a physician certifying that the individual being admitted requires no more than personal care and supervision but does not require nursing care. (III)

This rule is intended to implement Iowa Code section 135C.23(2).

481—63.16(135C) Dental services.

63.16(1) The residential care facility for the mentally retarded personnel shall assist residents to obtain regular and emergency dental services. (III)

63.16(2) Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)

63.16(3) Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)

63.16(4) All dental reports or progress notes shall be included in the clinical record. (III)

63.16(5) Personal care staff shall assist the resident in carrying out dentist's recommendations. (III)

63.16(6) Dentists shall be asked to participate in the in-service program of the facility. (III)

481—63.17(135C) Records.

63.17(1) *Resident record.* The licensee shall keep a permanent record on all residents admitted to a residential care facility for the mentally retarded with all entries current, dated, and signed. (III) The record shall include:

a. Name and previous address of resident; (III)

b. Birth date, sex, and marital status of resident; (III)

c. Church affiliation; (III)

d. Physician's name, telephone number, and address; (III)

e. Dentist's name, telephone number, and address; (III)

f. Name, address, and telephone number of next of kin or legal representative; (III)

g. Name, address, and telephone number of person to be notified in case of emergency; (III)

h. Mortician's name, telephone number, and address; (III)

i. Pharmacist's name, telephone number, and address; (III)

j. Physical examination and medical history; (III)

k. Certification by the physician that the resident requires no more than personal care and supervision, but does not require nursing care; (III)

l. Physician's orders for medication, treatment, and diet in writing and signed by the physician; (III)

m. A notation of yearly or other visits to physician or other professional services; (III)

n. Any change in the resident's condition; (II, III)

o. If the physician has certified that the resident is capable of taking prescribed medications, the resident shall be required to keep the administrator advised of current medications, treatments, and diet. The administrator shall keep a listing of medication, treatments, and diet prescribed by the physician for each resident; (III)

p. If the physician has certified that the resident is not capable of taking prescribed medication, it must be administered by a qualified person of the facility. A qualified person shall be defined as either a registered or licensed practical nurse or an individual who has completed the state-approved training course in medication administration; (II)

q. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication; (II, III)

r. A notation describing condition on admission, transfer, and discharge; (III)

s. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)

t. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)

u. Disposition of valuables. (III)

63.17(2) *Incident record.*

a. Each residential care facility for the mentally retarded shall maintain an incident record report and shall have available incident report forms. (III)

b. Report of incidents shall be in detail on a printed incident report form. (III)

c. The person in charge at the time of the incident shall oversee the preparation and sign the incident report. (III)

d. The report shall cover all accidents where there is apparent injury or where hidden injury may have occurred. (III)

e. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)

f. A copy of the incident report shall be kept on file in the facility. (III)

63.17(3) *Retention of records.*

a. Records shall be retained in the facility for five years following termination of services. (III)

b. Records shall be retained within the facility upon change of ownership. (III)

c. Rescinded, effective 7/14/82.

d. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

63.17(4) *Reports to the department.* The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

63.17(5) *Personnel record.*

a. An employment record shall be kept for each employee consisting of the following information: name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, date and reason for discharge or resignation. (III)

b. The personnel records shall be made available for review upon request by the department. (III)

481—63.18(135C) Drugs.

63.18(1) *Drug storage.*

a. Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedroom but locked storage must be provided. (III)

b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

(1) A cabinet with a lock shall be provided which can be used for storage of drugs, solutions, and prescriptions; (III)

(2) A bathroom shall not be used for drug storage; (III)

(3) The drug storage cabinet shall be kept locked; (III)

(4) Schedule II drugs, as defined by Iowa Code chapter 124, shall be kept in a locked box within the locked medication cabinet; (II)

(5) The medicine cabinet key shall be in the possession of the employee charged with the responsibility of administering medications; (II, III)

(6) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items; (III)

(7) Drugs for external use shall be stored separately from drugs for internal use; (III)

(8) All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons; (I, II)

(9) The drug cabinet shall have a work counter, both the counter and cabinet shall be well-lighted; (III)

(10) Running water shall be available in the room in which the medicine cabinet is located or in an adjacent room; (III)

(11) Inspection of drug storage condition shall be made by the administrator and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician's order, and drugs improperly stored. (III)

c. Bulk supplies of prescription drugs shall not be kept in a residential care facility for the mentally retarded unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

63.18(2) *Drug safeguards.*

a. All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

b. Medication containers having soiled, damaged, illegible or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

c. The medications of each resident shall be kept or stored in the originally received containers. (II, III)

d. When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

e. Unused prescription drugs prescribed for residents who have died shall be destroyed by the person in charge with a witness and notation made on the resident's record, or, if a unit dose system is used, such drugs shall be returned to the supplying pharmacist. (III)

f. Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

g. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

h. Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

i. There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by the responsible person with a witness and notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

j. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The personal physician of the resident, in conjunction with the pharmacist, shall institute these policies and provide procedures for review and endorsement. (II, III)

k. No resident shall be allowed to keep in the resident's possession any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

l. No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

m. Each facility shall establish a policy cooperating with a licensed pharmacist to govern distributing prescribed medication to residents who are on leave from a facility. (III)

(1) Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 63.18(2)*"a,"* non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration.

(2) Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

(3) Medication distributed as above may be issued only by facility personnel responsible for administering medication.

63.18(3) *Drug administration.*

a. A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

b. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

c. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

d. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved residential aide course, nurse aide course, nurse aide training and testing program or nurse aide competency examination;

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

e. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

f. In an RCF/MR facility licensed for 15 or fewer beds, a person who has successfully completed a state-approved medication manager course may administer medications.

g. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph *"d"* of this subrule do not apply to this individual.

h. Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day they are administered, (II) unless the unit dose system is used.

i. Injectable medications shall be administered by a qualified nurse or physician.

j. Residents certified by their physician as capable of injecting their own insulin may do so. Insulin may be administered pursuant to *"i"* above or as otherwise authorized by the resident's physician. Authorization by the physician shall:

(1) Be in writing,

(2) Be maintained in the resident's record,

(3) Be renewed quarterly,

(4) Include the name of the individual authorized to administer the insulin,

(5) Include documentation by the physician that the authorized person is qualified to administer insulin to that resident.

k. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

481—63.19(135C) Dietary.

63.19(1) *Dietary staffing.*

a. In facilities licensed for over 15 beds, persons in charge of meal planning and food preparation shall complete the home study course on sanitation and food preparation offered by the department. (III)

b. In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

c. There shall be written work schedules and time schedules covering each type of job in the food service department. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area in facilities over 15 beds. (III)

63.19(2) *Nutrition and menu planning.*

a. Menus shall be planned and followed to meet nutritional needs of residents in accordance with the physician's orders. (II)

b. Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the food and nutrition board of the National Research Council, National Academy of Sciences. (II) Recommended daily dietary allowances are:

(1) Milk—two or more cups served as beverage or used in cooking;

(2) Meat group—two or more servings of meat, fish, poultry, eggs, cheese or equivalent; at least four to five ounces edible portion per day;

(3) Vegetable and fruit group—four or more servings (two cups). This shall include a citrus fruit or other fruit and vegetable important for vitamin C daily, a dark green or deep yellow vegetable for vitamin A at least every other day, and other fruits and vegetables, including potatoes;

(4) Bread and cereal group—four or more servings of whole-grain, enriched or restored;

(5) Foods other than those listed will usually be included to meet daily energy requirements (calories) to add to the total nutrients and variety of meals.

c. At least three meals or their equivalent shall be served daily, at regular hours. (II)

(1) There shall be no more than a 14-hour span between substantial evening meal and breakfast. (II, III)

(2) To the extent medically possible, bedtime nourishments shall be offered routinely to all residents. Special nourishments shall be available when ordered by physician. (II, III)

d. Menus shall include a variety of foods prepared in various ways. The same menu shall not be repeated on the same day of the following week. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

g. A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

63.19(3) *Dietary storage, food preparation, and service.*

a. All food and drink shall be clean, wholesome, free from spoilage, and safe for human consumption. (II, III)

b. The use of food from salvaged, damaged, or unlabeled containers shall be prohibited. (III)

c. All perishable or potentially hazardous food shall be stored at safe temperatures of 45°F (7°C) or below, or 140°F (60°C) or above. (III)

d. No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (III)

e. Supplies of staple foods for a minimum of a one-week period and or perishable foods for a minimum of a two-day period shall be maintained on the premises. Minimum food portion requirements for a low-cost plan shall conform to information supplied by the nutrition section of the department of health. (II, III)

f. Table service shall be attractive. Dishes shall be free of cracks, chips, and stains. (III)

g. If family-style service is used, all leftover prepared food that has been on the table shall be properly handled. (III)

h. Poisonous compounds shall not be kept in food storage or preparation areas. (II)

63.19(4) *Sanitation in food preparation area.*

a. "Food Service Sanitation Manual," revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C., shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with food service sanitation.

b. Residents shall not be allowed in the food preparation area, unless indicated in their individualized care plans. (III)

c. In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)

d. All foods, while being stored, prepared, displayed, served, or transported shall be protected against contamination from dust, flies, rodents, and other vermin. (II, III)

e. Food shall be protected from unclean utensils and worn surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, and overhead leakage. (II, III)

f. All appliances and work areas shall be kept clean. (III)

g. There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds. (III)

h. A schedule for duties to be performed daily shall be posted in each food area. (III)

i. All cooking stoves in facilities of 15 or more beds shall be provided with a properly sized exhaust system and hood to eliminate excess heat, moisture, and odors from the kitchen. (III)

j. Spillage and breakage shall be cleaned up immediately. (III)

k. All garbage not mechanically disposed of shall be kept in nonabsorbent, cleanable containers pending disposal. All filled containers shall be covered and stored in a sanitary manner. (III)

l. The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff. (III)

m. The walls, ceilings, and floors of all rooms in which food is prepared and served shall be in good repair, smooth, washable, and shall be kept clean. (III)

n. There shall be no washing, ironing, sorting, or folding of laundry in the food service area. Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)

o. Ice shall be stored and handled in such a manner as to prevent contamination. Ice scoops should be sanitized daily and kept in a clean container. (III)

p. There shall be no animals or birds in the food preparation area. (III)

q. No dishes or cooking utensils shall be towel dried. (III)

r. In facilities of over 15 beds directions for the dishwashing procedure shall be posted and available to all kitchen personnel. (III)

s. If there is a dishwashing machine, it must provide a wash temperature of 140°F (60°C) to 160°F (71°C) and a rinse temperature of 170°F (70°C) to 180°F (82°C). (III)

t. The washing and sanitizing of dishes and utensils shall meet approved sanitation procedures and practices. In facilities of 15 or more beds, a mechanical dishwashing machine or three-compartment sink shall be used for washing dishes; a booster heater for the third compartment or sanitizing agent shall be used. (III)

u. All dishes, silverware, and cooking utensils shall be stored above the floor in a sanitary manner, in a clean, dry place protected from flies, splashes, dust, and other contaminants. (III)

v. Procedures for washing and handling dishes shall be followed in order to protect the welfare of the residents and employees. Persons handling dirty dishes shall not handle clean dishes without washing their hands. (III)

w. Dishes, silverware, and cooking utensils shall be properly cleaned by prerinsing or scraping, washing, sanitizing, and air-drying. (III)

63.19(5) *Hygiene of food service personnel.*

a. Food service personnel shall be free of communicable diseases and practice hygienic food-handling techniques. In the event food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. Personnel recovering from a diagnosed intestinal infection shall submit a report from their physician showing freedom from infection before returning to work in the food service department. (II, III)

b. Staff employees who are full-time food service personnel shall wear clean, washable uniforms that are not used for duties outside the food service area. In all facilities, employees shall wear clean, washable clothing when in the food service area. (III)

c. Hairnets shall be worn by all staff food service personnel. Total enclosure of facial hair shall be provided for staff personnel. (III)

d. Clean aprons and hairnets shall be available for use by other personnel in emergency situations. (III)

e. Persons handling food shall be knowledgeable of good hand-washing techniques. A hand-wash sink shall be provided in or adjacent to the food service area. Continuous on-the-job training on sanitation shall be encouraged. (III)

f. The use of tobacco shall be prohibited in the kitchen. (III)

63.19(6) *Food and drink.* All food and drink consumed within the facility shall be clean and wholesome and comply with local ordinances and applicable provisions of state and federal laws. (II, III)

481—63.20(135C) Orientation program.

63.20(1) The administrator or designee shall be responsible for developing a written, organized orientation program for all residents. (III)

63.20(2) The program shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the medical or health care, recovery, and rehabilitation of the individual. (III)

481—63.21(135C) Individualized program of care.

63.21(1) The individualized program of care, including specific goals and regular evaluation of progress, shall incorporate the social services, psychological, educational activities, and medical needs of the residents, and shall be designed by an interdisciplinary team. (II)

63.21(2) Each residential care facility for the mentally retarded shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

a. The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

b. The program shall include individual goals for each resident. (III)

c. The activity program shall include both group and individual activities. (III)

d. Residents shall be encouraged, but not forced, to participate in the activity program. (III)

63.21(3) Coordination of activities program.

a. Each residential care facility for the mentally retarded with over 15 beds shall employ a person to direct the activities program. (III)

[1]*b.* [2]Staffing for the activity program shall be provided on the minimum basis of 45 minutes per licensed bed per week. (II, III)

c. The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

d. The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

e. There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

63.21(4) Duties of activity coordinator. The activity coordinator shall:

a. Have access to all residents' records excluding financial records; (III)

b. Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

c. Keep all necessary records including:

(1) Attendance; (III)

(2) Individual resident progress notes recorded at regular intervals (at least every three months). (III)

(3) Monthly calendars, prepared in advance. (III)

d. Coordinate the activity program with all other services in the facility; (III)

e. Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

63.21(5) Supplies, equipment, and storage.

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III) These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc.

b. Storage shall be provided for recreational equipment and supplies. (III)

c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

[1] Emergency, pursuant to Iowa Code section 17A.5(2)*"b"*(2).

[2] Objection filed 2/14/79, see Objection following 481—Ch 57.

481—63.22(135C) Care review committee. Each facility shall have a care review committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for care review committees promulgated by the department of elder affairs. (II)

63.22(1) Role of committee in complaint investigations.

a. The department shall notify the facility's care review committee of a complaint from the public. The department shall not disclose the name of a complainant.

b. The department may refer complaints to the care review committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department of elder affairs. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation of the investigation.

c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the care review committee and the department of elder affairs of its findings, including any citations and fines issued.

d. Results of all complaint investigations addressed by the care review committee shall be forwarded to the department within ten days of completion of the investigation.

63.22(2) The care review committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

63.22(3) When requested, names, addresses and telephone numbers of family members shall be given to the care review committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the member's name, address or telephone number given to the care review committee.

481—63.23(135C) Safety. The licensee of a residential care facility for the mentally retarded shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

63.23(1) *Fire safety.*

a. All residential care facilities for the mentally retarded shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size and condition of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

63.23(2) *Safety duties of administrator.* The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency which shall be rehearsed at least quarterly. (III)

a. The plan shall be available for review upon request. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

63.23(3) *Resident safety.*

a. Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when the resident is under direct supervision. (II, III)

b. Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

c. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

d. Smoking shall be permitted only in designated areas. (II, III)

e. Residents shall receive adequate supervision to ensure against hazards from themselves, others, or elements in the environment. (II, III)

63.23(4) *Restraints.*

a. Residents shall not be kept behind locked doors.

b. Temporary seclusion of residents shall be used only in an emergency to prevent injury to the resident or to others pending transfer to appropriate placements.

c. A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room.

d. Divided doors shall be of such type that when the upper half is closed the lower section shall close.

481—63.24(135C) Housekeeping.

63.24(1) Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

63.24(2) Each resident unit shall be cleaned on a routine schedule. (III)

63.24(3) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

63.24(4) A hallway or corridor shall not be used for storage of equipment. (III)

63.24(5) All odors shall be kept under control by cleanliness and proper ventilation. (III)

63.24(6) Clothing worn by personnel shall be clean and washable. (III)

63.24(7) Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

63.24(8) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

63.24(9) Polishes used on floors shall provide a nonslip finish. (III)

63.24(10) Throw or scatter rugs shall not be permitted. (III)

63.24(11) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

63.24(12) Cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials shall not be accessible to residents except as indicated in individualized programs of care. (II, III)

63.24(13) Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

481—63.25(135C) Maintenance.

63.25(1) Each facility shall establish a maintenance program to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. In facilities over 15 beds, this program shall be established in writing and available for review by the department. (III)

63.25(2) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

63.25(3) Draperies and furniture shall be clean and in good repair. (III)

63.25(4) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

63.25(5) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the National Electrical Code. (III)

63.25(6) All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

63.25(7) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. (III)

63.25(8) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

63.25(9) The facility shall be kept free of flies, other insects, and rodents. (III)

63.25(10) Janitor closet.

a. Facilities shall be provided with storage for cleaning equipment, supplies, and utensils. (III)

b. Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

c. In facilities licensed for over 15 beds, a janitor's closet shall be provided. It shall be equipped with water for filling scrub pails and janitor's sink for emptying scrub pails. (III)

481—63.26(135C) Laundry.

63.26(1) All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

63.26(2) Except for related activities, the laundry room shall not be used for other purposes. (III)

63.26(3) Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

63.26(4) Residents' personal laundry shall be marked with an identification. (III)

63.26(5) Bed linens, towels, washcloths, and residents' clothing shall be clean and stain-free. (III)

63.26(6) If laundry is done in the facility, the following shall be provided:

a. A clean, dry, well-lighted area to accommodate a washer and dryer of adequate size to serve the needs of the facility. (III)

b. In facilities of over 15 beds, the laundry room shall be divided into separate areas, one for sorting soiled linen and one for sorting and folding clean linen. (III)

481—63.27(135C) Garbage and waste disposal.

63.27(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

63.27(2) All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

63.27(3) All containers shall be thoroughly cleaned each time the containers are emptied. (III)

63.27(4) All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

63.27(5) Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

481—63.28(135C) Buildings, furnishings, and equipment.

63.28(1) *Buildings—general requirements.*

a. For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than 7 feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within 7 feet of the floor shall be protected by screen guards of not more than ¼-inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates, except closets used for the storage of resident's clothing. (III)

j. All stairways in resident-occupied areas shall have substantial handrails on both sides. (III)

k. Each stairway shall have protective barriers. (III)

l. Screens of 16 mesh per square inch shall be provided at all hold-open openings. (III)

m. Screen doors shall swing outward and be self-closing. At the discretion of the state fire marshal, screens for fire doors may swing in. (III)

n. All resident rooms shall have a door. (III)

o. All rooms in resident-occupied areas shall have general lighting switched at the entrance to each room. (III)

63.28(2) *Furnishings and equipment.*

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

d. Night lights may be required in corridors, at stairways, attendant's stations and resident's bedrooms, and hazardous areas with no less than 1 foot-candle throughout the area at all times. (III)

63.28(3) *Dining and living rooms.*

a. Every facility over 15 beds shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 63.28(3)*"e"* of the rules are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment. (III)

f. Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably furnished. (III)

(3) When space is provided to be used only for activities and recreational purposes, the area shall be at least 15 square feet per licensed bed. At least 50 percent of the required area must be in one room. (III)

g. Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) When space is provided to be used only for dining, the area shall total at least 15 square feet per licensed bed. (III)

63.28(4) *Bedrooms.*

a. Each resident shall be provided with a standard, single, or twin bed, substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. (III)

b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; clean, comfortable pillows of average bed size. (III)

c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)

d. There shall be a comfortable bedside chair per resident bed. The resident's personal wishes shall be considered. (III)

e. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)

g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

h. There shall be a wardrobe or closet in each resident's room. Minimum clear dimensions shall be 1 foot 10 inches deep by 1 foot 8 inches wide with full hanging space and provide a clothes rod and shelf. In a multiple bedroom, closet or wardrobe space shall be assigned each resident sufficient for the resident's needs. (III)

i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)

j. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)

k. Reading lamps shall be provided each resident in the resident's room. (III)

l. Each room shall have sufficient accessible mirrors to serve residents' needs. (III)

m. Usable floor space of a room shall be no less than 8 feet in any major dimension. (III)

n. Bedrooms shall have a minimum of 80 square feet of usable floor space per bed. (III)

o. There shall be no more than four residents per room. (III)

p. Each resident room shall be provided with light and ventilation by means of a window or windows with an area equal to one-eighth of the total floor area. The windows shall be openable. (III)

63.28(5) *Bath and toilet facilities.*

a. Provision shall be made for bars to hold individual towels and washcloths. (III)

b. In facilities of over 15 beds all lavatories shall have paper towel dispensers and an available supply of soap. (III)

c. Minimum numbers of toilet and bath facilities shall be one lavatory, one toilet for each five residents, and one tub or shower for each ten residents or fraction thereof. (III)

d. There shall be a minimum of one bathroom with tub or shower, toilet stool and lavatory on each floor in multistory buildings for facilities licensed for over 15 beds. Separate toilets for the sexes shall be provided. (III)

e. Grab bars shall be provided at all toilet stools, tubs, and showers. Grab bars, accessories, and anchorage shall have sufficient strength to sustain a deadweight of 250 pounds for five minutes. (III)

f. Each toilet room shall have a door. (III)

g. All toilet, bath, and shower facilities shall be supplied with adequate safety devices appropriate to the needs of the individual residents. Raised toilet seats shall be available for residents who are aged or infirm. (III)

h. Toilet and bath facilities shall have an aggregate outside window area of at least 4 square feet. Facilities having a system of mechanical ventilation are exempt from this regulation. (III)

i. Every facility shall provide a toilet with grab bars and lavatory for the public and staff. (III)

63.28(6) *Heating.* A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

63.28(7) *Water supply.*

a. Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)

b. Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)

c. A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)

d. The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)

e. Hot and cold running water under pressure shall be available in the facility. (III)

f. Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department. (III)

63.28(8) *Sewage system.*

a. Sewage shall be collected and disposed of in a manner approved by the department. Disposal into a municipal system will be considered as meeting this requirement. (III)

b. Private sewage systems shall conform to the rules and regulations of the department of environmental quality, state health department, and the natural resources council. (III)

c. Every facility shall have an interior plumbing system complete with flushing device. (III)

63.28(9) *Attendant's station.* In facilities over 15 beds, an attendant's station with a minimum of 40 square feet shall be provided which is centrally located in the resident area and shall have a well-lighted desk with the necessary equipment for the keeping of required records and supplies. (III)

481—63.29(135C) Family and employee accommodations.

63.29(1) Children under 14 years of age shall not be allowed into the service areas in facilities of more than 15 beds. (III)

63.29(2) The residents' bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)

63.29(3) In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

63.29(4) In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

63.29(5) In facilities of more than 15 beds, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

481—63.30(135C) Animals. No animals shall be allowed within the facility except with written approval of the department and under controlled conditions. (III)

481—63.31(135C) Environment and grounds.

63.31(1) A residential care facility for the mentally retarded shall be constructed in a neighborhood free from excessive noise, dirt, polluted or odorous air, or similar disturbances. (III)

63.31(2) There shall be an area available for outdoor activities calculated at 25 square feet per licensed bed. (III) Open-air porches may be included in meeting such requirement.

481—63.32(135C) Supplies.

63.32(1) *Linen supplies.*

a. There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

63.32(2) *First-aid kit.* A first-aid emergency kit shall be available on each floor in every facility. (II, III)

63.32(3) *General supplies.*

a. All equipment shall be properly cleaned and sanitized before use by another resident. (III)

b. Clean and sanitary storage shall be provided for equipment and supplies. (III)

481—63.33(135C) Residents' rights in general.

63.33(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 63.33(2) to 63.33(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

63.33(2) Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

a. Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

b. As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

63.33(3) Policies and procedures regarding the use of chemical and physical restraints shall define the use of restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

63.33(4) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

63.33(5) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

63.33(6) Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. The information must be provided upon admission or in the case of residents already in the facility upon the facility's adoption or amendment of resident right policies.

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English-speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

c. A statement shall be signed by the resident, or responsible party, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party, if applicable. In the case of a mentally retarded resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

e. All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English-speaking, deaf, or blind residents of such changes. (II)

63.33(7) Each resident or responsible party shall be fully informed in a contract as required in rule 63.14(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges not covered by the facility's basic per diem rate. (II)

63.33(8) Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the department of health and human services protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or mentally retarded individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

a. The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either, shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

b. The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

c. If the physician determines or in the case of a confused or mentally retarded resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

d. Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

481—63.34(135C) Involuntary discharge or transfer.

63.34(1) A facility shall not involuntarily discharge or transfer a resident from a facility except: for medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), and by reason of action pursuant to Iowa Code chapter 229. (I, II)

a. "Medical reasons" for transfer or discharge are based on the resident's needs and are determined and documented in the resident's record by the attending physician. Transfer or discharge may be required to provide a different level of care. (II)

b. "Welfare" of a resident or that of other residents refers to their social, emotional, or physical well-being. A resident might be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with their needs and rights). Evidence that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall be in writing and shall include specific information to support this determination. (II)

c. Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. The 30-day requirement shall not apply in any of the following instances:

(1) If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) If the transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

d. The notice required by paragraph *"c"* shall contain all of the following information:

(1) The stated reason for the proposed transfer or discharge. (II)

(2) The effective date of the proposed transfer or discharge. (II)

(3) A statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department of inspections and appeals designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may

write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." (II)

e. A request for a hearing made under 63.34(1)*"d"*(3) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

f. The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, responsible party, and Iowa department of elder affairs long-term care ombudsman of record not later than five full business days after receipt of the request. This notice shall also inform the licensee, resident or responsible party, that they have a right to appear at the hearing in person or be represented by their attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department of elder affairs long-term care ombudsman shall have the right to appear at the hearing.

g. The hearing shall be heard by a department of inspections and appeals designee pursuant to Iowa Code chapter 17A. (The hearing shall be public unless the resident or the resident's representative requests in writing that it be closed.) The licensee or designee shall have the opportunity to present to the representative of the department any oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and responsible party shall also have an opportunity to present to the representative of the department any oral testimony or written material to show just cause why a transfer or discharge should not be made. In a determination as to whether a transfer or discharge is authorized, the burden of proof rests on the party requesting the transfer or discharge.

h. Based upon all testimony and materials submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department of elder affairs long-term care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision.

i. A copy of the notice required by paragraph *"c"* shall be personally delivered to the resident and a copy placed in the resident's record. A copy shall also be transmitted to the department, the resident's responsible party, physician, the person or agency responsible for the resident's placement, maintenance, and care in the facility, and the department of elder affairs long-term care ombudsman.

j. If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

k. The involuntary transfer or discharge shall be discussed with the resident, the resident's responsible party, and the person or agency responsible for the resident's placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's record. (II)

l. The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident's record. (II)

(1) Counseling shall be provided by a qualified individual who meets one of the following criteria:

1. Has a bachelor's or master's degree in social work from an accredited college. (II)

2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with public or private agency. (II)

3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)

4. Is a licensed psychologist or psychiatrist. (II)

5. Is any other person of the resident's choice. (II)

(2) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be discharged or transferred. (II)

(3) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

m. In the case of an emergency transfer or discharge as outlined in 63.34(1)*"c"*(1), the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident's file and it must contain all the information required by 63.34(1)*"d"*(1) and (2). In addition, the notice must contain a statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals within 7 days after receiving this notice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." A hearing requested pursuant to this subrule shall be held in accordance with paragraphs *"f," "g,"* and *"h."* (II)

n. Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department of inspections and appeals. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

63.34(2) Intrafacility transfer:

a. Residents shall not be relocated from room to room within a licensed health care facility arbitrarily. (I, II) Involuntary relocation may occur only in the following situations and such situation shall be documented in the resident's record.

(1) Incompatibility with or disturbing to other roommates, as documented in the resident's record.

(2) For the welfare of the resident or other residents of the facility.

(3) For medical, nursing or psychosocial reasons, as documented in the resident's record, as judged by the attending physician, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.

(4) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex.

(5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

b. Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident, or responsible party include:

(1) Change from private pay status to Title XIX, except as outlined in 63.34(2)*"a"*(5). (II)

(2) As punishment or behavior modification (except as specified in 63.34(2)*"a"*(1). (II)

(3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph *"a,"* the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. Notification shall be documented in the resident's record and signed by the resident or responsible party. (II)

d. If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately or as soon as possible of the condition requiring emergency relocation and the notification shall be documented. (II)

481—63.35(135C) Resident rights. Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise the resident's rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

63.35(1) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

63.35(2) The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

a. Designation of an employee responsible for handling grievances and recommendations. (II)

b. A method of investigating and assessing the validity of a grievance or recommendation. (II)

c. Methods of resolving grievances. (II)

d. Methods of recording grievances and actions taken. (II)

63.35(3) The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, care review committee members, the text of Iowa Code section 135C.46, etc., to provide to residents a further course of redress. (II)

481—63.36(135C) Financial affairs—management. Each resident, who has not been assigned a guardian or conservator by the court, may manage personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

63.36(1) The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

63.36(2) An employee shall be designated in writing to be responsible for resident accounts. (II)

63.36(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or mentally retarded resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

63.36(4) If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

63.36(5) A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

63.36(6) A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

481—63.37(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical

and physical restraints, except in an emergency for the shortest amount of time necessary to protect the resident from injury to the resident or to others, pending the immediate transfer to an appropriate facility. The decision to use restraints on an emergency basis shall be made by the designated charge person who shall promptly report the action taken to the physician and the reasons for using restraints shall be documented in the resident's record. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

63.37(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

63.37(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

63.37(3) Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff or as a substitute for program. (II)

63.37(4) Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain that separation until the abuse investigation is completed. (I, II)

63.37(5) Suspected abuse reports. The department shall investigate all complaints of dependent adult abuse which are alleged to have happened in a health care facility. The department shall inform the department of human services of the results of all evaluations and dispositions of dependent adult abuse investigations.

63.37(6) Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

This rule is intended to implement Iowa Code subsections 235B.3(1) and 235B.3(11).

481—63.38(135C) Resident records. Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

63.38(1) The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

63.38(2) Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

63.38(3) The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

481—63.39(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of the resident's dignity and individuality, including privacy in treatment and in care for the resident's personal needs. (II)

63.39(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

63.39(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

63.39(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

63.39(4) Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

63.39(5) Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply under emergency conditions. (II)

481—63.40(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

63.40(1) Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

63.40(2) If the plan of care requires activities for therapeutic or training reasons, the plan for these activities shall be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time-limited and reviewed at least quarterly. (II)

63.40(3) Residents who perform work for the facility must receive remuneration unless such work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staff requirements. (II)

481—63.41(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

63.41(1) Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

63.41(2) Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

a. The resident refuses to see the visitor. (II)

b. The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)

c. The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

63.41(3) Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

63.41(4) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

63.41(5) Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

63.41(6) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

63.41(7) Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified mental retardation professional or facility administrator for refusing permission. (II)

63.41(8) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly

management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

481—63.42(135C) Resident activities. Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified mental retardation professional as appropriate in the resident's record. (II)

63.42(1) Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

63.42(2) All residents shall have the freedom to refuse to participate in these activities. (II)

481—63.43(135C) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

63.43(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

63.43(2) Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

63.43(3) Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of such items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

63.43(4) A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

63.43(5) A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

481—63.44(135C) Family visits. Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room, if possible. (II)

63.44(1) The facility shall provide for needed privacy in visits between spouses. (II)

63.44(2) Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why an arrangement would have an adverse effect on the health of the resident. (II)

63.44(3) Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an arrangement would have an adverse effect on the health of the resident. (II)

481—63.45(135C) Choice of physician. Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility. (II)

481—63.46(135C) Incompetent resident.

63.46(1) Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

63.46(2) The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility

shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

481—63.47(135C) Specialized license for three- to five-bed facilities. The specialized license is for residential care facilities which serve persons with mental retardation, chronic mental illness and other developmental disabilities having five or fewer residents as specified in Iowa Code section 225C.26. The facility is exempt from Iowa Code section 135.63. For this specialized license, all rules of 481—Chapter 63 apply except those which are deleted or amended, as indicated in subsequent rules.

63.47(1) The provider may apply for a specialized license from the department of inspections and appeals. Before the license is granted, the provider shall meet all of the following requirements:

a. Compliance with program requirements pursuant to Iowa Code chapter 135C and administrative rules relating to residential care facilities adopted by the state board of health, or standards adopted by the Accreditation Council for Services for Persons with Mental Retardation and Other Developmental Disabilities (1984). The program of care shall emphasize an age-appropriate and least restrictive program.

b. The facility shall be located in areas zoned for single- or multiple-family housing, or be located in an unincorporated area, and shall be constructed in compliance with applicable local housing codes and rules adopted for this classification of license by the state fire marshal. (II, III)

c. The facility shall be appropriately accessible to residents who have disabilities. (II, III)

d. Written plans shall demonstrate that the facility meets the needs of the residents pursuant to individual program plans meeting age-appropriate and least restrictive program requirements. (II)

e. Written plans shall demonstrate the residents have reasonable access to employment for job-related training, education, generic community resources, or integrated opportunities to promote community interaction. (II)

f. Unless documented as appropriate within the residents' individual program plans, populations with primary diagnosis of chronic mental illness or mental retardation/developmental disability may not be residents of the same specialized license facility. (II, III)

63.47(2) The housing for persons with mental retardation, chronic mental illness, and other developmental disabilities, developed pursuant to this rule shall be eligible for funding utilized by licensed residential care facilities for the mentally retarded.

63.47(3) Rescinded IAB 6/27/90, effective 8/1/90.

63.47(4) Rescinded IAB 6/27/90, effective 8/1/90.

63.47(5) The director of the department of inspections and appeals shall appoint a specialized license committee not to exceed nine members. This committee shall monitor the program rules and procedures adopted for this classification of license.

63.47(6) All conditions and criteria in 481—Chapter 63 apply to the specialized license with the exception of the following deletions: 481—63.7(135C), 63.8(2)*"b,"* 63.8(7)*"b,"* 63.13(1)*"l,"* 63.18(1)*"b"* (9), 63.19(1)*"a," "b," "c,"* 63.19(2)*"c"*(1), *"e," "g,"* 63.19(4)*"a," "b," "c," "g," "h," "i," "l," "n," "p," "q," "r," "t,"* 63.19(5)*"b," "c," "d,"* 63.21(1), (2), (3) *"a"* to *"e,"* (4)*"a," "b,""c"*(1) to (3), *"d," "e,"* 63.21(5)*"c,"* 63.23(3)*"c,"* 63.23(4)*"c," "d,"* 63.24(1), (7), (10), 63.25(10)*"b,"* 63.26(1) to (4), (6)*"b,"* 63.27(3) to (5), 63.28(1)*"a," "b," "f," "g," "k," "l," "m," "o,"* 63.28(2)*"c,"*63.28(3)*"a," "d," "e," "f"*(3), *"g"*(2), 63.28(5)*"b," "i,"* 63.28(9), 63.29(1), (4), (5), 63.33(6)*"d."*

63.47(7) The following rules in Chapter 63 are amended for this specialized license as follows:

1. 63.3(1)*"a"* and 63.3(2)—Delete all references to 481—Chapter 60.

2. 63.8(1)*"a"*—Add "or qualified mental health professional (III)" after "qualified mental retardation professional". (III)

3. 63.8(2)—Add "For purposes of the specialized license, the administrator may act as an administrator for not more than three residential care facilities for the mentally retarded, chronic mentally ill, and developmentally disabled." (II)

4. 63.9(1)—Add "For purposes of the specialized license there shall be written personnel policies in all facilities to include hours of work and attendance at the education program." (III)

5. 63.11(1)*"a"*—Delete the words "a managerial role of" in line 2.

6. 63.11(2)*"b"*—Delete the second sentence and "with 15 or less beds" in the third sentence.

7. 63.14(5)*"b"*—Add "or guardian" after "resident" in the first line.

8. 63.17(1)—Add a new paragraph: "v.Current Individual Program Plans (IPP)".

9. 63.17(5)*"a"*—Add "For the specialized license, a job description shall be in the individual's personnel file." (III)

10. 63.19(2)*"b"*—Delete from the end "Recommended daily dietary allowances are:" Also delete subparagraphs (1) to (5).

11. 63.19(2)*"f"*—Delete the second sentence.

12. 63.19(3)*"e"*—Delete "for a minimum of a one-week period" in the first line.

13. 63.19(4)*"m"*—Delete "smooth, washable," in the second line.

14. 63.19(4)*"o"*—Delete the second sentence.

15. 63.19(4)*"s"*—Add "and rinse" after "wash" in the first line and then delete the rest of the sentence after "(60°C)".

16. 63.19(4)*"w"*—Change "or" to "and" in the first line and delete ",washing, sanitizing, and air-drying".

17. 63.19(5)*"b"*—Delete the second sentence.

18. 63.19(5)*"f"*—Add "during food preparation" after "kitchen".

19. 63.24(9)—Change "nonslip" to "slip-resistant" in the first sentence.

20. 63.25(1)—Delete the second sentence.

21. 63.28(1)*"j"*—Change "on both sides" in the first line to "on at least one side".

22. 63.28(4)*"n"*—Change to read "Bedrooms shall have a minimum of 60 square feet for double, 80 square feet for single, and 100 square feet physical (wheelchair)." (III)

23. 63.28(4)*"o"*—Change "four" to "two".

24. 63.28(5)*"c"*—Amend to read: "Minimum numbers of toilets and bath facilities shall be one for each five residents." (III)

25. 63.28(5)*"d"*—Amend to read: "There shall be a minimum of one bathroom with tub or shower, toilet stool, and lavatory on each floor in the multistory buildings." (III)

26. 63.28(5)*"e"*—Amend to read: "Grab bars shall be provided as needed." (III)

27. 63.33(8)—Change any reference of "responsible party" to "legal guardian".

28. 63.33(8)*"c"*—Delete "in the case of a confused or mentally retarded resident". Change any reference of "responsible party" to "legal guardian".

29. 63.33(8)*"d"*—Change any reference of "responsible party" to "legal guardian".

30. 63.46(1)—Change any reference of "responsible party" to "legal guardian" and delete the rest of the paragraph after "state law".

63.47(8) "Qualified mental health professional" is a person who:

a. Holds a master's degree from an accredited educational institution with coursework relevant to the position for which the person is hired;

b. Has at least two years' relevant experience supervised by a qualified mental health professional in assessing mental health problems and needs of persons in providing appropriate mental health services for those persons;

c. Holds a current Iowa license when required by Iowa licensure law.

63.47(9) "Mental retardation" as used in this chapter shall also include the chronically mentally ill and the developmentally disabled for purposes of this specialized license.

a. For the specialized license, "persons with mental retardation" means persons with significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, manifested during the developmental period.

(1) "General intellectual functioning" is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning;

(2) "Significantly subaverage functioning" is defined as approximately 70 IQ or below;

(3) "Adaptive behavior" is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group;

(4) "Developmental period" is defined as the period of time between conception and the eighteenth birthday.

b. For the specialized license, "persons with developmental disabilities" means persons with a severe, chronic disability which:

(1) Is attributable to mental or physical impairment, or a combination of physical and mental impairments;

(2) Is manifested before the person attains the age of 22;

(3) Is likely to continue indefinitely;

(4) Results in substantial functional limitations in three or more of the following areas of life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency; and

(5) Reflects the person's need for a combination and sequence of services which are of lifelong or extended duration.

c. For the specialized license, "persons with chronic mental illness" means adults aged 18 or older, with persistent mental or emotional disorders that seriously impair their functioning relative to such primary aspects of daily living as personal relations, living arrangement or employment. Persons with chronic mental illness typically meet at least one of the following criteria:

(1) Have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or in-patient hospitalization);

(2) Have experienced a single episode of continuous, structured supportive residential care other than hospitalization.

In addition, such persons typically meet at least two of the following criteria, on a continuing or intermittent basis for at least two years:

1. Are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history;

2. Require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help;

3. Show severe inability to establish or maintain a personal social support system;

4. Require help in basic living skills;

5. Exhibit inappropriate social behavior which results in demand for intervention by the mental health or judicial system.

In atypical instances chronically mentally ill persons may vary from the above criteria.

63.47(10) For the specialized license, there shall be implemented an individual program plan (IPP) of goals and objectives for each resident developed using evaluations, assessments and progress reports. (II)

63.47(11) For the specialized license, "age-appropriate" shall mean activities, settings, personal appearance and possessions commensurate with the person's chronological age.

63.47(12) For the specialized license, "least restrictive" shall mean the availability to the person of programs, services and settings that give the greatest opportunity for human development and to associate with and become part of the general society.

63.47(13) "Individual program plan" shall be a written plan for the provision of services to the person and, when appropriate, to the person's family, that is developed and implemented, using an interdisciplinary process, which identifies the person's and, when appropriate, the person's family's functional status, strengths, and needs, and service activities designed to enable a person to maintain or move toward independent functioning. The plan is developed in accordance with the developmental model, which is a service approach that recognizes and assumes the potential for positive change, growth, and sequential development in all people. (II)

a. An individual program plan shall be developed and implemented for each individual accepted for service, regardless of the individual's chronological age or developmental level. (I, II)

b. The interdisciplinary team shall develop the plan. (II) For the purpose of the specialized license, the team shall include:

(1) The person, the person's legal guardian, and the person's family unless the family's participation is contrary to the wishes of the adult person who has not been legally determined to be incompetent; (II, III)

(2) The service coordinator or case manager; (II, III)

(3) All current service providers; and (II, III)

(4) Other persons whose appropriateness may be identified through the diagnosis and evaluation or current reevaluation. (III)

c. The person or the person's legal guardian has the ultimate authority to accept or reject the plan unless otherwise determined by court. (III)

d. The resident and the facility retain the rights of appeal and due process from the interdisciplinary team decisions. (II, III)

63.47(14) Goals and objectives shall be stated separately and a time frame shall be specified for their achievement. (II, III)

a. Each individual enrolled shall have an individual program plan. (II)

b. The initial individual program plan shall be developed within 30 calendar days after the individual is enrolled in this service. (II)

c. The individual program shall be developed by an appropriately constituted interdisciplinary team. (II)

d. The individual program plan shall state specific objectives to reach identified goals and shall identify the individuals responsible for implementation. (II, III)

e. Goals and objectives shall be stated separately. (II, III)

f. Goals and objectives shall be assigned projected evaluation completion dates and shall be reviewed at least annually. (II, III)

g. Goals and objectives shall be expressed in behavioral terms that provide measurable indices of progress. (II)

h. Goals and objectives shall be sequenced with a developmental progression appropriate to the individual. (II, III)

i. Goals and objectives of the individual program plans shall be assigned priorities by the interdisciplinary team and implemented with documentation of needed resources. (II, III)

j. The individual program plan shall be written in terms that are understandable to all concerned. (II, III)

63.47(15) Where implementation is a shared responsibility, the individual program plan shall identify the agencies or persons responsible for delivering the services required. (III)

63.47(16) A review of the individual program plan shall be made at least quarterly by a member or members of the individual's interdisciplinary team, as determined by the team, in order to ensure the continuing implemented appropriateness of the plan and any necessary action to be initiated. (II)

a. Problems or changes that call for review of the individual program plan by the team shall be indicated. (II)

b. The team shall be convened at least annually to review the individual program plan where problems or changes that call for review by the team are indicated. (II, III)

c. The team review shall assess the individual's response to activities designed to achieve the objective stated in the individual program plan. (II, III)

d. The team review shall modify activities or objectives as necessary. (II, III)

e. The team review shall determine the services that are needed. (II, III)

f. The team review shall include consideration of the advisability of continued enrollment or alternative placements. (II, III)

481—63.48(135C) County care facilities. In addition to Chapter 63 licensing rules, county care facilities licensed as residential care facilities for the mentally retarded must also comply with department of human services rules, Iowa Administrative Code 441—Chapter 37. Violation of any

standard established by the department of human services is a Class II violation pursuant to Iowa Administrative Code 481—56.2(135C).

481—63.49(135C) Another business or activity in a facility. A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs *"a"* through *"j"* of this rule. (I, II, III)

63.49(1) The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

a. Health and safety risks for residents;

b. Compatibility of the proposed business or activity with the facility program;

c. Noise created by the proposed business or activity;

d. Odors created by the proposed business or activity;

e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;

f. Use of the facility's corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;

g. Proposed staffing for the business or activity;

h. Sharing of services and staff between the proposed business or activity and the facility;

i. Facility layout and design; and

j. Parking area utilized by the business or activity.

63.49(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

63.49(3) A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 60. (I, II, III)

481—63.50(135C) Respite care services. Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A facility which chooses to provide respite care services must meet the following requirements related to respite care services and must be licensed as a health care facility.

63.50(1) A facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

63.50(2) Rules regarding involuntary discharge or transfer rights do not apply to residents who are being cared for under a respite care contract.

63.50(3) The facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements for contracts between a health care facility and resident, except the requirements concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons.

63.50(4) Respite care services shall not be provided by a facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.1, 135C.2(5), 135C.2(6), 135C.6(1), 135C.14(3), 135C.14(5), 135C.14(8), 135C.25, 135C.25(3), 135C.36, 227.4, 235B.1(6), and 235B.1(11) and 1988 Iowa Acts, chapter 1239.

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◊ Two or more ARCs

1 Effective date of 63.15(2)*"a"* and *"b"* delayed 70 days by the Administrative Rules Review Committee, IAB 2/26/86.

Effective date of 63.15(2)*"a"* and *"b"* delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAC 6/4/86.

[2] See IAB, Inspections and Appeals Department.

[3] Two ARCs

[4] Rule 481—63.49(135C), effective 7/1/92.

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).)

"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.

"Sensitive area" means a screening tool used to determine if a public water supply well warrants a more in-depth assessment. It is not intended to be a mechanism to assign a risk classification to the public water supply well receptor. "Sensitive area" describes the area within the Iowa Geological Survey's designated five-year capture zone for any public water supply well or, if the Iowa Geological Survey has not designated a five-year capture zone for a public water supply well, the area within a 2,500-foot radius of the public water supply well and where the Iowa Geological Survey has given the public water supply well aquifer a source water protection aquifer designation of "susceptible" or "highly susceptible."

"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.

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 overfill prevention equipment.

(1) Except as provided in subparagraph (2), to prevent spilling and overfilling associated with product transfer to the UST system, owners and operators must use the following spill and overfill 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. Overfill 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 overfilling, alert the operator with a high-level alarm one minute before overfilling, 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 overfilling.

(2) Owners and operators are not required to use the spill and overfill 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 overfill prevention equipment.* To prevent spilling and overfilling associated with product transfer to the UST system, all existing UST systems must comply with new UST system spill and overfill 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, Liquified 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.

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:

Scheduled for Phase-in of Release Detection					
Year System Was Installed	Year When Release Detection is Required (by December 22 of the Year Indicated)				
	1989	1990	1991	1992	1993
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."*

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. Continously, 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.

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.

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.

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. If a public water supply well is located within 2,500 feet of the underground storage tank source area, a Tier 2 assessment must be completed for this pathway in accordance with 135.10(455B), unless the department agrees with the recommendation of the owner or operator's groundwater professional that it is unlikely the public water supply well is at risk, even without the benefit of soil and groundwater plume definition and a Tier 2 pathway assessment. The groundwater professional may take into account the factors specified in 135.10(11)*"h."*

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).

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."* A public water supply screening and risk assessment must be conducted in accordance with 135.10(4)*"f"* for this pathway.

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. 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.

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 1levels 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. The groundwater professional shall identify all public water supply wells located outside the applicable modeled plume but within 2,500 feet of the leaking underground storage tank site. The certified groundwater professional shall conduct a preliminary assessment of the potential risk of impact from the underground storage tank release to the public water supply well based on available information and taking into account the assessment factors in 135.10(11)*"h"* and other relevant considerations. The certified groundwater professional shall submit a public water supply well risk assessment report either prior to or along with the Tier 2 site cleanup report. The risk assessment shall, at a minimum, provide an analysis of the potential risk of impact from the underground storage tank site release to the public water supply well and a recommendation as to whether it is unlikely the underground storage tank release poses an unreasonable risk of impact to the well. If the groundwater professional determines that a professional judgment cannot reasonably

be offered without collection of further data, the report shall make a recommendation as to what further data might be developed to assess the risk to the well.

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 ($\mu g/m^3_{air}$)	**Soil Gas ($\mu g/m^3$)**
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.* The department shall review the public water supply well risk assessment report submitted pursuant to135.10(4) independently or as part of its review of the Tier 2 site cleanup report. Factors which the department may consider when reviewing the risk assessment report include, but are not limited to:

(1) The location of the underground storage tank site within a sensitive area as defined in 135.2(455B) for any identified public water supply well and if so, the potential risk of impact to the well taking into account the well's capture zone and the aquifer susceptibility designation.

(2) Reports of petroleum constituents in the raw or finished water samples from the public water supply well.

(3) Whether corrective action may be required or has been completed for other receptors or pathways which could prevent impact to the public water supply well.

(4) Test results showing the presence or absence of detectable levels of petroleum constituents in a public water supply well, and to what extent the underground storage tank site release or other facilities in the area may be a source or contributing source.

(5) The presence of elevated concentrations of chemicals of concern in the soil or groundwater relative to the distance to the public water supply well and groundwater fate and transport data from other contaminated sources in the vicinity.

(6) Available information on the pumping capacity of the public water supply well and related zone of capture.

(7) Detections of chemicals in water samples tending to establish that the integrity of the well has been compromised or that there is a connection between the contaminated aquifer and the well's source water aquifer.

(8) Available information, including hydrogeological data from other sources in the vicinity, as to the nature and extent of any confining layer between the public water supply well aquifer and the contaminated aquifer.

(9) Information supplied from the public water supply well operator including but not limited to well construction, age, integrity, and pumping capacity.

(10) Water quality data and detections of chemicals tending to establish that the integrity of the well has been compromised or that there is a connection between the contaminated aquifer and the public water supply well.

(11) The distance between the leaking underground storage tank site and the public water supply well.

(12) The age of the release.

(13) Alternative modeling including, but not limited to, mass flux modeling.

If the department concurs with the certified groundwater professional's risk analysis and recommendation that it is unlikely the underground storage tank site release poses an unreasonable risk of impact to the public water supply well, the department may classify the well as no action required.

If after taking into account the groundwater professional's risk analysis, professional recommendations and other relevant data, the department does not accept the certified groundwater professional's recommendations, the department must demonstrate that there is a hydrogeological connection between the underground storage tank contaminated aquifer and the public water supply well and that the underground storage tank release more likely than not poses an unreasonable risk of impact to the public water supply well. If the department establishes this level of proof, it may disapprove the assessment report and require the owner and operator through their certified groundwater professional to submit a Tier 3 work plan. The work plan shall propose what further assessment methods and data would be sufficient to confirm the nature and extent of any risk of impact to the public water supply well from the underground storage tank site release. As an alternative to submitting a Tier 3 work plan for this receptor, owners or operators may participate in a corrective action meeting process to develop a Tier 3 work plan or other corrective action plan, which would be incorporated into a memorandum of agreement or other written agreement approved by the department.

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 SSTL line are achieved. If it is shown that concentrations at all applicable points have been reduced to below the SSTL 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 SSTL 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 reimplementation 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. 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 an 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

Nominal Tank Capacity (gallons)	Number of Samples	Location on Centerline
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.

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. Clients 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 on a biennial basis by an UST compliance inspector certified by the department under 567—Chapter 134. The initial site inspection shall be submitted to the department no later than December 31, 2007.

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.

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 hydorcarbons 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 $1x10^{-4}$.

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 $1x10^{-4}$; 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:

$$RBSL_w \left[\frac{mg}{L - H_2O}\right] = \frac{TR \times BW \times AT_c \times \frac{365\ days}{year}}{SF_o \times IR_w \times EF \times ED}$$

Noncarcinogens:

$$RBSL_w \left[\frac{mg}{L - H_2O}\right] = \frac{THQ \times RfD_o \times BW \times AT_n \times \frac{365\ days}{year}}{IR_w \times EF \times ED}$$

Soil Leaching to Groundwater Equations

$$RBSL_{sl} \left[\frac{mg}{kg - soil}\right] = \frac{RBSL_w \left[\frac{mg}{L - H_2O}\right]}{LF}$$

$$LF \left[\frac{mg/L - H_2O}{mg/kg - soil}\right] = \frac{\rho_s}{(\theta_{ws} + k_s\rho_s + H\theta_{as})\left(1 + \frac{U\delta}{IW}\right)}$$

Soil Vapor to Enclosed Space Equations

$$RBSL_{sv}\left[\frac{mg}{kg-soil}\right] = \frac{RBSL_{air}\left[\frac{\mu g}{m^3-air}\right]}{VF_{sv}}\left(\frac{mg}{1000\ \mu g}\right)$$

$$VF_{sv}\left[\frac{(mg/m^3-air)}{(mg/kg-soil)}\right] = \frac{\frac{H\rho_s}{(\theta_{ws}+k_s\rho_s+H\theta_{as})}\left[\frac{D_s^{eff}/L_s}{ER\ L_B}\right]}{1+\left[\frac{D_s^{eff}/L_s}{ER\ L_B}\right]+\left[\frac{D_s^{eff}/L_s}{\left(D_{crack}^{eff}/L_{crack}\right)\eta}\right]}\left(10^3\ \frac{cm^3-kg}{m^3-g}\right)$$

$$D_{crack}^{eff}\left[\frac{cm^2}{s}\right] = D^{air}\ \frac{\theta_{acrack}^{3.33}}{\theta_T^2} + D^{wat}\frac{1}{H}\frac{\theta_{wcrack}^{3.33}}{\theta_T^2}$$

$$D_s^{eff}\left[\frac{cm^2}{s}\right] = D^{air}\ \frac{\theta_{as}^{3.33}}{\theta_T^2} + D^{wat}\frac{1}{H}\frac{\theta_{ws}^{3.33}}{\theta_T^2}$$

Indoor Air Inhalation Equations

Carcinogens:

$$RBSL_{air}\left[\frac{\mu g}{m^3\text{ - air}}\right] = \frac{TR \times BW \times AT_c \times \frac{365\text{ days}}{year} \times \frac{1000\ \mu g}{mg}}{SF_i \times IR_{air} \times EF \times ED}$$

Noncarcinogens:

$$RBSL_{air}\left[\frac{\mu g}{m^3\text{ - air}}\right] = \frac{THQ \times RfD_i \times BW \times AT_n \times \frac{\frac{365}{kdays}}{year} \times \frac{1000\ \mu g}{mg}}{IR_{air} \times EF \times ED}$$

Groundwater Vapor to Enclosed Space Equations

$$RBSL_{gw}\left[\frac{mg}{L - H_2O}\right] = \frac{RBSL_{air}\left[\frac{\mu g}{m^3 - air}\right]}{VF_{gw}}\left(\frac{mg}{1000\ \mu g}\right)$$

$$VF_{gw}\left[\frac{(mg/m^3 - air)}{(mg/L - H_2O)}\right] = \frac{H\left[\frac{D_s^{eff}/L_{gw}}{ER\ L_B}\right]}{1 + \left[\frac{D_s^{eff}/L_{gw}}{ER\ L_B}\right] + \left[\frac{D_s^{eff}/L_{gw}}{\left(D_{crack}^{eff}/L_{crack}\right)^{\eta}}\right]}\left(\frac{10^3 L}{m^3}\right)$$

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_{acrack}	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_2O/cm^3-soil)
θ_{ws}	volumetric water content in vadose zone (cm^3-H_2O/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^{eff}_{crack}	effective diffusion coefficient through foundation cracks (cm^2/s)
D^{eff}_{s}	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_2O)/(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_2O/kg-C)
k_s	soil-water sorption coefficient (L-H_2O/kg-soil), f_{oc} x K_{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_2O)/(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)
$RBSL_{air}$	Risk-Based Screening Level for indoor air ($\mu g/m^3$-air)
$RBSL_{gw}$	Risk-Based Screening Level for vapor from groundwater to enclosed space air inhalation (mg/L-H_2O)
$RBSL_{sl}$	Risk-Based Screening Level for soil leaching to groundwater (mg/kg-soil)
$RBSLs_v$	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_2O)
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_2O))
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_2O/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_2O/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}).

$$C_s^{sat}(\text{mg/kg-soil}) = S/\rho_s \times (H\theta_{as} + \theta_{ws} + k_s \rho_s)$$

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)

$$C(x) = C_s \exp\left(\frac{x_m}{2\alpha_x}\left[1-\sqrt{1+\frac{4\lambda\alpha_x}{u}}\right]\right) erf\left(\frac{S_w}{4\sqrt{\alpha_y x_m}}\right) erf\left(\frac{S_d}{4\sqrt{\alpha_z x_m}}\right)$$

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
αx, αy, αz: 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

Parameter		Default Value	Required
θ_{ws}	volumetric water content in vadose zone	0.1cm^3-H_2O/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_2O/cm^3-soil	default
I	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
αx	dispersivity in the x direction	0.1x	default
αy	dispersivity in the y direction	0.33αx	default
αz	dispersivity in the z direction	0.05αx	default
θe	effective porosity	0.1	default

where $u=Ki/\theta e$

First-order Decay Coefficients

Chemical	Default Valueλ (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
Lgw	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
Lcrack	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
Lcrack	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% napthalene, 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); $u=Ki/\theta e$
K: hydraulic conductivity
i: groundwater head gradient
θe: effective porosity
λ: first-order decay coefficient, chemical specific
αx, αy, αz: 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_2O/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_2O/cm^3-soil	default
I	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
αx	dispersivity in the x direction	0.1x	default
αy	dispersivity in the y direction	$0.33\alpha x$	default
αz	dispersivity in the z direction	$0.05\alpha x$	default
θe	effective porosity	0.1	default

where $u=Ki/\theta e$

Groundwater Transport Modeling Parameters (continued)

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
Lgw	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
Lcrack	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
Lcrack	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

Diesel and Waste Oil			Chemical-Specific Values for Tier 1			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
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% napthalene, 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

Waste Oil			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
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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[2] August 6, 2008, effective date of **ARC 6892B** delayed 70 days by Administrative Rules Review Committee at its July 2008 meeting.

NATURAL RESOURCE COMMISSION[571]

[Prior to 12/31/86, see Conservation Commission [290], renamed Natural Resource Commission[571] under the "umbrella" of Department of Natural Resources by 1986 Iowa Acts, chapter 1245]

TITLE I
GENERAL

CHAPTER 1
OPERATION OF NATURAL RESOURCE COMMISSION

1.1(17A,455A) Scope
1.2(17A,455A) Time of meetings
1.3(17A,455A) Place of meetings
1.4(17A,455A) Notification of meetings
1.5(17A,455A) Attendance and participation by the public
1.6(17A,455A) Quorum and voting requirements
1.7(17A,455A) Conduct of meeting
1.8(17A,455A) Minutes, transcripts, and recordings of meetings
1.9(17A,455A) Officers and duties
1.10(17A,455A) Election and succession of officers
1.11(68B) Sales of goods and services

CHAPTER 2
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

2.1(22) Adoption by reference

CHAPTER 3
SUBMISSION OF INFORMATION AND COMPLAINTS—INVESTIGATIONS

3.1(17A) Adoption by reference

CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING

4.1(17A) Adoption by reference

CHAPTER 5
PETITIONS FOR RULE MAKING

5.1(17A) Adoption by reference

CHAPTER 6
DECLARATORY RULINGS

6.1(17A) Adoption by reference

CHAPTER 7
RULES OF PRACTICE IN CONTESTED CASES

7.1(17A) Adoption by reference

CHAPTER 8
CONTRACTS FOR PUBLIC IMPROVEMENTS AND PROFESSIONAL SERVICES

8.1(17A) Adoption by reference

CHAPTER 9
STATE MIGRATORY WATERFOWL, TROUT AND HABITAT STAMP DESIGN CONTESTS

9.1(483A,484A) Design contests
9.2(483A,484A) Selection of promoter
9.3(483A,484A) Stamp design—related proceeds

9.4(483A,484A) Design
9.5(483A,484A) Commissioned design
9.6(483A,484A) Financial records
9.7(483A,484A) Title to property

CHAPTER 10
FORFEITED PROPERTY

10.1(809) Purpose
10.2(809) Definitions
10.3(809) Jurisdiction
10.4(809) Supervisor approval
10.5(809) Disposition of general property
10.6(809) Disposition of weapons
10.7(809) Property destroyed
10.8(809) Disposition of furs

CHAPTER 11
WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

11.1(17A) Adoption by reference
11.2(17A) Report to commission

CHAPTER 12
CONSERVATION EDUCATION

12.1(455A) Purpose
12.2(455A) Conservation education program policy
12.3(455A) Conservation education program board
12.4(455A) Definitions
12.5(455A) Eligibility for funds
12.6(455A) Grant applications, general procedures
12.7(455A) Conflict of interest
12.8(455A) Criteria
12.9(455A) Grantee responsibilities
12.10(455A) Board review and approval
12.11(455A) Waivers of retroactivity
12.12(455A) Penalties
12.13(455A) Remedy
12.14(455A) Termination for convenience
12.15(455A) Termination for cause
12.16(455A) Responsibility of grantee at termination
12.17(455A) Appeals

CHAPTER 13
PERMITS AND EASEMENTS FOR CONSTRUCTION AND
OTHER ACTIVITIES ON PUBLIC LANDS AND WATERS

13.1(461A) Purpose
13.2(461A) Definitions
13.3(461A) Permit required
13.4(461A) Application
13.5(461A) Permit issued or denied
13.6(461A) Additional information or analysis required
13.7(461A) Leases and easements
13.8(461A) Appeals
13.9(461A) Unauthorized construction

TITLE II
LICENSES, PERMITS AND CONCESSION CONTRACTS

CHAPTER 14
CONCESSIONS

14.1(461A) Definitions
14.2(461A) Advertising or notice procedure
14.3(461A) Bidding process
14.4(461A) Selection of a concessionaire
14.5(461A) Concession contract—general
14.6(461A) Dispute resolution
14.7(461A) Suspension or termination for cause
14.8(461A) Severability

CHAPTER 15
GENERAL LICENSE REGULATIONS

15.1(483A) Hunter safety and ethics education program
15.2(483A) License depositaries
15.3(483A) Lost or destroyed license blanks
15.4(483A) Fishing license exemption for patients of substance abuse facilities
15.5(481A) Authorization to use a crossbow for deer and turkey hunting during the bow season by handicapped individuals
15.6(481A) Multiple offenders—revocation and suspension of hunting, fishing, and trapping privileges from those persons who are determined to be multiple offenders
15.7(483A) Free hunting and fishing license for low-income persons 65 years of age and older, or low-income persons who are permanently disabled
15.8(483A) Free lifetime fishing license for persons who have severe physical or mental disabilities
15.9(483A) Volunteer bow and fur harvester education instructors, snowmobile and all-terrain vehicle (ATV) safety instructors, boating safety instructors and hunter education instructors
15.10(483A) Transportation tags for military personnel on leave from active duty
15.11(483A) Refunds or changes for special deer and turkey permits and general licenses
15.12(483A) Electronic license sales
15.13(456A) Wildlife violator compact

CHAPTER 16
DOCKS AND OTHER STRUCTURES ON PUBLIC WATERS

16.1(461A,462A) Definitions

DIVISION I
PRIVATE, COMMERCIAL AND PUBLIC DOCKS

16.2(461A,462A) Scope of division and classes of permits
16.3(461A,462A) Standard requirements for all docks
16.4(461A,462A) Class I permits for standard private docks
16.5(461A,462A) Class I permits for docks permitted by Corps of Engineers
16.6(461A,462A) Class II permits for docks authorized by cities and counties that own or otherwise control shoreline property
16.7(461A,462A) Class III permits for nonstandard private docks
16.8(461A,462A) Class IV permits for commercial docks
16.9(461A,462A) Exceptions for renewal of Class III and Class IV permits for existing docks
16.10(461A,462A) Exceptions to Class III and Class IV permits for new structures
16.11 Reserved

16.12(461A,462A) Initial decision and right of appeal
16.13(461A,462A) Application forms and administrative fees
16.14 to 16.16 Reserved
16.17(461A,462A) Duration and transferability of permits; refund of application fees; suspension, modification, or revocation of permits; complaint investigation; property line location
16.18(461A,462A) Exemptions from winter removal requirement
16.19(461A,462A) General conditions of all dock permits
16.20(461A,462A) Permit criteria for rafts, platforms, or other structures
16.21 to 16.24 Reserved

DIVISION II
DOCK MANAGEMENT AREAS

16.25(461A) Designation or modification of dock management areas
16.26(461A) Procedures and policies for dock site permits and hoist or slip assignments in dock management areas
16.27(461A) Standard requirements for dock management area docks
16.28(461A) Dock management area permit restrictions and conditions
16.29(461A) Fees for docks in dock management areas
16.30(461A) Suspension, modification or revocation of dock management area permits
16.31(461A) Persons affected by DMA permit—hearing request

CHAPTER 17
BARGE FLEETING REGULATIONS

17.1(461A) Purpose
17.2(461A) Policy
17.3(461A) Applicability
17.4(461A) Definitions
17.5(461A) Barge fleeting leases
17.6(461A) Restricted areas
17.7(461A) Prohibited areas
17.8(461A) Riparian rights
17.9(461A) Standards
17.10(461A) Application
17.11(461A) Application review and approval
17.12(461A) Lease fee
17.13(461A) Renewals
17.14(461A) Disputes concerning leases
17.15(461A) Lease revocation
17.16(461A) Nonuse

CHAPTER 18
RENTAL FEE SCHEDULE FOR STATE-OWNED PROPERTY, RIVERBED, LAKEBED, AND WATERFRONT LANDS

18.1(461A) General
18.2(461A) Table 1—Areas designated for industrial or commercial use by the natural resource commission
18.3(461A) Table 2—Areas designated for noncommercial use or use by nonprofit organizations
18.4(461A) Other fees

CHAPTER 19
SAND AND GRAVEL PERMITS

19.1(461A) Purpose
19.2(461A) Definitions
19.3(461A) Permit applications
19.4(461A) Permit conditions and operating procedures

CHAPTER 20
MANUFACTURER'S CERTIFICATE OF ORIGIN

20.1(462A) Definitions
20.2(462A) Applicability
20.3(462A) Certificate of origin—content
20.4(462A) Procedure—manufacturer
20.5(462A) Procedure—dealer
20.6(462A) Procedure—purchaser
20.7(462A) Procedure—county recorder
20.8(462A) Vessel titling

TITLE III
ASSISTANCE PROGRAMS

CHAPTER 21
AGRICULTURAL LEASE PROGRAM

21.1(456A) Purpose
21.2(456A) Definitions
21.3(456A) Agricultural lease policy
21.4(456A) Lease procedures

CHAPTER 22
WILDLIFE HABITAT ON PRIVATE LANDS PROMOTION PROGRAM

22.1(456A,483A) Purpose
22.2(456A,483A) Authority
22.3(456A,483A) Project scope
22.4(456A,483A) Availability of funds
22.5(483A) Winter habitat areas
22.6(456A,483A) Shelterbelts
22.7(456A,483A) Pheasant and quail restoration practices
22.8(456A,483A) Cost reimbursement
22.9(456A,483A) Wildlife habitat enhancement on public and private lands

CHAPTER 23
WILDLIFE HABITAT PROMOTION WITH LOCAL ENTITIES PROGRAM

23.1(483A) Purpose and definitions
23.2(483A) Availability of funds
23.3(483A) Eligibility
23.4(483A) Project limitations
23.5(483A) Eligibility for cost-sharing assistance
23.6(483A) Application for assistance
23.7(483A) Project review and selection
23.8(483A) Commission review
23.9(483A) Grant amendments
23.10(483A) Timely commencement of projects
23.11(483A) Project period
23.12(483A) Payments

23.13(483A) Record keeping and retention
23.14(483A) Penalties

CHAPTER 24
BLUFFLANDS PROTECTION PROGRAM AND REVOLVING LOAN FUND

24.1(161A) Purpose
24.2(161A) Allocation of funds
24.3(161A) Definitions
24.4(161A) Types of acquisitions
24.5(161A) Application for loans
24.6(161A) Approval of loan applications
24.7(161A) Interest and other terms of loan agreements
24.8(161A) Eligible expenditures with loan funds
24.9(161A) Custody and management of land during loan term
24.10(161A) Loans not to exceed appraised value

CHAPTER 25
CERTIFICATION OF LAND AS NATIVE PRAIRIE OR WILDLIFE HABITAT

25.1(427) Purpose
25.2(427) Definitions
25.3(427) Restrictions
25.4(427) Maintenance
25.5(427) Certification
25.6(427) Application for exemption
25.7(427) Decertification

CHAPTER 26
RELOCATION ASSISTANCE

26.1(316) Definitions
26.2(316) Actual reasonable moving costs and related expenses
26.3(316) Replacement housing payments for homeowners
26.4(316) Replacement housing payments for tenants and certain others
26.5(316) Notice of relocation assistance advisory service
26.6(316) Preconstruction project certificate
26.7(316) Record of payment determinations and claims for benefits paid
26.8(316) Last resort housing

CHAPTER 27
LANDS AND WATERS CONSERVATION FUND PROGRAM

27.1(456A) Purpose
27.2(456A) Apportionment distribution
27.3(456A) Eligibility requirements
27.4(456A) Assistance ceiling
27.5(456A) Grant application submission
27.6(456A) Project review and selection
27.7(456A) Public participation
27.8(456A) Commission review
27.9(456A) Federal review
27.10(456A) Grant amendments
27.11(456A) Timely commencement of projects
27.12(456A) Project period
27.13(456A) Reimbursements

27.14(456A) Ineligible items
27.15(456A) Record keeping and retention

CHAPTER 28
SNOWMOBILE AND ALL-TERRAIN VEHICLE REGISTRATION
REVENUE COST-SHARE PROGRAM

28.1(321G) Definitions
28.2(321G) Purpose and intent
28.3(321G) Distribution of funds
28.4(321G) Application procedures
28.5(321G) Review and selection committees
28.6(321G) Director's review of approved projects
28.7(321G) Project selection criteria
28.8(321G) Eligibility of projects
28.9(321G) Use of funded items
28.10(321G) Disposal of equipment, facilities or property
28.11(321G) Record keeping
28.12(321G) Sponsors bonded
28.13(321G) Items eligible for funding specific to the all-terrain vehicle program
28.14(321G) Items eligible for funding specific to the snowmobile program
28.15(321G) Competitive bids
28.16(321G) Prepayment for certain anticipated costs
28.17(321G) Expense documentation, balance payment or reimbursement
28.18(321G) Use of funds

CHAPTER 29
LOCAL RECREATION INFRASTRUCTURE GRANTS PROGRAM

29.1(8,77GA,ch1219) Purpose
29.2(8,77GA,ch1219) Definitions
29.3(8,77GA,ch1219) Eligibility requirements
29.4(8,77GA,ch1219) Assistance ceiling and cost share
29.5(8,77GA,ch1219) Minimum grant amount
29.6(8,77GA,ch1219) Grant application submission
29.7(8,77GA,ch1219) Project review and selection
29.8(8,77GA,ch1219) Rating system not used
29.9(8,77GA,ch1219) Applications not approved for funding
29.10(8,77GA,ch1219) Commission review
29.11(8,77GA,ch1219) Grant amendments
29.12(8,77GA,ch1219) Timely commencement of projects
29.13(8,77GA,ch1219) Payments
29.14(8,77GA,ch1219) Record keeping and retention
29.15(8,77GA,ch1219) Eligible projects
29.16(8,77GA,ch1219) Project life and recovery of funds
29.17(8,77GA,ch1219) Unlawful use of funds
29.18(8,77GA,ch1219) Remedy
29.19(8,77GA,ch1219) Ineligibility

CHAPTER 30
WATERS COST-SHARE AND GRANT PROGRAMS

DIVISION I
WATER RECREATION ACCESS COST-SHARE PROGRAM

30.1(452A) Title and purpose
30.2(452A) Availability of funds

30.3(452A) Eligibility of development projects
30.4(452A) Eligibility of acquisition projects
30.5(452A) Projects not eligible
30.6(452A) Waiver of retroactivity
30.7(452A) Establishing project priorities
30.8(452A) Application procedures
30.9(452A) Cost-sharing rates
30.10(452A) Joint sponsorship
30.11(452A) Control of project site
30.12(452A) Project agreements
30.13(452A) Reimbursement procedures
30.14(77GA,SF2381) Implementation of pilot program for state and local cooperative lake rehabilitation
30.15 to 30.50 Reserved

DIVISION II
WATER TRAILS DEVELOPMENT PROGRAM AND LOW-HEAD DAM PUBLIC HAZARD PROGRAM

30.51(455A,461A,462A) Definitions
30.52(455A,461A,462A) Purpose and intent
30.53(455A,461A,462A) Program descriptions
30.54(455A,461A,462A) Announcement of funding opportunity
30.55(455A,461A,462A) Grant requirements
30.56(455A,461A,462A) Application procedures
30.57(455A,461A,462A) Proposal evaluation
30.58(455A,461A,462A) Sponsor eligibility
30.59(455A,461A,462A) Project eligibility
30.60(455A,461A,462A) Cost-share requirements
30.61(455A,461A,462A) Evaluation criteria
30.62(455A,461A,462A) Disbursement of awards
30.63(455A,461A,462A) Water trails advisory committee

CHAPTER 31
PUBLICLY OWNED LAKES PROGRAM

31.1(456A) Purpose
31.2(456A) Definitions
31.3(456A) Priority of watersheds
31.4(456A) Application
31.5(456A) Application review
31.6(456A) Commission approvals

CHAPTER 32
PRIVATE OPEN SPACE LANDS

32.1(9H) Applicability
32.2(9H) Definition

CHAPTER 33
RESOURCE ENHANCEMENT AND PROTECTION PROGRAM:
COUNTY, CITY AND PRIVATE OPEN SPACES GRANT PROGRAMS

Part 1
GENERAL PROVISIONS

33.1(455A) Purpose
33.2(455A) Resource enhancement policy
33.3(455A) Definitions
33.4(455A) Restrictions

33.5(455A) Grant applications, general procedures
33.6(455A) Appraisals
33.7(455A) Groundwater hazard statements
33.8(455A) Rating systems not used
33.9(455A) Applications not selected for grants
33.10(455A) Similar development projects
33.11(455A) Commission review and approval
33.12(455A) Timely commencement and completion of projects
33.13(455A) Waivers of retroactivity
33.14(455A) Project amendments
33.15(455A) Payments
33.16(455A) Record keeping and retention
33.17(455A) Penalties
33.18 Reserved
33.19(455A) Property tax reimbursement
33.20(455A) Public hearing
33.21(455A) Conflict of interest
33.22(455A) Public communications
33.23 to 33.29 Reserved

Part 2
COUNTY GRANTS

33.30(455A) County conservation account
33.31 to 33.39 Reserved

Part 3
CITY GRANTS

33.40(455A) Competitive grants to cities
33.41 to 33.49 Reserved

Part 4
PRIVATE GRANTS

33.50(455A) Private cost-sharing program

CHAPTER 34
COMMUNITY FORESTRY
GRANT PROGRAM (CFGP)

34.1(461A) Purpose
34.2(461A) Definitions
34.3(461A) Availability of funds
34.4(461A) Eligibility of forestry development projects
34.5(461A) Eligibility of community tree planting projects
34.6(461A) Projects not eligible
34.7(461A) Eligible applicants
34.8(461A) Establishing project priorities
34.9(461A) Application procedures
34.10(461A) Requirements for funding
34.11(461A) Project agreements
34.12(461A) Reimbursement procedures

CHAPTER 35
FISH HABITAT PROMOTION FOR COUNTY CONSERVATION BOARDS

35.1(483A) Purpose and definitions
35.2(483A) Availability of funds
35.3(483A) Program eligibility

35.4(483A) Eligibility for cost-sharing assistance
35.5(483A) Application for assistance
35.6(483A) Project review and selection
35.7(483A) Commission review
35.8(483A) Grant amendments
35.9(483A) Timely commencement of projects
35.10(483A) Project period
35.11(483A) Payments
35.12(483A) Record keeping and retention
35.13(483A) Penalties

TITLE IV
RECREATIONAL VESSEL AND VEHICLE REGISTRATION AND SAFETY

CHAPTER 36
GREEN VALLEY LAKE SPECIAL WATER ACTIVITY RULES

36.1(462A) General
36.2(462A) Inboard boats
36.3(462A) Racing craft
36.4(462A) Wake
36.5(462A) Speed
36.6(462A) Hours
36.7(462A) Ski zone
36.8(462A) Traffic pattern
36.9(462A) Designated activities in ski zone
36.10(462A) Designated areas
36.11(462A) Traffic
36.12(462A) Lifesaving device
36.13(462A) Speed
36.14(462A) Distance from shore
36.15(462A) Horsepower limitation

CHAPTER 37
BOATING SAFETY EQUIPMENT

37.1(462A) Fire extinguishers
37.2(462A) Flame arrester required
37.3 to 37.5 Reserved
37.6(462A) Lights on vessels
37.7(462A) Lighting requirements for sailing vessels
37.8(462A) Sailing vessels with auxiliary power
37.9 to 37.12 Reserved
37.13(462A) Buoyant safety equipment

CHAPTER 38
BOAT REGISTRATION AND NUMBERING

38.1(462A) Emblem placed
38.2 to 38.5 Reserved
38.6(462A) Procedure for application for boat registration number—content
38.7 to 38.9 Reserved
38.10(462A) Information on certificate
38.11(462A) Registration applied for card
38.12(462A) Vessels in storage
38.13 and 38.14 Reserved

38.15(462A) Numbering pattern to be used
38.16 to 38.18 Reserved
38.19(462A) Display of number on vessel, as to size, block type and contrasting color
38.20(462A) Special certificates for boat dealers or manufacturers
38.21(462A) Boat dealer's annual report of vessels with expired registrations
38.22 to 38.24 Reserved
38.25(462A) Number designating passenger capacity
38.26(462A) Monthly reports by county recorders
38.27 to 38.29 Reserved
38.30(462A) Boats for hire

CHAPTER 39
BOATING PASSENGER CAPACITY

39.1(462A) U.S. Coast Guard capacity rating
39.2(462A) Vessels assigned a capacity rating by the manufacturer
39.3(462A) Vessels not containing capacity rating information
39.4(462A) Incorrect registration

CHAPTER 40
BOATING SPEED AND DISTANCE ZONING

40.1(462A) Restricted areas
40.2(462A) Uniform buoy system
40.3(462A) Commission approval
40.4(462A) Right for aggrieved party to appeal
40.5(462A) Rathbun Lake, Appanoose County—zoned areas
40.6(462A) Red Rock Lake, Marion County—zoned areas
40.7(462A) Coralville Lake, Johnson County—zoned areas
40.8(462A) Saylorville Lake, Polk County—zoned areas
40.9(462A) Lake Odessa in Louisa County
40.10(462A) Mississippi River lock and dam safety zone
40.11(462A) Joyce Slough Area
40.12(462A) Swan Slough, Camanche, Iowa
40.13(462A) Massey Slough
40.14(462A) Black Hawk County waters
40.15(462A) Mitchell County waters
40.16(462A) Maquoketa River
40.17(462A) Zoning of off-channel waters of the Wapsipinicon River in Pinicon Ridge Park in Linn County
40.18(462A) Speed restrictions on Lake Manawa
40.19(462A) Zoning of Little Wall Lake
40.20(462A) Lake Icaria, Adams County—watercraft use
40.21(462A) Zoning of the Des Moines River
40.22(462A) Upper Gar Lake, Dickinson County
40.23(462A) Zoning of the Mississippi River, Guttenberg river mile 616, Clayton County
40.24(462A) Mt. Ayr City Lake (Loch Ayr)
40.25(462A) Iowa River in Iowa City, Johnson County
40.26(462A) Zoning of the Mississippi River, Dubuque, Dubuque County
40.27(462A) Zoning Harpers Slough, Harpers Ferry, Allamakee County
40.28(462A) Black Hawk Lake, Sac County—zoned areas
40.29(462A) Speed and other restrictions on Brown's Lake, Woodbury County
40.30(462A) Speed and other restrictions on Snyder Bend Lake, Woodbury County
40.31(462A) Speed restrictions on East Okoboji and West Okoboji Lakes in Dickinson County

40.32(462A) Spirit Lake, Dickinson County—zoned areas
40.33(462A) Speed restrictions on the Mississippi River, Jackson County, at Spruce Creek County Park
40.34(462A) Speed restrictions on the Mississippi River, Jackson County, at the city of Sabula
40.35(462A) Speed restrictions on the Greene Impoundment of the Shell Rock River
40.36(462A) Zoning of the Iowa River, Iowa Falls, Hardin County
40.37(462A) Zoning of Crystal Lake
40.38(462A) Five Island Lake, Palo Alto County
40.39(462A) Lost Island Lake, Palo Alto and Clay Counties
40.40(462A) Ingham Lake, Emmet County
40.41(462A) Storm Lake, Buena Vista County
40.42(462A) Raccoon River Regional Park Lake, Polk County
40.43(462A) Zoning of the Mississippi River, Bellevue, Jackson County
40.44(462A) Three Mile Lake, Union County—watercraft use
40.45(462A) Zoning of the Cedar River
40.46(462A) Zoning of Carter Lake, Pottawattamie County
40.47(462A) Zoning of the Mississippi River, McGregor, Clayton County
40.48(462A) Zoning of the Mississippi River, Marquette, Clayton County
40.49(462A) Zoning of Green Island, Jackson County
40.50(462A) Mooring of vessels on riparian property of the state of Iowa
40.51(462A) Little River Lake, Decatur County
40.52(462A) Zoning of the Mississippi River, Johnson Slough, Clayton County
40.53(462A) Zoning of the Mississippi River, Mud Lake, Dubuque County
40.54(462A) Nighttime speed limit, Dickinson County
40.55(462A) Zoning of Clear Lake, Cerro Gordo County
40.56 Reserved
40.57(462A) Zoning of Catfish Creek, Mines of Spain State Recreation Area, Dubuque County
40.58(462A) Zoning of Lake Cornelia, Wright County

CHAPTER 41
BOATING NAVIGATION AIDS

41.1(462A) Definitions
41.2(462A) Waterway markers
41.3(462A) Authority to place markers
41.4(462A) Maintenance of waterway markers
41.5 and 41.6 Reserved
41.7(462A) Display of waterway markers
41.8(462A) Specifications for waterway markers
41.9(462A) Waterway marking devices
41.10(462A) The diver's flag

CHAPTER 42
BOATING ACCIDENT REPORTS

42.1(462A) Accident report
42.2(462A) Procedure
42.3(462A) Contents

CHAPTER 43
MOTORBOAT NOISE

43.1(462A) Definitions
43.2(462A) Sound level limitation
43.3(462A) Serviceability

CHAPTER 44
BOATING, SPECIAL EVENTS

44.1(462A) Registration exemption
44.2(462A) Sponsoring organizations

CHAPTER 45
BOAT MOTOR REGULATIONS

45.1(462A) Horsepower rating
45.2(462A) Alteration of horsepower rating
45.3(462A) Propulsion mechanism not in use
45.4(462A) Horsepower limitations on artificial lakes
45.5(462A) Artificial marshes

CHAPTER 46
ALL-TERRAIN VEHICLE AND SNOWMOBILE BONDING

46.1(321G) Bond required before issuance of title or registration

CHAPTER 47
VESSEL BONDING

47.1(462A) Bond required before issuance of title or registration

CHAPTER 48
INSPECTION OF PERMANENTLY MOORED VESSELS

48.1(462A) Purpose
48.2(462A) Definitions
48.3(462A) Inspection requirements
48.4(462A) Inspectors
48.5(462A) Statewide inspection contract
48.6(462A) Submission
48.7(462A) Notification to the commission

CHAPTER 49
OPERATION OF MOTOR VEHICLES IN MEANDERED
STREAMS, NAVIGABLE STREAMS AND TROUT STREAMS

49.1(462A) Purpose and intent
49.2(462A) Definitions
49.3(462A) Stream identification process
49.4(462A) Motor vehicle prohibition in meandered streams, trout streams and navigable streams
49.5(462A) Motor vehicle prohibition in meandered streams

CHAPTER 50
ALL-TERRAIN VEHICLE AND SNOWMOBILE
ACCIDENT REPORTS, TITLING, REGISTRATION AND NUMBERING

50.1(321G) Accident report
50.2(321G) Registration and titling—required forms
50.3(321G) All-terrain vehicle and snowmobile safety-education classes
50.4 Reserved
50.5(321G) Registration applied for card and proof of purchase
50.6(321G) Placement in storage
50.7(321G) Application for and placement of new or replacement vehicle identification number (VIN)
50.8(321G) Identification number
50.9(321G) Procedure for placement of registration decal

50.10(321G) Special certificates for dealers or manufacturers
50.11(321G) Dealer's annual report of expired registrations
50.12(321G) Monthly all-terrain vehicle reports by county recorders
50.13(321G) Monthly snowmobile vehicle reports by county recorders

TITLE V
MANAGEMENT AREAS AND PRACTICES

CHAPTER 51
GAME MANAGEMENT AREAS

51.1(481A) Definitions
51.2(481A) Jurisdiction
51.3(481A) Use of firearms
51.4(481A) Use of horses on game management areas
51.5(481A) Dogs prohibited—exception
51.6(481A) Use of blinds and decoys on game management areas
51.7(481A) Trapping on game management areas
51.8(481A) Motor vehicle restrictions
51.9(481A) Employees exempt
51.10(481A) Use of nontoxic shot on wildlife areas
51.11(481A) Rock climbing and rappelling
51.12(481A) Camping restrictions

CHAPTER 52
WILDLIFE REFUGES

52.1(481A) Established

CHAPTER 53
CONTROLLED HUNTING AREAS

53.1(481A) Definitions
53.2 Reserved
53.3(481A) Waterfowl hunting on Lake Odessa

CHAPTER 54
RESTRICTION ON REMOVAL OF PLANT LIFE

54.1(461A) Mushrooms and asparagus
54.2(461A) Fruit
54.3(461A) American ginseng
54.4(461A) Trees

CHAPTER 55
NONPERMANENT STRUCTURES

55.1(461A) Ice fishing shelters

CHAPTERS 56 to 60
Reserved

TITLE VI
PARKS AND RECREATION AREAS

CHAPTER 61
STATE PARKS AND RECREATION AREAS

61.1(461A) Applicability
61.2(461A) Definitions
61.3(461A) Establishment of centralized reservation system operating procedures and policies
61.4(461A) Camping

61.5(461A) Rental facilities
61.6(461A) Vessel storage fees
61.7(461A) Restrictions—area and use
61.8(461A) Certain conditions of public use applicable to specific parks and recreation areas
61.9(461A) Mines of Spain hunting, trapping and firearms use
61.10(461A) After-hours fishing—exception to closing time
61.11(461A) Designated areas for after-hours fishing
61.12(461A) Vessels prohibited
61.13(461A) Severability
61.14(461A) Restore the outdoors program
61.15(461A,463C) Honey Creek Resort State Park

CHAPTER 62
STATE FOREST CAMPING

62.1(461A) Applicability
62.2(461A) Definitions
62.3(461A) Camping areas established and marked
62.4(461A) Campground reservations
62.5(461A) Camping fees and registration
62.6(461A) Camping restrictions
62.7(461A) Camping time limit
62.8(461A) Camping refused
62.9(461A) Firearms use prohibited
62.10(461A) Hours
62.11(461A) Horses and pets
62.12(461A) Noise

CHAPTER 63
KEG BEER RULES

63.1(111,123) Purpose
63.2(111,123) Applicability
63.3(111,123) Definitions
63.4(111,123) Prohibited areas
63.5(111,123) Procedure
63.6(461A,123) Deposit disposition
63.7(111,123) Responsibility agreement

CHAPTER 64
METAL DETECTORS USE IN STATE AREAS

64.1(461A) Definitions
64.2(461A) Use areas
64.3(461A) Archaeological/scientific studies
64.4(461A) Found items
64.5(461A) Lost item search by owner
64.6(461A) Tools used
64.7(461A) Digging limitations and restoration
64.8(461A) Disposal of litter

CHAPTER 65
FIREWORKS DISPLAYS—
STATE PARKS AND RECREATION AREAS

65.1(461A) Entities eligible for permits
65.2(461A) Application procedure
65.3(461A) Fireworks display procedures

CHAPTER 66
SAYLORVILLE MULTIUSE TRAIL

66.1(461A,481A) Applicability
66.2(456A,481A) Wildlife refuge
66.3(481A) Hunting and trapping restrictions
66.4(461A) Area use restrictions

CHAPTER 67
DEVELOPMENT AND MANAGEMENT OF RECREATION TRAILS
ON STATE FORESTS, PARKS, PRESERVES AND RECREATION AREAS

67.1(456A,461A) Applicability
67.2(456A,461A) Definitions
67.3(456A,461A) Purpose
67.4(456A,461A) Establishment of trails
67.5(456A,461A) Designation of recreation trails
67.6(456A,461A) Guidelines for trail location
67.7(456A,461A) Control of trail use
67.8(456A,461A) Use of designated trails

CHAPTERS 68 to 70
Reserved

TITLE VII
FORESTRY

CHAPTER 71
NURSERY STOCK SALE TO THE PUBLIC

71.1(456A,461A) Purpose
71.2(456A,461A) Procedures
71.3(456A,461A) Nursery stock prices

CHAPTER 72
TIMBER BUYERS

72.1(456A) Definitions
72.2(456A) Applicability of rules
72.3(456A) Forms

CHAPTER 73
FOREST AND FRUIT-TREE RESERVATIONS

73.1(427C,456A) Criteria for establishing and maintaining forest and fruit-tree reservations
73.2(427C,456A) County assessor's annual report on forest and fruit-tree reservations to the department of natural resources

CHAPTER 74
FOREST LAND ENHANCEMENT PROGRAM (FLEP)

74.1(461A) Purpose
74.2(461A) Definitions
74.3(461A) Project scope

74.4(461A) Availability of funds
74.5(461A) Forest land enhancement program areas
74.6(461A) Cost reimbursement

CHAPTER 75
Reserved

TITLE VIII
SEASONS, LIMITS, METHODS OF TAKE

CHAPTER 76
UNPROTECTED NONGAME

76.1(481A) Species

CHAPTER 77
ENDANGERED AND THREATENED PLANT AND ANIMAL SPECIES

77.1(481B) Definitions
77.2(481B) Endangered, threatened, and special concern animals
77.3(481B) Endangered, threatened, and special concern plants
77.4(481B) Exemptions

CHAPTER 78
GINSENG HARVESTING AND SALE

78.1(456A) Definitions
78.2(456A) Season for legal harvest
78.3(456A) Ginseng permits
78.4(456A) Dealer's records
78.5(456A) Certification of shipments
78.6(456A) Inspection
78.7(456A) Restrictions

CHAPTER 79
FISH STOCKING PROCEDURES AND FEES FOR PRIVATE WATERS

79.1(481A) Purpose
79.2(481A) Application procedures
79.3(481A) Fish stocks
79.4(481A) Fees

CHAPTER 80
SALVAGE OF FISH AND GAME

80.1(481A) Salvage
80.2(481A) Game killed by motor vehicle
80.3(481A) Confiscated fish or game

CHAPTER 81
FISHING REGULATIONS

81.1(481A) Seasons, territories, daily bag limits, possession limits, and length limits
81.2(481A) Exceptions to seasons and limits, set in 81.1(481A)

CHAPTER 82
COMMERCIAL FISHING

INLAND WATERS

82.1(482) Contract policy

MISSISSIPPI AND MISSOURI RIVERS

82.2(482) Commercial taking

CHAPTER 83
SCUBA AND SKIN SPEARING OF ROUGH FISH

83.1(481A) When permitted
83.2(481A) Prohibited areas
83.3(481A) Permitted equipment
83.4(481A) Prohibited equipment
83.5(481A) Diver's flag
83.6(481A) Employees exempt

CHAPTER 84
PROMISCUOUS FISHING

84.1(481A) General

CHAPTER 85
TROTLINES

85.1(481A) Trotlines where permitted

CHAPTER 86
TURTLES

86.1(481A,482) Taking

CHAPTER 87
MUSSEL REGULATIONS

87.1(481A) Seasons, areas, methods, species, limits

CHAPTER 88
FISHING TOURNAMENTS

88.1(462A,481A) Definition
88.2(462A,481A) Permit required
88.3(462A,481A) Application procedures
88.4(462A,481A) Permit conditions

CHAPTER 89
AQUACULTURE

89.1(481A) Approved aquaculture species
89.2(481A) Importation permit
89.3(481A) Disease-free certification

CHAPTER 90
AQUATIC INVASIVE SPECIES

90.1(456A) Definitions
90.2(456A) Aquatic invasive species
90.3(456A) Restrictions
90.4(456A) Infested waters

CHAPTER 91
WATERFOWL AND COOT HUNTING SEASONS

91.1(481A) Duck hunting
91.2(481A) Coots (split season)
91.3(481A) Goose hunting
91.4(481A) Closed areas
91.5(481A) Canada goose hunting within closed areas
91.6(481A) Youth waterfowl hunt

CHAPTER 92
MIGRATORY GAME BIRDS

92.1(481A) General
92.2(481A) Duck stamp
92.3(481A) Hunting methods
92.4(481A) Restrictions applicable to possession, tagging, and record-keeping requirements
92.5(481A) Transportation within the state or between states
92.6(481A) Wounded, live migratory game birds
92.7(481A) Harvest information program (HIP)

CHAPTER 93
COMMERCIAL USE OF CAPTIVE-REARED WATERFOWL

93.1(481A) General
93.2(481A) Required markings
93.3(481A) Definitions
93.4(484B) Marked for shooting
93.5(481A) Commercial sale of captive-reared waterfowl by a taxidermist

CHAPTER 94
NONRESIDENT DEER HUNTING

94.1(483A) Licenses
94.2(483A) Season dates
94.3(483A) Shooting hours
94.4(481A) Limits
94.5(483A) Zones open to hunting
94.6(483A) License quotas
94.7(483A) Method of take
94.8(483A) Application procedure
94.9(483A) Transportation tag
94.10(481A) Deer hunting season for severely disabled persons
94.11(481A) Harvest reporting

CHAPTER 95
GAME HARVEST REPORTING AND LANDOWNER-TENANT REGISTRATION

95.1(481A) Harvest reporting system
95.2(481A) Verifying eligibility for free landowner or tenant licenses

CHAPTER 96
PHEASANT, QUAIL AND GRAY (HUNGARIAN)
PARTRIDGE HUNTING SEASONS

96.1(481A) Pheasant season
96.2(481A) Gray (Hungarian) partridge season
96.3(481A) Quail season

CHAPTER 97
COMMON SNIPE, VIRGINIA RAIL AND SORA, WOODCOCK AND RUFFED GROUSE HUNTING SEASONS

97.1(481A) Common snipe season
97.2(481A) Virginia rail and sora season
97.3(481A) Woodcock season
97.4(481A) Ruffed grouse season

CHAPTER 98
WILD TURKEY SPRING HUNTING

RESIDENT WILD TURKEY SPRING HUNTING

98.1(483A) General
98.2(483A) Means and method of take
98.3(483A) Procedures to obtain licenses
98.4(483A) Transportation tag
98.5(483A) Eligibility for free landowner/tenant turkey licenses
98.6(483A) Youth spring wild turkey hunt
98.7(481A) Harvest reporting
98.8 Reserved

NONRESIDENT WILD TURKEY SPRING HUNTING

98.9(483A) General
98.10(483A) Zones open to hunting
98.11(483A) License quotas
98.12(483A) Means and method of take
98.13(483A) Application procedure
98.14(483A) Transportation tag
98.15(481A) Harvest reporting

CHAPTER 99
WILD TURKEY FALL HUNTING BY RESIDENTS

99.1(481A) General
99.2(481A) Licenses
99.3(481A) Seasons
99.4(481A) Zones
99.5(481A) Quotas
99.6(481A) Daily, season, and possession bag limits
99.7(481A) Shooting hours
99.8(481A) Means and method of take
99.9(481A) Procedures to obtain licenses
99.10(481A) Transportation tag
99.11(481A) Eligibility for free landowner/tenant turkey licenses
99.12(481A) Harvest reporting

CHAPTER 100
CROW AND PIGEON REGULATIONS

100.1(481A) Crow season
100.2(481A) Pigeons

CHAPTER 101
FALCONRY REGULATIONS

101.1(481A) Falconry regulations
101.2(481A) Facilities and equipment

101.3(481A) Taking and possession provision
101.4(481A) Annual reports
101.5(481A) Other provisions
101.6(481A) Compliance

CHAPTER 102
FALCONRY REGULATIONS FOR HUNTING GAME

102.1(481A) General
102.2(481A) Migratory bird regulations
102.3(481A) Small game
102.4(481A) Means and methods of take
102.5(481A) Exclusions

CHAPTER 103
MOBILE RADIO TRANSMITTERS

103.1(481A) Definitions
103.2(481A) Falconry
103.3(481A) Hunting dogs

CHAPTER 104
WILDLIFE IMPORTATION, TRANSPORTATION AND DISEASE MONITORING

104.1(481A) Definitions
104.2(481A) Chronic wasting disease in captive cervids
104.3(481A) Chronic wasting disease in captive cervids—herd monitoring program
104.4(481A) Identification of animals
104.5(481A) Supervision of the CCWDSI program
104.6(481A) Surveillance procedures
104.7(481A) Official cervid CWD tests
104.8(481A) Investigation of CWD affected animals identified through surveillance
104.9(481A) Duration of quarantine
104.10(481A) Herd plan
104.11(481A) Identification and disposal requirements
104.12(481A) Cleaning and disinfecting
104.13(481A) Methods for obtaining certified CWD cervid herd status
104.14(481A) Recertification of CWD cervid herds
104.15(481A) Movement into a certified CWD cervid herd
104.16(481A) Movement into a monitored CWD cervid herd
104.17(481A) Recognition of monitored CWD cervid herds
104.18(481A) Recognition of certified CWD cervid herds
104.19(481A) Intrastate movement requirements
104.20(481A) Import requirements
104.21(481A) Prohibited movement of cervid carcasses
104.22(481A) Inspection

CHAPTER 105
DEER POPULATION MANAGEMENT ZONES

105.1(481A) Purpose
105.2(481A) Definitions
105.3(481A) Special deer management zones
105.4(481A) State parks and recreation areas
105.5(481A) Urban deer management zones
105.6(481A) Iowa Army Ammunition Plant (IAAP) deer management zone

105.7(481A) County park deer management zones
105.8(481A) Special deer management zones on private land

CHAPTER 106
DEER HUNTING BY RESIDENTS

106.1(481A) Licenses
106.2(481A) Season dates
106.3(481A) Shooting hours
106.4(481A) Limits
106.5(481A) Areas closed to hunting
106.6(481A) Paid deer license quotas and restrictions
106.7(481A) Method of take
106.8(481A) Procedures to obtain licenses
106.9(481A) Transportation tag
106.10(481A) Youth deer and severely disabled hunts
106.11(481A) Deer depredation management
106.12(481A) Eligibility for free landowner/tenant deer licenses
106.13(481A) Harvest reporting

CHAPTER 107
RABBIT AND SQUIRREL HUNTING

107.1(481A) Cottontail rabbit season
107.2(481A) Jackrabbit season
107.3(481A) Squirrel season

CHAPTER 108
MINK, MUSKRAT, RACCOON, BADGER, OPOSSUM, WEASEL,
STRIPED SKUNK, FOX (RED AND GRAY), BEAVER, COYOTE, RIVER OTTER,
BOBCAT, GRAY (TIMBER) WOLF AND SPOTTED SKUNK SEASONS

108.1(481A) Mink, muskrat and weasel
108.2(481A) Raccoon, badger, opossum and striped skunk
108.3(481A) Red and gray fox
108.4(481A) Beaver
108.5(481A) Coyote
108.6(481A) Gray (timber) wolf and spotted skunk
108.7(481A) River otter and bobcat
108.8(481A) Accidental capture of a river otter or bobcat during a closed season
108.9(481A) Trapping restrictions

CHAPTER 109
GROUNDHOG SEASON

109.1(481A) Groundhog

CHAPTER 110
TRAPPING LIMITATIONS

110.1(481A) Public roadside limitations—snares, body-gripping, and conibear type traps
110.2(481A) Snares
110.3(481A) Body-gripping and conibear type traps
110.4(481A) Foothold and leghold traps
110.5(481A) Removal of animals from traps and snares
110.6(481A) Trap tag requirements
110.7(481A) Colony traps

CHAPTER 111
SCIENTIFIC COLLECTING AND WILDLIFE REHABILITATION

111.1(481A) Definitions
111.2(481A) Scientific collector's license
111.3(481A) Wildlife salvage permit
111.4(481A) Educational project permit
111.5(481A) Wildlife rehabilitation permit
111.6(481A) Application qualifications
111.7(481A) Evaluation committee
111.8(481A) Disposition of animals
111.9(481A) General conditions for permits

CHAPTER 112
HUNTING PRESERVES

112.1(484B) Definitions
112.2(484B) Hunting preserve operator's license
112.3(484B) Land leases required
112.4(484B) Boundary signs required
112.5(484B) Fencing required—ungulates
112.6(484B) Records and annual report
112.7(484B) Game bird transportation tags
112.8(484B) Ungulate transportation tags
112.9(484B) Processed game birds
112.10(484B) Processed ungulates
112.11(484B) Health requirements—game birds and ungulates
112.12(484B) General conditions for permits

CHAPTER 113
RESTITUTION FOR POLLUTION CAUSING INJURY TO WILD ANIMALS

113.1(481A) Applicability
113.2(481A) Definitions
113.3(481A) Liability to the state
113.4(481A) Assessment
113.5(481A) Compensation

CHAPTER 114
NUISANCE WILDLIFE CONTROL

114.1(456A) Nuisance wildlife control program
114.2(456A) Definitions
114.3(456A) Nuisance wildlife control operator's permit
114.4(456A) Application requirements
114.5(456A) Nuisance wildlife control operator's guidebook
114.6(456A) Nuisance wildlife control operator's test and interview
114.7(456A) Records and record-keeping requirements
114.8(456A) Annual activity report
114.9(456A) Permit renewal
114.10(456A) Helper
114.11(456A) Capture methods and trap tagging
114.12(456A) Endangered and threatened wildlife species
114.13(456A) Special Canada goose control permits
114.14(456A) Disposition of captured nuisance wildlife
114.15(456A) General conditions for permits

114.16(456A) Permit refusal
114.17(456A) Penalties

CHAPTER 115
WHITETAIL HUNTING PRESERVES

115.1(81GA,SF206) Definitions
115.2(81GA,SF206) Hunting preserve operator's registration
115.3(81GA,SF206) Boundary signs required
115.4(81GA,SF206) Fencing required
115.5(81GA,SF206) Records and annual report
115.6(81GA,SF206) Whitetail transportation tags
115.7(81GA,SF206) Processed whitetail
115.8(81GA,SF206) Health requirements—whitetail
115.9(81GA,SF206) Chronic wasting disease testing
115.10(81GA,SF206) Positive chronic wasting disease test results
115.11(81GA,SF206) General conditions for registration

CHAPTER 116
HELP US STOP HUNGER PROGRAM ADMINISTRATION

116.1(483A) Purpose
116.2(483A) Definitions
116.3(483A) Restrictions
116.4(483A) HUSH council
116.5(483A) Duties of the department
116.6(483A) Duties of venison distributor
116.7(483A) Meat processors
116.8(483A) Partnerships with other organizations

CHAPTER 40
BOATING SPEED AND DISTANCE ZONING
[Prior to 12/31/86, Conservation Commission[290] Ch 30]

571—40.1(462A) Restricted areas. All vessels, except authorized emergency vessels, shall be operated in compliance with, and all persons engaged in water recreation activities, shall obey restrictions with posted areas marked with a uniform waterway buoy or official signs adopted by the natural resource commission.

571—40.2(462A) Uniform buoy system. All buoys placed shall be those of the uniform waterway marking system adopted by the natural resource commission and shall be constructed, placed, and maintained in accordance with Iowa Code chapter 462A and Iowa Administrative Code 571—Chapters 40 and 41.

571—40.3(462A) Commission approval. The placement of buoys or official signs that restrict speed and distance or involve special zoning restrictions shall be approved by the natural resource commission.

571—40.4(462A) Right for aggrieved party to appeal. Any finding or establishment of areas involving special speed and distance or zoning restrictions by the natural resource commission may be appealed by aggrieved party upon written notice. A hearing thereon shall be held by the natural resource commission within 30 days thereafter.

571—40.5(462A) Rathbun Lake, Appanoose County—zoned areas.

40.5(1) Areas may be specifically designated for swimming and wading.

40.5(2) Areas may be designated restricted speed areas.

571—40.6(462A) Red Rock Lake, Marion County—zoned areas.

40.6(1) Areas may be specifically designated for swimming and wading.

40.6(2) Areas may be designated restricted speed areas.

40.6(3) Areas may be designated as “no anchoring” areas.

571—40.7(462A) Coralville Lake, Johnson County—zoned areas.

40.7(1) Areas may be specifically designated for swimming and wading.

40.7(2) Areas may be designated restricted speed areas.

571—40.8(462A) Saylorville Lake, Polk County—zoned areas.

40.8(1) Areas may be specifically designated for swimming and wading.

40.8(2) Areas may be designated restricted speed areas.

571—40.9(462A) Lake Odessa in Louisa County.

40.9(1) Areas may be designated restricted speed areas.

40.9(2) All motorboats, except authorized emergency vessels, shall be operated at no-wake speed year around, on that portion of Lake Odessa known as the Sand Run Chute, lying south of the main lake to a point 100 yards south of the Sand Run Chute boat ramp.

40.9(3) All motorboats, except authorized emergency vessels, shall be operated at no-wake speed year around, on those portions of Lake Odessa known as the lateral ditch, between the main lake and Bebee Pond, and on the channel between Yankee Chute and Beaver Pond.

571—40.10(462A) Mississippi River lock and dam safety zone. A safety zone is hereby established in Iowa waters above and below all navigation lock and dam structures on the Mississippi River between the Iowa-Minnesota border and the Iowa-Missouri border. The established zone shall be 600 feet upstream and 150 feet downstream from the roller gate or tainter gate section of the structure.

40.10(1) The safety zone does not include the area directly above and below the navigation lock structure.

40.10(2) The safety zone does not include the area directly above and below the solid fill portion of the dam and structure.

40.10(3) The safety zone shall be recognized by the state of Iowa only when plainly marked as follows:

a. Upstream signs worded—Restricted area keep 600 feet from dam.

b. Downstream signs worded—Restricted area keep 150 feet from dam.

c. Flashing red lights will be used to make the outer limits of the restricted areas.

40.10(4) No boat or vessel of any type, except authorized vessels, shall enter the established safety zones recognized by the state of Iowa as described in this rule.

571—40.11(462A) Joyce Slough Area. The Joyce Slough Area, a portion of the Mississippi River within the city of Clinton, Iowa, is hereby zoned to be a harbor area and vessels traveling therein shall not travel at speeds in excess of five miles per hour.

571—40.12(462A) Swan Slough, Camanche, Iowa. A restricted speed zone is hereby established in all or part of the main channel of Swan Slough (Mississippi River mile 510.2 to 511.3), Camanche, Iowa, as designated by buoys.

571—40.13(462A) Massey Slough. Operation of vessels in Massey Slough of the Mississippi River at Massey Station, Dubuque County, Iowa, extending from a northerly to southerly direction from the upper end to the lower end of the slough, encompassing the water in Section 14, Township 88N, Range 3E of the 5th P.M., tract number NFIA-26M.

40.13(1) All boats underway must maintain a speed of less than five miles per hour in said waters.

40.13(2) Reserved.

571—40.14(462A) Black Hawk County waters. Operation of vessels in Black Hawk County on the Cedar River and any connected backwaters shall be governed by this departmental rule as well as all applicable state laws and regulations.

40.14(1) No vessel, except authorized emergency vessels, shall be operated in marked areas at a speed greater than the limit designated by buoys, signs, or other approved uniform waterway marking devices marking the area.

40.14(2) All vessels, except authorized emergency vessels, shall be operated at a no-wake speed when within 600 feet of the Franklin Street bridge. This 600-foot zone shall be designated by buoys, signs, or other approved uniform waterway marking devices.

40.14(3) No vessel shall tow skiers, surfboard riders, or other towable devices within the zone established by 40.14(2).

571—40.15(462A) Mitchell County waters. Operation of vessels in Mitchell County on the following impounded waters:

Cedar River from Mitchell Dam, thence upriver to the County "S" bridge.

Cedar River from the St. Ansgar Mill Dam, thence upriver to the Newberg Bridge crossing Highway 105.

Cedar River from the Otranto Dam upriver to the Great Western Railway Bridge crossing the Cedar River.

The Stacyville Pool, on the Little Cedar River at Stacyville, Iowa.

40.15(1) Water recreation activities as restricted within posted areas which are marked with approved buoys shall be obeyed.

40.15(2) Reserved.

571—40.16(462A) Maquoketa River. Operation of vessels of the impoundment of the Maquoketa River in Delaware County, Iowa, extending westerly and northerly from the line between Sections 29 and 30 in Delhi Township in said county, to the line between Sections 10 and 15 in Milo Township in said county which impoundment is sometimes known and referred to as Hartwick Lake or Lake Delhi.

40.16(1) Water recreation activity restrictions shall be obeyed, including restrictions within posted areas which are marked with approved buoys.

40.16(2) No motorboat shall be operated at speeds greater than ten miles per hour at any time between the hours from one hour after sunset to one hour before sunrise.

571—40.17(462A) Zoning of off-channel waters of the Wapsipinicon River in Pinicon Ridge Park in Linn County. No motorboat shall be operated at a speed which will create a wake within the zoned area designated by regulatory buoys or signs on the off-channel waters of the Wapsipinicon River above the dam at Central City, Linn County, Iowa.

The zoned area will be the off-channel waters created in and adjacent to the developed recreation areas of the Pinicon Ridge Park on the west and south bank of the Wapsipinicon River above the dam at Central City, Linn County.

571—40.18(462A) Speed restrictions on Lake Manawa. No motorboat shall be operated at a speed greater than five miles per hour within the zoned areas 300 feet from shore around Lake Manawa in Pottawattamie County.

571—40.19(462A) Zoning of Little Wall Lake. No motorboat shall be operated at a speed which will create a wake within the zoned area designated by regulatory buoys on Little Wall Lake in Hamilton County.

The zoned area will not exceed approximately 20 acres in the northeast portion of the lake identified by a line from a point on the high-water mark approximately 296.6 feet west of the southeast corner of the southwest quarter of Section 10, Township 86 North, Range 24 West; thence northwest to the high-water mark which is 775 feet south and 319 feet west of the northeast corner of the northwest quarter of the southwest quarter of Section 10, Township 86 North, Range 24 West.

571—40.20(462A) Lake Icaria, Adams County—watercraft use. Motorboats of outboard or inboard-outdrive type shall be permitted on Lake Icaria. The following rules shall govern vessel operation on Lake Icaria in Adams County.

40.20(1) All vessels shall be operated at a no-wake speed when within 50 feet of another vessel which is not underway or is operating at a no-wake speed.

40.20(2) Zoned areas.

a. No vessel, except authorized emergency vessels, shall be permitted in areas specifically designated for swimming and wading which are plainly marked by the use of buoys or signs in accordance with 571—Chapter 41.

b. No motorboats, except authorized emergency vessels, shall be operated in marked bay areas at a speed greater than the limit designated by buoys or signs marking said bay. Said buoys or signs shall be in accordance with 571—Chapter 41.

c. No motorboats, except authorized emergency vessels, shall be operated in restricted speed areas between the nearest shore and a line designated by uniform marker buoys or signs at a speed greater than the limit designated on the buoys or signs marking the area. Such zoned areas shall be not less than 50 feet nor more than 400 feet from shore. Said buoys or signs shall be in accordance with 571—Chapter 41.

571—40.21(462A) Zoning of the Des Moines River. Vessel operation on the Des Moines River from its confluence with the Mississippi River in Lee County to the northerly meander lines of both the East and West Branches, shall be governed by this departmental rule as well as all applicable state laws and regulations.

40.21(1) No vessel, except authorized emergency vessels, shall be operated in marked areas at a speed greater than the limit designated by buoys marking said areas.

40.21(2) No vessel, except authorized emergency vessels, shall be permitted in areas specifically designated for swimming and wading which are plainly marked by the use of buoys.

571—40.22(462A) Upper Gar Lake, Dickinson County. Upper Gar Lake (5 mile per hour zone between the Henshaw Bridge at the north end of Upper Gar and south end of East Lake and the Old Sawmill Bridge at the south end of Upper Gar and the north end of Minnewashta).

571—40.23(462A) Zoning of the Mississippi River, Guttenberg river mile 616, Clayton County.

40.23(1) All vessels operated between the ice dike and Bussey Lake access shall be operated at a no-wake speed.

40.23(2) The city will designate the no-wake zone with buoys approved by the natural resource commission.

571—40.24(462A) Mt. Ayr City Lake (Loch Ayr). A motorboat shall not be operated within 100 feet of shore at a speed greater than ten miles per hour.

571—40.25(462A) Iowa River in Iowa City, Johnson County. No person shall operate any vessel towing persons on water skis, surfboards, or similar devices on the Iowa River in the area bounded by the Coralville Mill Dam and the Burlington Street Dam, except during regattas, races, marine parades, tournaments, or exhibitions authorized by the natural resource commission to be held in such area.

571—40.26(462A) Zoning of the Mississippi River, Dubuque, Dubuque County.

40.26(1) All vessels shall be limited to no more than five miles per hour in Lake Peosta Cut south and east of the Hawthorn Street municipal boat launching ramp.

40.26(2) A restricted speed zone (five miles per hour/no-wake) is established in the vicinity of Chaplain Schmitt Memorial Island in proximity to the Schmitt Island municipal launching ramp and in waters adjacent to the southerly shoreline in the area of the Dubuque Yacht Basin.

40.26(3) A restricted speed zone of five miles per hour for the northern portion of Shawondassee Slough. Marker buoys shall be placed at a point approximately 750 feet upstream from the existing speed zone.

571—40.27(462A) Zoning Harpers Slough, Harpers Ferry, Allamakee County.

40.27(1) All vessels operated in Harpers Slough between a point 200 feet above the state ramp and 200 feet out from the west shore extending downstream to a point known as Sandy Point Road Dead-End, shall operate at a no-wake speed.

40.27(2) The city of Harpers Ferry will designate the no-wake zone with buoys approved by the natural resource commission.

571—40.28(462A) Black Hawk Lake, Sac County—zoned areas.

40.28(1) No motorboat shall operate at a speed which will create a wake within the zoned area marked by the regulatory buoys. The zoned area shall be the area commonly known as Town Bay on the northwest corner of Black Hawk Lake in Sac County.

40.28(2) Areas may be specifically designated for swimming by the use of regulatory buoys.

571—40.29(462A) Speed and other restrictions on Brown's Lake, Woodbury County. All vessels shall be operated at a no-wake speed within the two zoned areas designated by buoys or other approved uniform waterway markers.

40.29(1) *Zone 1.* Zone 1 shall extend 570 yards from the boat ramp east to the regulatory buoys and 150 yards west from the boat ramp.

40.29(2) *Zone 2.* Zone 2 shall begin at the regulatory buoys located at the 24-inch steel pipe and shall extend west.

40.29(3) *Swimming.* Areas may be specifically designated for swimming by the use of regulatory buoys.

571—40.30(462A) Speed and other restrictions on Snyder Bend Lake, Woodbury County. All vessels shall be operated at a no-wake speed within the zoned area 400 yards from the boat ramp south to the regulatory sign and buoys.

Areas may be specifically designated for swimming by the use of regulatory buoys.

571—40.31(462A) Speed restrictions on East Okoboji and West Okoboji Lakes in Dickinson County. No motorboat shall be operated at a speed which will create a wake within the three zoned areas designated by regulatory buoys on East Okoboji and West Okoboji Lakes in Dickinson County.

40.31(1) Zone 1. Zone 1 shall be a line from the east side of Givens Point to the south end of Arnolds Park City Beach on West Okoboji. Also, a line 150 yards east from the north end of the railroad trestle bridge at Clair Wilson State Park south to the shoreline of East Okoboji.

40.31(2) Zone 2. Zone 2 shall be the area which is 300 feet north of the area commonly known as the Narrows on East Okoboji and 200 feet south of the area commonly known as the Narrows on East Okoboji.

40.31(3) Zone 3. Zone 3 shall be the area 50 feet east of the bridge between East Okoboji and Upper Gar on the East Okoboji side running in a northwesterly direction toward the end of the island from Gingles Point then west toward the shoreline.

40.31(4) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.31(5) The following areas are zoned 5 miles per hour on West Okoboji.

a. Zone 1. Zone 1 shall be the area commonly known as Okoboji Harbor at the northwest corner of West Okoboji.

b. Zone 2. Zone 2 shall be the area commonly known as the canals in the city of Wahpeton including Turtle Lake.

c. Zone 3. Zone 3 shall be the area commonly known as Lazy Lagoon located in the Triboji Area on West Okoboji.

d. Zone 4. Zone 4 shall be the area commonly known as Little Millers Bay. The zone shall start at Pinkies Point and extend southeasterly (160 degrees) approximately 370 yards until bisecting the southern shoreline of Little Millers Bay.

e. Zone 5. Zone 5 shall be the area commonly known as Little Emmerson Bay. The zone shall start at Breezy Point and extend southwesterly (235 degrees) approximately 330 yards until bisecting the west shoreline of Little Emmerson Bay.

571—40.32(462A) Spirit Lake, Dickinson County—zoned areas.

40.32(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.32(2) The following areas are zoned 5 miles per hour on Spirit Lake, Dickinson County:

a. Zone 1 shall be the area commonly known as Templar Park Lagoon located midlake on the west shore of Spirit Lake.

b. Reserved.

571—40.33(462A) Speed restrictions on the Mississippi River, Jackson County, at Spruce Creek County Park. No motorboat shall operate at a speed to exceed 5 miles per hour within the area designated by buoys or other approved uniform waterway markers, beginning at the entrance of Spruce Creek harbor and extending southeast 550 feet and extending east 150 feet from shore. The Jackson County conservation board will designate the speed zone with uniform waterway markers (buoys) approved by the natural resource commission.

571—40.34(462A) Speed restrictions on the Mississippi River, Jackson County, at the city of Sabula. No motorboat shall operate at a speed to exceed five miles per hour within the four zoned areas designated by buoys or other approved uniform waterway markers.

40.34(1) *Zone 1.* Zone 1 shall extend 200 feet from shore and begin at a point 250 feet upstream of the north Sabula city boat ramp and ending at a point downstream where Bank Street intersects the river bank.

40.34(2) *Zone 2.* Zone 2 shall extend 200 feet from shore and extend 100 feet upstream and 100 feet downstream from the entrance to the Island City Harbor.

40.34(3) *Zone 3.* Zone 3 shall extend 200 feet into South Sabula Lake from the county boat ramp and 100 feet to the west of the ramp and 600 feet to the east of the ramp.

40.34(4) *Zone 4.* Zone 4 shall extend 200 feet in all directions beginning at the center of the "cut" into Lower Sabula Lake.

The city of Sabula shall designate the speed zones with uniform waterway markers (buoys) approved by the natural resource commission.

571—40.35(462A) Speed restrictions on the Greene Impoundment of the Shell Rock River. No motorboat shall be operated at a speed exceeding five miles per hour in the two zoned areas of the Greene Impoundment designated by buoys or other approved uniform waterway markers. The first zoned area extends from the dam in the city of Greene, upstream approximately one-quarter mile to the north boundary of the city park in which the lower boat ramp is located. The second zoned area extends from the county bridge over the Shell Rock River on the north side of section 28 of Union Township in Floyd County, downstream approximately one-quarter mile to the south boundary of Gates Bridge County Park. The city of Greene and Floyd County shall designate their respective speed zones with uniform waterway markers (buoys) approved by the natural resource commission.

571—40.36(462A) Zoning of the Iowa River, Iowa Falls, Hardin County.

40.36(1) All vessels operated in a designated zone between the River Street Bridge and the dock at Dougan's Landing shall be operated at a no-wake speed.

40.36(2) The city of Iowa Falls shall designate and maintain the no-wake zone with marker buoys approved by the natural resource commission.

571—40.37(462A) Zoning of Crystal Lake. No motorboat shall be operated at a speed which will create a wake within the 25-acre zoned area designated by regulatory buoys on Crystal Lake in Hancock County.

571—40.38(462A) Five Island Lake, Palo Alto County.

40.38(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.38(2) Reserved.

571—40.39(462A) Lost Island Lake, Palo Alto and Clay Counties.

40.39(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.39(2) Reserved.

571—40.40(462A) Ingham Lake, Emmet County.

40.40(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.40(2) Reserved.

571—40.41(462A) Storm Lake, Buena Vista County.

40.41(1) Areas may be specifically designated for swimming by the use of regulatory buoys.

40.41(2) Reserved.

571—40.42(462A) Raccoon River Regional Park Lake, Polk County.

40.42(1) All vessels shall be operated at a no-wake speed.

40.42(2) A 40-acre body of water located in the southeast corner, and separate from the main lake, shall be designated for nonmotorized and electric motors only. The city of West Des Moines will designate the area with regulatory buoys and signs.

40.42(3) Areas may be specifically designated for swimming by the use of regulatory buoys.

571—40.43(462A) Zoning of the Mississippi River, Bellevue, Jackson County.

40.43(1) All vessels shall be operated at a no-wake speed within the area designated by buoys or other approved uniform waterway markers beginning at the mouth of Mill Creek and extending upstream 900 feet, and extending 200 feet perpendicular from shore. The area shall be designated by a minimum of four approved buoys to be uniformly placed along the 900-foot length of the zone parallel to the shore.

40.43(2) The city of Bellevue will designate the no-wake zone with buoys approved by the natural resource commission.

571—40.44(462A) Three Mile Lake, Union County—watercraft use. Motorboats of outboard or inboard-outdrive type shall be permitted on Three Mile Lake. The following rules shall govern vessel operation on Three Mile Lake in Union County.

40.44(1) All vessels shall be operated at a no-wake speed when within 50 feet of another vessel which is not underway or is operating at a no-wake speed.

40.44(2) Zoned areas.

a. No vessel, except authorized emergency vessels, shall be permitted in areas specifically designated for swimming and wading which are plainly marked by use of regulatory buoys in accordance with Iowa Administrative Code 571—Chapter 41. The Union County conservation board shall designate and maintain a swimming area(s) by the use of regulatory buoys approved by the natural resource commission.

b. No motorboats, except authorized emergency vessels, shall be operated in marked bay areas at a speed greater than the limit designated by buoys or signs marking said bay. No motorboats, except authorized emergency vessels, shall be operated other than at a no-wake speed above a line of buoys placed across the lake at the point where County Road H33 intersects the lake. All buoys or signs shall be in accordance with 571—Chapter 41.

c. No motorboats, except authorized emergency vessels, shall be operated in restricted speed areas between the nearest shore and a line designated by regulatory buoys or signs at a speed greater than the limit designated on the buoys or signs marking the area. Such zoned areas shall be not less than 50 feet nor more than 400 feet from shore. Said buoys or signs shall be in accordance with 571—Chapter 41.

571—40.45(462A) Zoning of the Cedar River.

40.45(1) *Nashua, Chickasaw County.* All vessels operated in a designated zone extending east 150 feet from the intersection of Wabash Street and Charles City Road and north 380 feet shall be operated at a no-wake speed. The city of Nashua shall designate and maintain the no-wake zone with marker buoys approved by the natural resource commission.

40.45(2) *Nashua, Chickasaw County.* All vessels operated in a designated zone extending north 131 feet from the intersection of Wabash Street and the north entrance to Cedar View Circle and east 80 feet and west 80 feet from this point along the shoreline and extending 110 feet north into the lake shall be operated at no-wake speed. The city of Nashua shall designate and maintain the no-wake zone with marker buoys approved by the natural resource commission.

40.45(3) *Charles City, Floyd County.* All vessels operated in a designated zone extending 300 feet upstream from the upper dam shall be operated at a speed not greater than five miles per hour. The city of Charles City shall designate and maintain the five miles per hour speed zone with marker buoys approved by the natural resource commission.

571—40.46(462A) Zoning of Carter Lake, Pottawattamie County.

40.46(1) All vessels operated in a designated zone known as Shoal Pointe Canal shall be operated at a no-wake speed.

40.46(2) The city of Carter Lake shall designate and maintain the no-wake zone with marker buoys approved by the natural resource commission.

571—40.47(462A) Zoning of the Mississippi River, McGregor, Clayton County.

40.47(1) All vessels, except commercial barge traffic, shall be operated at a no-wake speed within the area of river mile markers 634 and 633.4 and designated by buoys or other approved uniform waterway markers.

40.47(2) The city of McGregor will designate the no-wake zone with buoys approved by the natural resource commission.

571—40.48(462A) Zoning of the Mississippi River, Marquette, Clayton County.

40.48(1) All vessels, except commercial barge traffic, shall be operated at a no-wake speed within the area of river mile markers 634.5 and 634.9 and designated by buoys or other approved uniform waterway markers.

40.48(2) The city of Marquette will designate and maintain the no-wake zone with buoys approved by the natural resource commission.

571—40.49(462A) Zoning of Green Island, Jackson County. All motorboats except authorized emergency vessels shall operate at no-wake speed year around on boat channels adjacent to the interior channel 4 levee at the Green Island State Wildlife area. Both channels begin at the Green Island county road parking lot and proceed north 7920 feet along each side of the channel 4 levee to an intersection with the Snag Slough complex.

571—40.50(462A) Mooring of vessels on riparian property of the state of Iowa. Where the state of Iowa owns riparian property adjacent to sovereign land or water, mooring of vessels is prohibited between sunset and sunrise on those riparian or sovereign lands or waters where posted by either official buoys or official signs of the department of natural resources.

571—40.51(462A) Little River Lake, Decatur County. Motorboats of outboard or inboard-outdrive type shall be permitted on Little River Lake. Vessels operating within a designated area beginning at the dam and extending north approximately to the mouth of "Bait Shop Bay" may operate at speeds greater than no-wake. The Decatur County conservation board shall designate the speed zone with marker buoys approved by the natural resource commission.

571—40.52(462A) Zoning of the Mississippi River, Johnson Slough, Clayton County. All vessels shall be operated at a no-wake speed within the area of river mile markers 627 and 629.8, in a backwater known as Johnson Slough and designated by marker buoys approved by the natural resource commission.

571—40.53(462A) Zoning of the Mississippi River, Mud Lake, Dubuque County. All vessels shall be operated at a no-wake speed within the area of river mile markers 587.6 to 589.3, in a backwater known as Mud Lake and designated by marker buoys approved by the natural resource commission.

571—40.54(462A) Nighttime speed limit, Dickinson County. No vessels, except authorized emergency vessels, shall be operated at speeds greater than 25 miles per hour at any time between one-half hour after sunset and sunrise on all lakes located in Dickinson County.

571—40.55(462A) Zoning of Clear Lake, Cerro Gordo County.

40.55(1) Areas may be specifically designated for swimming with the use of regulatory buoys.

40.55(2) Areas within close proximity of dredging operations may be designated restricted speed areas.

571—40.56 Reserved.

571—40.57(462A) Zoning of Catfish Creek, Mines of Spain State Recreation Area, Dubuque County. All vessels shall be operated at no-wake speed within the area beginning at the mouth of

Catfish Creek and extending upstream to the confluence of Catfish Creek and Granger Creek and designated by uniform marker buoys approved by the natural resource commission.

571—40.58(462A) Zoning of Lake Cornelia, Wright County. All vessels shall be operated at a no-wake speed in the boat harbor and at the boat harbor entrance within the zoned area extending 300 feet from two points on shore and 100 feet in width, equidistant from either side of the harbor entrance. The Wright County conservation board shall designate the boat harbor entrance and the public swimming area with uniform marker buoys approved by the natural resource commission.

These rules are intended to implement the provisions of Iowa Code sections 462A.17, 462A.26, and 462A.31.

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◊ Two or more ARCs

PUBLIC HEALTH DEPARTMENT[641]

Rules of divisions under this department "umbrella" include Substance Abuse[643], Professional Licensure[645], Dental Examiners[650], Medical Examiners[653], Nursing Board[655] and Pharmacy Examiners[657]

CHAPTER 1
NOTIFICATION AND SURVEILLANCE OF REPORTABLE COMMUNICABLE AND INFECTIOUS DISEASES, POISONINGS AND CONDITIONS

1.1(139A) Definitions
1.2(139A) Authority
1.3(139A) Reportable diseases
1.4(135,139A) Reporting and investigation
1.5(139A) Reporting forms
1.6(139A) Who should report
1.7(139A) Treatment of infant eyes
1.8(139A) Isolation
1.9(135,139A) Quarantine and isolation
1.10(139A) Disinfection
1.11(141A) Contagious or infectious disease notification at time of death
1.12(135,137,139A) Quarantine and isolation—model rule for local boards
1.13(135,139A) Area quarantine

CHAPTER 2
HEPATITIS PROGRAMS

VIRAL HEPATITIS PROGRAM—VACCINATIONS AND TESTING

2.1(135) Definitions
2.2(135) Purpose
2.3(135) Exposure risks for hepatitis C virus
2.4(135) Information for public distribution
2.5(135) Hepatitis vaccination and testing program
2.6 to 2.8 Reserved

HEPATITIS C AWARENESS PROGRAM—VETERANS

2.9(135) Definitions
2.10(135) Purpose
2.11(135) Awareness materials
2.12(135) Awareness information
2.13(135) Resources for hepatitis follow-up and treatment

CHAPTER 3
EARLY HEARING DETECTION AND INTERVENTION

3.1(80GA,ch102) Definitions
3.2(80GA,ch102) Purpose
3.3(80GA,ch102) Goal and outcomes
3.4(80GA,ch102) Screening the hearing of all newborns
3.5(80GA,ch102) Procedures required of birthing hospitals
3.6(80GA,ch102) Procedures required of birth centers
3.7(80GA,ch102) Procedures to ensure that children born in locations other than a birth center or birthing hospital receive a hearing screening
3.8(80GA,ch102) Reporting hearing screening results and information to the department
3.9(80GA,ch102) Conducting and reporting diagnostic audiologic assessments to the department
3.10(80GA,ch102) Sharing of information and confidentiality
3.11(80GA,ch102) Reporting requirements for AEAs

3.12(80GA,ch102) Procedure to accommodate parental objection
3.13(80GA,ch102) Civil/criminal liability

CHAPTER 4
CENTER FOR CONGENITAL AND INHERITED DISORDERS
4.1(136A) Program explanation
4.2(136A) Definitions
4.3(136A) Iowa neonatal metabolic screening program (INMSP)
4.4(136A) Expanded maternal serum alpha-fetoprotein screening program
4.5(136A) Regional genetic consultation service (RGCS)
4.6(136A) Neuromuscular and other related genetic disease program (NMP)
4.7(136A) Iowa registry for congenital and inherited disorders

CHAPTER 5
MATERNAL DEATHS
5.1(135) Reporting of maternal deaths
5.2(135) Ascertainment of maternal deaths
5.3(135) Reviewing of maternal deaths

CHAPTER 6
VENEREAL DISEASE PROPHYLACTICS
6.1(135) Definitions
6.2(135) Application for permit
6.3(135) Permit number and decal to be displayed
6.4(135) Compliance
6.5(135) Standards

CHAPTER 7
IMMUNIZATION AND IMMUNIZATION EDUCATION: PERSONS ATTENDING ELEMENTARY OR SECONDARY SCHOOLS, LICENSED CHILD CARE CENTERS OR INSTITUTIONS OF HIGHER EDUCATION
7.1(139A) Definitions
7.2(139A) Persons included
7.3(139A) Persons excluded
7.4(139A) Required immunizations
7.5(139A) Required education
7.6(139A) Proof of immunization
7.7(139A) Provisional enrollment
7.8(139A) Records and reporting
7.9(139A) Providing immunization services
7.10(139A) Compliance
7.11(22) Iowa's immunization registry
7.12(22) Release of immunization information

CHAPTER 8
Reserved

CHAPTER 9
OUTPATIENT DIABETES EDUCATION PROGRAMS
9.1(135) Scope
9.2(135) Definitions
9.3(135) Powers and duties
9.4(135) Application procedures for American Diabetes Association recognized programs
9.5(135) Renewal procedures for American Diabetes Association recognized programs

9.6(135) Application procedures for programs not recognized by the American Diabetes Association
9.7(135) Diabetes program management for programs not recognized by the American Diabetes Association
9.8(135) Program staff for programs not recognized by the American Diabetes Association
9.9(135) Renewal application procedures for programs not recognized by the American Diabetes Association
9.10(135) Annual report
9.11(135) Enforcement
9.12(135) Complaints
9.13(135) Appeal process
9.14(135) Formal contest

CHAPTER 10
Reserved

CHAPTER 11
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

FINANCIAL ASSISTANCE
TO ELIGIBLE HIV-INFECTED PATIENTS

11.1 to 11.15 Reserved

CERTIFICATION OF LABORATORIES
FOR HIV TESTING

11.16(141) Purpose
11.17(141) Definitions
11.18(141) Responsibilities of the department
11.19(141) Initial application and certification requirements
11.20 Reserved
11.21(141) Renewal of laboratory certification
11.22(141) Reinstatement of certification
11.23(141) Application fees and inspection costs
11.24(141) Requirements for laboratory personnel
11.25(141) Laboratory procedures and procedure manual requirements
11.26(141) Notification of certain changes during a certification period
11.27(141) Testing methodologies and confirmation of positive test results
11.28(141) Record maintenance and documentation of the testing process
11.29(141) Reporting of test results to the department
11.30(141) Complaints or noncompliance
11.31(141) Adverse actions and the appeal process
11.32 to 11.34 Reserved

TRAINING PROGRAMS

11.35(141) Purpose
11.36 to 11.39 Reserved

DIRECT NOTIFICATION OF AN IDENTIFIABLE THIRD PARTY

11.40(141) Purpose
11.41 to 11.44 Reserved

EMERGENCY CARE PROVIDERS
EXPOSED TO CONTAGIOUS OR
INFECTIOUS DISEASES

11.45(139B,141) Purpose
11.46(139B,141) Definitions
11.47(139B,141) General provisions

11.48(139B,141) Contagious or infectious diseases, not including HIV—hospitals
11.49(139B,141) Contagious or infectious diseases, not including HIV—health care providers
11.50(139B,141) HIV infection—hospitals
11.51(139B,141) HIV infection—health care providers
11.52(139B,141) Immunity
11.53(139B,141) Confidentiality
11.54 to 11.69 Reserved

HIV-RELATED TEST FOR CONVICTED OR ALLEGED SEXUAL-ASSAULT OFFENDERS AND THE VICTIMS

11.70(709B) Purpose
11.71(709B) Definitions
11.72(709B) HIV test—convicted or alleged sexual assault offender
11.73(709B) Medical examination costs
11.74(709B) Testing, reporting, and counseling—penalties
11.75 to 11.79 Reserved

HIV HOME COLLECTION

11.80(126) Purpose
11.81(126) Definitions
11.82(126) HIV home testing kit
11.83(126) HIV home collection kit

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

11.84(141A) Definitions
11.85(141A) Purpose
11.86(141A) Eligibility requirements
11.87(141A) Enrollment process
11.88(141A) Distribution requirements
11.89(141A) ADAP waiting list
11.90(141A) Appeals
11.91(141A) Confidentiality

CHAPTER 12
APPROVAL OF CONFIRMATORY LABORATORIES FOR PRIVATE SECTOR DRUG-FREE WORKPLACE TESTING

12.1(730) Purpose
12.2(730) Definitions
12.3(730) Powers and duties
12.4(730) Application procedures and requirements
12.5(730) Requirements of laboratory personnel involved in confirmatory testing for alcohol or other drugs, or their metabolites
12.6(730) Quality assurance program and procedure manual requirements
12.7(730) Analytical quality control
12.8(730) Sample security and confidentiality of test results
12.9(730) Confirmatory testing
12.10(730) Documentation of the confirmatory testing process
12.11(730) Reporting of confirmed positive test results to the medical review officer
12.12(730) Reporting requirements to department
12.13(730) Approval, renewal, and inspection fees
12.14(730) Renewal
12.15(730) Reciprocity
12.16(730) Changes during approval periods
12.17(730) Enforcement

12.18(730) Denial, suspension, modification or revocation of approval
12.19(730) Restoration of approval
12.20(730) Appeals process
12.21(730) Complaints

CHAPTER 13
Reserved

CHAPTER 14
RESIDENTIAL WATER TREATMENT

14.1(714) Purpose
14.2(714) Applicability
14.3(714) Definitions
14.4(714) Performance testing
14.5(714) Approval of third-party testing agencies
14.6(714) Labeling and manufacturer's performance data sheet
14.7(714) Consumer information pamphlet
14.8(714) Registration
14.9(714) Penalties

CHAPTER 15
SWIMMING POOLS AND SPAS

15.1(135I) Applicability
15.2(135I) Scope
15.3(135I) Definitions and abbreviations

SWIMMING POOLS

15.4(135I) Swimming pool operations
15.5(135I) Construction and reconstruction

ADMINISTRATION

15.6(135I) Enforcement
15.7(135I) Variances
15.8(135I) Penalties
15.9(135I) Registration
15.10(135I) Training courses
15.11(135I) Swimming pool/spa operator qualifications
15.12(135I) Fees
15.13(135I) 28E agreements
15.14(135I) Application denial or partial denial—appeal
15.15 to 15.50 Reserved

SPAS

15.51(135I) Spa operations
15.52(135I) Construction and reconstruction

CHAPTERS 16 to 19
Reserved

CHAPTER 20
COMMUNITY WATER FLUORIDATION GRANT PROGRAM

20.1(135) Purpose
20.2(135) Definitions
20.3(135) Applications
20.4(135) Review and rating of applications

20.5(135) Project contracts
20.6(135) Implementation procedures
20.7(135) Reimbursement
20.8(135) Termination
20.9(135) Appeals

CHAPTER 21
CENTRAL REGISTRY FOR
BRAIN AND SPINAL CORD INJURIES

21.1(135) Purpose
21.2(135) Definitions
21.3(135) Reportable injuries
21.4(135) Who reports and under what circumstances
21.5(135) Method and frequency of reporting
21.6(135) Confidentiality
21.7(135) Quality assurance

CHAPTER 22
PRACTICE OF TATTOOING

22.1(135) Purpose
22.2(135) Definitions
22.3(135) General provisions
22.4(135) Sanitation and infection control
22.5(135) Equipment
22.6(135) Procedures
22.7(135) Application for permit—fees
22.8(135) Variances
22.9(135) Adverse actions and the appeal process

CHAPTER 23
Reserved

CHAPTER 24
PRIVATE WELL TESTING, RECONSTRUCTION, AND
PLUGGING—GRANTS TO COUNTIES

24.1(135) Applicability
24.2(135) Definitions
24.3(135) Eligibility
24.4(135) Goal and objectives
24.5(135) Eligible grant costs
24.6(135) Ineligible grant costs
24.7(135) Performance requirements
24.8(135) Contents of grant application
24.9(135) Grant application submission
24.10(135) Multicounty grant applications
24.11(135) Grant period
24.12(135) Record keeping and retention
24.13(135) Grant amendments
24.14(135) Termination or forfeiture of grant funds

CHAPTER 25
STATE PLUMBING CODE

25.1(135) Adoption
25.2(135) Applicability
25.3(135) Fuel gas piping
25.4(135) Amendments to the Uniform Plumbing Code
25.5(135) Backflow prevention with containment

CHAPTER 26
BACKFLOW PREVENTION ASSEMBLY TESTER REGISTRATION

26.1(135K) Applicability
26.2(135K) Definitions
26.3(135K) Registration required
26.4(135K) Backflow prevention assembly tester training
26.5(135K) Registration
26.6(135K) Standards of conduct
26.7(135K) Penalty
26.8(135K) Denial, suspension or revocation

CHAPTERS 27 to 37
Reserved

CHAPTER 38
GENERAL PROVISIONS FOR RADIATION MACHINES
AND RADIOACTIVE MATERIALS

38.1(136C) Purpose and scope
38.2(136C) Definitions
38.3(136C) Exemptions from the regulatory requirements
38.4(136C) General regulatory requirements
38.5 Reserved
38.6(136C) Prohibited uses
38.7(136C) Communications
38.8(136C) Fees
38.9(136C) Administrative enforcement actions
38.10(136C) Deliberate misconduct

CHAPTER 39
REGISTRATION OF RADIATION MACHINE FACILITIES, LICENSURE OF RADIOACTIVE
MATERIALS AND TRANSPORTATION OF RADIOACTIVE MATERIALS

39.1(136C) Purpose and scope
39.2(136C) Definitions
39.3(136C) Requirements for registration of X-ray and other electronic machines that produce radiation
39.4(136C) Requirements for licensing of radioactive materials
39.5(136C) Transportation of radioactive material

CHAPTER 40
STANDARDS FOR PROTECTION AGAINST RADIATION

GENERAL PROVISIONS

40.1(136C) Purpose and scope
40.2(136C) Definitions
40.3(136C) Implementation
40.4 to 40.9 Reserved

RADIATION PROTECTION PROGRAMS

40.10(136C) Radiation protection programs
40.11 to 40.14 Reserved

OCCUPATIONAL DOSE LIMITS

40.15(136C) Occupational dose limits for adults
40.16(136C) Compliance with requirements for summation of external and internal doses
40.17(136C) Determination of external dose from airborne radioactive material
40.18(136C) Determination of internal exposure
40.19(136C) Determination of prior occupational dose
40.20(136C) Planned special exposures
40.21(136C) Occupational dose limits for minors
40.22(136C) Dose equivalent to an embryo/fetus
40.23 to 40.25 Reserved

RADIATION DOSE LIMITS FOR INDIVIDUAL MEMBERS OF THE PUBLIC

40.26(136C) Dose limits for individual members of the public
40.27(136C) Compliance with dose limits for individual members of the public

RADIOLOGICAL CRITERIA FOR LICENSE TERMINATION

40.28(136C) Radiological criteria for license termination
40.29(136C) Radiological criteria for unrestricted use
40.30(136C) Criteria for license termination under restricted conditions
40.31(136C) Alternate criteria for license termination

TESTING FOR LEAKAGE OR CONTAMINATION OF SEALED SOURCES

40.32(136C) Testing for leakage or contamination of sealed sources
40.33 to 40.35 Reserved

SURVEYS AND MONITORING

40.36(136C) Surveys and monitoring—general
40.37(136C) Conditions requiring individual monitoring of external and internal occupational dose
40.38 to 40.41 Reserved

CONTROL OF EXPOSURE FROM EXTERNAL SOURCES IN RESTRICTED AREAS

40.42(136C) Control of access to high radiation areas
40.43(136C) Control of access to very high radiation areas
40.44(136C) Control of access to very high radiation areas—irradiators
40.45 to 40.47 Reserved

RESPIRATORY PROTECTION AND CONTROLS TO RESTRICT INTERNAL EXPOSURE IN RESTRICTED AREAS

40.48(136C) Use of process or other engineering controls
40.49(136C) Use of other controls
40.50(136C) Use of individual respiratory protection equipment
40.51 to 40.53 Reserved

STORAGE AND CONTROL OF LICENSED OR REGISTERED SOURCES OF RADIATION

40.54(136C) Security and control of licensed radioactive material in quantities of concern
40.55(136C) Security and control of licensed or registered sources of radiation
40.56(136C) Control of sources of radiation not in storage
40.57 to 40.59 Reserved

PRECAUTIONARY PROCEDURES

40.60(136C) Caution signs
40.61(136C) Posting requirements

40.62(136C) Exceptions to posting requirements
40.63(136C) Labeling containers and radiation machines
40.64(136C) Exemptions to labeling requirements
40.65(136C) Procedures for receiving and opening packages
40.66 to 40.69 Reserved

WASTE DISPOSAL

40.70(136C) General requirements
40.71(136C) Method for obtaining approval of proposed disposal procedures
40.72(136C) Disposal by release into sanitary sewerage
40.73(136C) Treatment or disposal by incineration
40.74(136C) Disposal of specific wastes
40.75(136C) Transfer for disposal and manifests
40.76(136C) Compliance with environmental and health protection regulations
40.77 to 40.79 Reserved

RECORDS

40.80(136C) General provisions
40.81(136C) Records of radiation protection programs
40.82(136C) Records of surveys
40.83(136C) Records of tests for leakage or contamination of sealed sources
40.84(136C) Records of prior occupational dose
40.85(136C) Records of planned special exposures
40.86(136C) Records of individual monitoring results
40.87(136C) Records of dose to individual members of the public
40.88(136C) Records of waste disposal
40.89(136C) Records of testing entry control devices for very high radiation areas
40.90(136C) Form of records
40.91 to 40.94 Reserved

REPORTS

40.95(136C) Reports of stolen, lost, or missing licensed or registered sources of radiation
40.96(136C) Notification of incidents
40.97(136C) Reports of exposures, radiation levels, and concentrations of radioactive material exceeding the constraints or limits
40.98(136C) Reports of planned special exposures
40.99(136C) Reports of transactions involving nationally tracked sources
40.100(136C) Reports of individual monitoring
40.101(136C) Notifications and reports to individuals
40.102(136C) Reports of leaking or contaminated sealed sources
40.103 and 40.104 Reserved

ADDITIONAL REQUIREMENTS

40.105(136C) Vacating premises
40.106 to 40.109 Reserved

NOTICES, INSTRUCTIONS, AND REPORTS TO WORKERS; INSPECTIONS

40.110(136C) Posting of notices to workers
40.111(136C) Instructions to workers
40.112(136C) Notifications and reports to individuals
40.113(136C) Presence of representatives of licensees or registrants and workers during inspection
40.114(136C) Consultation with workers during inspections
40.115(136C) Requests by workers for inspections

40.116(136C) Inspections not warranted—informal review
40.117(136C) Employee protection

CHAPTER 41
SAFETY REQUIREMENTS FOR THE USE OF
RADIATION MACHINES AND CERTAIN USES
OF RADIOACTIVE MATERIALS

41.1(136C) X-rays in the healing arts
41.2(136C) Use of radionuclides in the healing arts
41.3(136C) Therapeutic use of radiation machines
41.4 and 41.5 Reserved
41.6(136C) X-ray machines used for screening and diagnostic mammography
41.7(136C) X-ray machines used for stereotactically guided breast biopsy

CHAPTER 42
MINIMUM CERTIFICATION STANDARDS FOR DIAGNOSTIC RADIOGRAPHERS,
NUCLEAR MEDICINE TECHNOLOGISTS, AND RADIATION THERAPISTS

42.1(136C) Purpose and scope
42.2(136C) General requirements
42.3(136C) Specific requirements for diagnostic radiographers
42.4(136C) Specific requirements for nuclear medicine technologists
42.5(136C) Specific requirements for radiation therapists
42.6(136C) Specific eligibility requirements for radiologist assistant
42.7(136C) Specific requirements for podiatric radiographers

CHAPTER 43
MINIMUM REQUIREMENTS FOR RADON TESTING AND ANALYSIS

43.1(136B) Purpose and scope
43.2(136B) Definitions
43.3(136B) General provisions
43.4(136B) Application for certification
43.5(136B) Revocation of certification
43.6(136B) Reporting requirements
43.7(136B) Training and continuing education programs
43.8(136B) Exemptions
43.9(136B) Enforcement
43.10(136B) Penalties
43.11(136B) Persons exempted from certification

CHAPTER 44
MINIMUM REQUIREMENTS FOR RADON MITIGATION

44.1(136B) Purpose and scope
44.2(136B) Definitions
44.3(136B) General provisions
44.4(136B) Application for credentialing
44.5(136B) Revocation of credentialing
44.6(136B) Additional record-keeping requirements
44.7(136B) Continuing education
44.8(136B) Exemptions
44.9(136B) Enforcement
44.10(136B) Penalties

CHAPTER 45
RADIATION SAFETY REQUIREMENTS FOR INDUSTRIAL RADIOGRAPHIC OPERATIONS

45.1(136C) General requirements for industrial radiography operations
45.2(136C) Radiation safety requirements for the use of radiation machines in industrial radiography
45.3(136C) Radiation safety requirements for use of sealed sources of radiation in industrial radiography
45.4(136C) Radiation safety requirements for the use of particle accelerators for nonhuman use
45.5(136C) Radiation safety requirements for analytical X-ray equipment
45.6(136C) Radiation safety requirements for well-logging, wireline service operations and subsurface tracer studies

CHAPTER 46
MINIMUM REQUIREMENTS FOR TANNING FACILITIES

46.1(136D) Purpose and scope
46.2(136D) Definitions
46.3(136D) Exemptions
46.4(136D) Permits and fees
46.5(136D) Construction and operation of tanning facilities
46.6(136D) Inspections, violations and injunctions

CHAPTERS 47 to 49
Reserved

CHAPTER 50
ORAL HEALTH

50.1(135) Purpose
50.2(135) Definitions
50.3(135) Dental director responsibilities
50.4(135) Oral health bureau functions
50.5(135) Funding

CHAPTER 51
DENTAL SCREENING

51.1(82GA,ch146,SF2111) Purpose
51.2(82GA,ch146,SF2111) Definitions
51.3(82GA,ch146,SF2111) Persons included
51.4(82GA,ch146,SF2111) Persons excluded
51.5(82GA,ch146,SF2111) Dental screening components
51.6(82GA,ch146,SF2111) Dental screening providers
51.7(82GA,ch146,SF2111) Time line for valid dental screening
51.8(82GA,ch146,SF2111) Proof of dental screening
51.9(82GA,ch146,SF2111) Dental screening documentation
51.10(82GA,ch146,SF2111) Assuring dental screening services
51.11(82GA,ch146,SF2111) Records
51.12(82GA,ch146,SF2111) Reporting
51.13(82GA,ch146,SF2111) Iowa's dental screening database
51.14(82GA,ch146,SF2111) Release of dental screening information
51.15(82GA,ch146,SF2111) Referral requirements
51.16(82GA,ch146,SF2111) Provider training

CHAPTERS 52 to 54
Reserved

CHAPTER 55
ADVISORY COUNCIL ON HEAD INJURIES

55.1(135) Council established
55.2(135) Meetings
55.3(135) Task forces
55.4(135) Minutes
55.5(135) Duties of the council
55.6(135) Conflict of interest

CHAPTER 56
BRAIN INJURY SERVICES PROGRAM

56.1(135) Definitions
56.2(135) Purpose
56.3(135) Waiver-eligible component
56.4(135) Cost-share component
56.5(135) Application process
56.6(135) Service providers and reimbursement
56.7(135) Available services/service plan
56.8(135) Redetermination
56.9(135) Appeal rights

CHAPTERS 57 to 66
Reserved

CHAPTER 67
BLOOD LEAD TESTING

67.1(135) Purpose
67.2(135) Definitions
67.3(135) Persons included
67.4(135) Persons excluded
67.5(135) Blood lead testing requirement
67.6(135) Time line for valid blood lead testing
67.7(135) Proof of blood lead testing
67.8(135) Referral requirements
67.9(135) Blood lead testing documentation
67.10(135) Records
67.11(135) Provider training

CHAPTER 68
CONTROL OF LEAD-BASED PAINT HAZARDS

68.1(135) Applicability
68.2(135) Definitions
68.3(135) Elevated blood lead (EBL) inspections required
68.4(135) Refusal of admittance
68.5(135) Lead hazard reduction required
68.6(135) Retaliation prohibited
68.7(135) Enforcement
68.8(135) Hearings
68.9(135) Variances

68.10(135) Injunction
68.11(135) Effective date

CHAPTER 69
RENOVATION, REMODELING, AND REPAINTING—
LEAD HAZARD NOTIFICATION PROCESS

69.1(135) Applicability
69.2(135) Definitions
69.3(135) Notification required
69.4(135) Notification required in multifamily housing
69.5(135) Emergency renovation, remodeling, and repainting
69.6(135) Certification of attempted delivery
69.7(135) Exemption
69.8(135) Record-keeping requirements
69.9(135) Compliance inspections
69.10(135) Enforcement
69.11(135) Waivers

CHAPTER 70
LEAD-BASED PAINT ACTIVITIES

70.1(135) Applicability
70.2(135) Definitions
70.3(135) Certification
70.4(135) Course approval and standards
70.5(135) Certification, interim certification, and recertification
70.6(135) Work practice standards for conducting lead-based paint activities in target housing and child-occupied facilities
70.7(135) Firms
70.8(135) Lead-safe work practices training program approval and lead-safe work practices contractor registration
70.9(135) Compliance inspections
70.10(135) Denial, suspension, or revocation of certification; denial, suspension, revocation, or modification of course approval; and imposition of penalties
70.11(135) Waivers

CHAPTER 71
EMERGENCY INFORMATION SYSTEM ON PESTICIDES FOR USE BY HEALTH CARE
PROVIDERS DURING MEDICAL EMERGENCIES

71.1(139A) Scope
71.2(139A) Definitions
71.3(139A) Operation of EIS

CHAPTER 72
CHILDHOOD LEAD POISONING
PREVENTION PROGRAM

72.1(135) Definitions
72.2(135) Approved programs
72.3(135) Level of funding
72.4(135) Appeals

CHAPTER 73
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

73.1(135)	Program explanation
73.2(135)	Adoption by reference
73.3(135)	Availability of rules
73.4(135)	Certain rules exempted from public participation
73.5(135)	Definitions
73.6(135)	Staffing of contract agencies
73.7(135)	Certification of participants
73.8(135)	Food delivery
73.9(135)	Food package
73.10(135)	Education
73.11(135)	Health services
73.12(135)	Appeals and fair hearings—local agencies and vendors
73.13(135)	Right to appeal—participant
73.14(135)	State monitoring of contract agencies
73.15(135)	Migrant services
73.16(135)	Civil rights
73.17(135)	Audits
73.18(135)	Reporting
73.19(135)	Program violation
73.20(135)	Data processing
73.21(135)	Outreach
73.22(135)	Caseload management
73.23(135)	Grant application procedures for contract agencies
73.24(135)	Participant rights

CHAPTER 74
FAMILY PLANNING SERVICES

74.1(135)	Program explanation
74.2(135)	Adoption by reference
74.3(135)	Rule coverage
74.4(135)	Definitions
74.5(135)	Grant application procedures for contract agencies
74.6(135)	Funding levels for contract agencies
74.7(135)	Agency performance
74.8(135)	Reporting
74.9(135)	Fiscal management
74.10(135)	Audits
74.11(135)	Denial, suspension, revocation, or reduction of contracts with contract agencies
74.12(135)	Right to appeal—contract agency

CHAPTER 75
STATEWIDE OBSTETRICAL AND NEWBORN INDIGENT PATIENT CARE PROGRAM

75.1(255A)	Definitions
75.2(255A)	Covered services
75.3(255A)	Quota assignment
75.4(255A)	Eligibility criteria
75.5(255A)	Application procedures
75.6(255A)	Reimbursement of providers

75.7(255A) Reassignment of county quotas
75.8(255A) Appeals and fair hearings

CHAPTER 76
MATERNAL AND CHILD HEALTH PROGRAM
76.1(135) Program explanation
76.2(135) Adoption by reference
76.3(135) Rule coverage
76.4(135) Definitions
76.5(135) MCH services
76.6(135) Client eligibility criteria
76.7(135) Client application procedures for MCH services
76.8(135) Right to appeal—client
76.9(135) Grant application procedures for community-based contract agencies
76.10(135) Funding levels for community-based contract agencies
76.11(135) Contract agency performance
76.12(135) Reporting
76.13(135) Fiscal management
76.14(135) Audits
76.15 Reserved
76.16(135) Denial, suspension, revocation or reduction of contracts with contract agencies
76.17(135) Right to appeal—contract agency

CHAPTER 77
LOCAL BOARDS OF HEALTH
77.1(137) Purpose of local boards of health
77.2(137) Definitions
77.3(137) Roles and responsibilities of local boards of health
77.4(137) Organization of local boards of health
77.5(137) Operating procedures of local boards of health
77.6(137) Expenses of board of health members

CHAPTER 78
DISTRICT HEALTH DEPARTMENTS
78.1(137) Minimum standards for district health departments
78.2(137) Preparation of district health department plan
78.3(137) Approval of district health departments
78.4(137) Additions to district health departments
78.5(137) Withdrawal from district health departments

CHAPTER 79
Reserved

CHAPTER 80
LOCAL PUBLIC HEALTH SERVICES
80.1(135) Purpose
80.2(135) Definitions
80.3(135) Local public health services state grant
80.4(135) Billing services to the local public health services state grant
80.5(135) Right to appeal
80.6(135) Case management
80.7(135) Local board of health services
80.8(135) Local public health services

80.9(135) Public health nursing services
80.10(135) Home care aide services

CHAPTER 81
GENERAL RULES FOR MIGRATORY LABOR CAMPS
81.1(138) Shelters
81.2(138) Water supply
81.3(138) Waste disposal
81.4(138) Bathing facilities
81.5(138) Central dining facilities
81.6(138) Safety and fire

CHAPTER 82
OFFICE OF MULTICULTURAL HEALTH
82.1(135) Purpose
82.2(135) Definitions
82.3(135) Responsibilities of the office of multicultural health
82.4(135) Advisory council

CHAPTER 83
Reserved

CHAPTER 84
STATE SUBSTITUTE MEDICAL DECISION-MAKING BOARD
84.1(135) Purpose
84.2(135) Composition of board
84.3(135) Appointment
84.4(135) Duties
84.5(135) Officers
84.6(135) Meetings
84.7(135) Panels
84.8(135) Review of local boards

CHAPTER 85
LOCAL SUBSTITUTE MEDICAL DECISION-MAKING BOARDS
85.1(135) Purpose
85.2(135) Definitions
85.3(135) Appointment of local boards
85.4(135) Filing an application
85.5(135) Notification of patient and review of application
85.6(135) Panel appointment and procedures
85.7(135) Panel determination of need for surrogate decision making
85.8(135) Panel determination regarding proposed medical care decision
85.9(135) Right of appeal
85.10(135) Procedure when there is no local board
85.11(135) Records and reports
85.12(135) Liability

CHAPTER 86
PLACES WHERE DEAD HUMAN BODIES ARE PREPARED
FOR BURIAL OR ENTOMBMENT
86.1(156) Purpose
86.2(156) Definitions
86.3(156) Licensing

86.4(156) Public access areas
86.5(156) Preparation room
86.6(156) Crematorium chambers
86.7(156) Inspection fees

CHAPTER 87
HEALTHY FAMILIES IOWA (HFI)

87.1(135) Purpose
87.2(135) Definitions
87.3(135) Applicant eligibility
87.4(135) Participant eligibility
87.5(135) Program requirements
87.6(135) Contractor assurance
87.7(135) Applicant appeal process
87.8(135) Participant right to appeal

CHAPTER 88
VOLUNTEER HEALTH CARE PROVIDER PROGRAM

88.1(135) Definitions
88.2(135) Purpose
88.3(135) Eligibility for defense and indemnification coverage
88.4(135) Sponsor program eligibility
88.5(135) Covered health care services
88.6(135) Defense and indemnification
88.7(135) Term of agreement
88.8(135) Reporting requirements and duties
88.9(135) Revocation of eligibility and registration
88.10(135) Procedure for revocation of eligibility and registration
88.11(135) Effect of suspension or revocation
88.12(135) Registration denied
88.13(135) Board notice of disciplinary action
88.14(135) Effect of eligibility certification
88.15(135) Reporting by volunteer health care provider and program

CHAPTER 89
DECISION-MAKING ASSISTANCE PROGRAM
AND PARENTAL NOTIFICATION OF INTENT
TO TERMINATE A PREGNANCY THROUGH ABORTION

89.1(135L) Title
89.2(135L) Purpose and scope
89.3(135L) Definitions
89.4 to 89.10 Reserved

DECISION-MAKING ASSISTANCE PROGRAM

89.11(135L) Purpose
89.12(135L) Initial appointment of a pregnant minor with a licensed physician from whom an abortion is sought and certification procedure for the decision-making assistance program
89.13 to 89.20 Reserved

NOTIFICATION PROCESS

89.21(135L) Notification of parent prior to the performance of abortion on a pregnant minor
89.22(135L) Exceptions to notification of parent
89.23(135L) Physician compliance

89.24 and 89.25 Reserved
89.26(135L) Fraudulent practice

CHAPTER 90
IOWA CHILD DEATH REVIEW TEAM

90.1(135) Purpose
90.2(135) Definitions
90.3(135) Agency
90.4(135) Membership
90.5(135) Officers
90.6(135) Meetings
90.7(135) Expenses of team members
90.8(135) Team responsibilities
90.9(135) Liaisons
90.10(135) Confidentiality and disclosure of information
90.11(135) Immunity and liability

CHAPTER 91
IOWA DOMESTIC ABUSE DEATH REVIEW TEAM

91.1(77GA,ch1221) Purpose
91.2(77GA,ch1221) Definitions
91.3(77GA,ch1221) Agency
91.4(77GA,ch1221) Membership
91.5(77GA,ch1221) Officers
91.6(77GA,ch1221) Meetings
91.7(77GA,ch1221) Expenses of team members
91.8(77GA,ch1221) Team responsibilities
91.9(77GA,ch1221) Liaisons
91.10(77GA,ch1221) Confidentiality and disclosure of information
91.11(77GA,ch1221) Immunity and liability

CHAPTER 92
IOWA FATALITY REVIEW COMMITTEE

92.1(135) Purpose
92.2(135) Definitions
92.3(135) Committee
92.4(135) Formation of the committee
92.5(135) Committee protocol for review
92.6(135) Content of report
92.7(135) Consultation with county attorney
92.8(135) Supplemental report
92.9(135) Confidentiality and disclosure of information
92.10(135) Immunity and liability

CHAPTER 93
ABUSE EDUCATION REVIEW PANEL

93.1(135) Purpose
93.2(135) Panel
93.3(135) Meetings
93.4(135) Duties
93.5(135) Standards for approval of curricula
93.6(135) Process for application review and approval
93.7(135) Process for appeal

CHAPTER 94
CHILD PROTECTION CENTER GRANT PROGRAM

94.1(135) Scope and purpose
94.2(135) Definitions
94.3(135) Goals
94.4(135) Review process
94.5(135) Eligibility and criteria
94.6(135) Appeals

CHAPTER 95
CERTIFICATE OF BIRTH—REGISTRATION FEE

95.1(144) Birth certificates—when filing fee required
95.2(144) Collection
95.3(144) Waivers
95.4(144) Fee deposit
95.5(144) Responsibilities of institutions
95.6 Reserved
95.7(144) County registrars
95.8(144) State registrar
95.9(144) Retention
95.10(144) Forms

CHAPTER 96
VITAL RECORDS

96.1(144) Definitions
96.2(144) Specification
96.3(144) Handling
96.4(144) Fees
96.5(144) Additional statistical data
96.6(144) General public accessibility
96.7(144) Direct tangible interest accessibility
96.8(144) County custodians' responsibility for maintenance of confidentiality

CHAPTER 97
Reserved

CHAPTER 98
FORMS UNIFORM

98.1(144) Forms property of Iowa department of public health
98.2(144) Preparation of certificates

CHAPTER 99
DELAYED BIRTH, DEATH AND MARRIAGE REGISTRATION

99.1(144) Foundling registration
99.2(144) Birth registration—five days to one year
99.3(144) Delayed birth registration—after one year
99.4(144) Who may file delayed certificate
99.5(144) Delayed certificate to be signed
99.6(144) Facts to be established for delayed registration of birth
99.7(144) Documentary evidence
99.8(144) Abstraction and certification by state registrar
99.9(144) Documents returned
99.10(144) Cancellation after one year

99.11(144) Duties of county registrar
99.12(144) Delayed registration of death records
99.13(144) Delayed registration of marriage records

CHAPTER 100
ESTABLISHMENT OF NEW CERTIFICATES OF BIRTH
100.1(144) Certificates, forms
100.2(144) Data required
100.3(144) Certificate following adoption
100.4(144) Certificate following legitimation
100.5(144) Certificate following determination of paternity
100.6(144) Minimum information required
100.7(144) Original certificate to be sealed

CHAPTER 101
DEATH CERTIFICATION, AUTOPSY AND DISINTERMENT
101.1(144) Report of autopsy findings
101.2(144) Attending physician not available
101.3(144) Hospital or institution may assist in preparation of certificate
101.4(135) Removal of dead body or fetus
101.5(144) Burial-transit permit
101.6(135) Transportation and disposition of dead body or fetus
101.7(135,144) Disinterment permits
101.8(144) Extension of time

CHAPTER 102
CORRECTION AND AMENDMENT OF VITAL RECORDS
102.1(144) Application to amend records
102.2(144) Correction of minor errors within first year
102.3(144) Amendments or major corrections
102.4(144) Correction of same item more than once
102.5(144) Methods of amending certificates
102.6(144) Amendment of birth certificate by paternity affidavit
102.7(144) Change of given names within first year
102.8(144) Addition of given names until seventh birthday
102.9(144) Addition of given name after seventh birthday
102.10(144) Legal change of name

CHAPTER 103
CONFIDENTIALITY OF RECORDS
103.1(144) Disclosure of data

CHAPTER 104
COPIES OF VITAL RECORDS
104.1(144) Certified copies and verifications
104.2(144) Cancellation of fraudulent records

CHAPTER 105
DECLARATION OF PATERNITY REGISTRY
105.1(144) Definitions
105.2(144) Registry established
105.3(144) Information to be provided
105.4(144) Change of address
105.5(144) Fees

105.6(144) Access to registry information
105.7(144) Revocation
105.8(144) Forms

CHAPTER 106
REPORTING OF TERMINATION OF PREGNANCY

106.1(144) Definitions
106.2(144) Report of termination of pregnancy
106.3(144) Confidentiality of released information
106.4(144) Confidentiality of reports submitted
106.5(144) Provider codes
106.6(144) Unlawful acts—punishment

CHAPTER 107
MUTUAL CONSENT VOLUNTARY ADOPTION REGISTRY

107.1(78GA,HF497) Definitions
107.2(78GA,HF497) Eligibility
107.3(78GA,HF497) Exception
107.4(78GA,HF497) Application
107.5(78GA,HF497) Notification
107.6(78GA,HF497) Withdrawal
107.7(78GA,HF497) Fees

CHAPTER 108
Reserved

CHAPTER 109
PRESCRIPTION DRUG DONATION REPOSITORY PROGRAM

109.1(135M) Definitions
109.2(135M) Purpose
109.3(135M) Eligibility criteria for program participation by medical facilities and pharmacies
109.4(135M) Standards and procedures for accepting donated prescription drugs and supplies
109.5(135M) Standards and procedures for inspecting and storing donated prescription drugs and supplies
109.6(135M) Standards and procedures for dispensing donated prescription drugs and supplies
109.7(135M) Eligibility criteria for individuals to receive donated prescription drugs and supplies
109.8(135M) Forms and record keeping
109.9(135M) Handling fee
109.10(135M) List of drugs and supplies program will accept
109.11(135M) Exemption from disciplinary action, civil liability and criminal prosecution

CHAPTER 110
CENTER FOR RURAL HEALTH
AND PRIMARY CARE

110.1(135) Purpose and scope
110.2(135) Definitions
110.3(135) Responsibilities of the center
110.4(135) Advisory committee to the center for rural health and primary care
110.5(135) Organization
110.6(135) Meetings
110.7 to 110.10 Reserved

PRIMECARRE COMMUNITY GRANT PROGRAM

110.11(135) Purpose
110.12 to 110.15 Reserved

PRIMECARRE PRIMARY CARE PROVIDER COMMUNITY SCHOLARSHIP PROGRAM

110.16(135) Purpose
110.17 to 110.20 Reserved

PRIMECARRE PRIMARY CARE PROVIDER LOAN REPAYMENT PROGRAM

110.21(135) Purpose

CHAPTER 111
Reserved

CHAPTER 112
BIOLOGICAL AGENT RISK ASSESSMENT

112.1(135) Purpose
112.2(135) Definitions
112.3(135) Biosecurity council established
112.4(135) Biological agent risk assessment
112.5(135) Requests for biological agent information
112.6(135) Exceptions

CHAPTER 113
PUBLIC HEALTH RESPONSE TEAMS

113.1(135) Definitions
113.2(135) Purpose
113.3(135) Sponsor agency
113.4(135) Public health response team members
113.5(135) Disaster medical assistance team
113.6(135) Environmental health response team
113.7(135) Legal and other protections
113.8(135) Reporting requirements and duties

CHAPTER 114
PREPAREDNESS ADVISORY COMMITTEE

114.1(135) Definitions
114.2(135) Purpose
114.3(135) Appointment
114.4(135) Membership
114.5(135) Officers
114.6(135) Meetings
114.7(135) Subcommittees
114.8(135) Expenses of preparedness advisory committee voting members
114.9(135) Gender balance

CHAPTERS 115 to 120
Reserved

CHAPTER 121
STANDARD FOR IMPACT RESISTANCE AND METHOD OF TESTING

121.1(135) Standard for impact-resistant lenses
121.2(135) Method of testing lenses

CHAPTERS 122 and 123
Reserved

CHAPTER 124
INTERAGENCY COORDINATING COUNCIL
FOR THE STATE MEDICAL EXAMINER

124.1(691) Purpose
124.2(691) Membership
124.3(691) Meetings
124.4(691) Duties
124.5(691) Minutes

CHAPTER 125
ADVISORY COUNCIL FOR THE STATE MEDICAL EXAMINER

125.1(691) Purpose
125.2(691) Membership
125.3(691) Meetings
125.4(691) Duties
125.5(691) Minutes

CHAPTER 126
STATE MEDICAL EXAMINER

126.1(144,331,691) Definitions
126.2 Reserved
126.3(691) Fees for autopsies and related services and reimbursement for related expenses
126.4(691) Fees for tissue recovery

CHAPTER 127
COUNTY MEDICAL EXAMINERS

127.1(144,331,691) Definitions
127.2(331,691) Duties of medical examiners—jurisdiction over deaths which affect the public interest
127.3(331,691) Autopsies
127.4(331,691) Fees
127.5(144,331,691) Death certificates—deaths affecting the public interest
127.6(331,691) Cremation
127.7(331,691) County medical examiner investigators
127.8(331,691) Deputy county medical examiners
127.9(331,691) Failure to comply with rules
127.10(331,691,22) Confidentiality
127.11(331,691,670) Indemnification

CHAPTERS 128 and 129
Reserved

CHAPTER 130
EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL

130.1(147A) Definitions
130.2(147A) Purpose
130.3(147A) Appointment
130.4(147A) Absences
130.5(147A) Officers
130.6(147A) Meetings
130.7(147A) Subcommittees

130.8(147A) Expenses of advisory council members
130.9(147A) Gender balance

CHAPTER 131
EMERGENCY MEDICAL SERVICES
PROVIDER EDUCATION/TRAINING/CERTIFICATION

131.1(147A) Definitions
131.2(147A) Emergency medical care providers—requirements for enrollment in training programs
131.3(147A) Emergency medical care providers—EMS provider authority
131.4(147A) Emergency medical care providers—certification, renewal standards, procedures, continuing education, and fees
131.5(147A) Training programs—standards, application, inspection and approval
131.6(147A) Continuing education providers—approval, record keeping and inspection
131.7(147A) Complaints and investigations—denial, citation and warning, probation, suspension, or revocation of emergency medical care personnel certificates or renewal
131.8(147A) Complaints and investigations—denial, citation and warning, probation, suspension, or revocation of training program or continuing education provider approval or renewal
131.9(147A) Reinstatement of certification
131.10(147A) Certification denial
131.11(147A) Emergency adjudicative proceedings
131.12(147A) Complaints, investigations and appeals

CHAPTER 132
EMERGENCY MEDICAL SERVICES—SERVICE PROGRAM AUTHORIZATION

132.1(147A) Definitions
132.2(147A) Authority of emergency medical care provider
132.3 to 132.6 Reserved
132.7(147A) Service program—authorization and renewal procedures, inspections and transfer or assignment of certificates of authorization
132.8(147A) Service program levels of care and staffing standards
132.9(147A) Service program—off-line medical direction
132.10(147A) Complaints and investigations—denial, citation and warning, probation, suspension or revocation of service program authorization or renewal
132.11 to 132.13 Reserved
132.14(147A) Temporary variances
132.15(147A) Transport options for fully authorized paramedic service programs

CHAPTER 133
WHITE FLASHING LIGHT AUTHORIZATION

133.1(321) Definitions
133.2(321) Purpose
133.3(321) Application
133.4(321) Approval, denial, probation, suspension and revocation of authorization
133.5(321) Appeal of denial, probation, or revocation of authorization

CHAPTER 134
TRAUMA CARE FACILITY CATEGORIZATION
AND VERIFICATION

134.1(147A) Definitions
134.2(147A) Trauma care facility categorization and verification
134.3(147A) Complaints and investigations and appeals—denial, citation and warning, probation, suspension, and revocation of verification as a trauma care facility

CHAPTER 135
TRAUMA TRIAGE AND TRANSFER PROTOCOLS

135.1(147A) Definitions
135.2(147A) Trauma triage and transfer protocols
135.3(147A) Offenses and penalties

CHAPTER 136
TRAUMA REGISTRY

136.1(147A) Definitions
136.2(147A) Trauma registry
136.3(147A) Offenses and penalties

CHAPTER 137
TRAUMA EDUCATION AND TRAINING

137.1(147A) Definitions
137.2(147A) Initial trauma education for Iowa's trauma system
137.3(147A) Continuing trauma education for Iowa's trauma system
137.4(147A) Offenses and penalties

CHAPTER 138
TRAUMA SYSTEM EVALUATION QUALITY IMPROVEMENT COMMITTEE

138.1(147A) Definitions
138.2(147A) System evaluation quality improvement committee (SEQIC)

CHAPTER 139
IOWA LAW ENFORCEMENT EMERGENCY CARE PROVIDER

139.1(147A) Definitions
139.2(147A) Authority of Iowa law enforcement emergency care provider
139.3(147A) Iowa law enforcement emergency care providers—requirements for enrollment in training programs
139.4(147A) Iowa law enforcement emergency care providers—certification, renewal standards and procedures, and fees
139.5(147A) Iowa law enforcement training programs
139.6(147A) Law enforcement AED service program authorization

CHAPTER 140
EMERGENCY MEDICAL SERVICES SYSTEM DEVELOPMENT GRANTS FUND

140.1(135) Definitions
140.2(135) Purpose
140.3(135) County EMS associations
140.4(135) County EMS system development grants

CHAPTER 141
LOVE OUR KIDS GRANT

141.1(321) Definitions
141.2(321) Purpose

141.3(321) Funding limitations
141.4(321) Use of funds
141.5(321) Application process
141.6(321) Application denial or partial denial—appeal

CHAPTER 142
OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDERS

142.1(144A) Definitions
142.2(144A) Purpose
142.3(144A,147A) Responsibilities of the department
142.4(144A,147A) EMS providers
142.5(144A) Guidelines for non-EMS health care providers, patients, and organizations
142.6(144A) Revocation of the out-of-hospital do-not-resuscitate order
142.7(144A) Personal wishes of family members or other individuals who are not authorized to act on the patient's behalf
142.8(144A) Transfer of patients
142.9(144A) Application to existing orders

CHAPTER 143
AUTOMATED EXTERNAL DEFIBRILLATOR GRANT PROGRAM

143.1(135) Purpose
143.2(135) Definitions
143.3(135) Application process
143.4(135) Early defibrillation program
143.5(135) Review process
143.6(135) Appeals

CHAPTERS 144 to 149
Reserved

CHAPTER 150
IOWA REGIONALIZED SYSTEM OF PERINATAL HEALTH CARE

150.1(135,77GA,ch1221) Purpose and scope
150.2(135,77GA,ch1221) Definitions
150.3(135,77GA,ch1221) Perinatal guidelines advisory committee
150.4(135,77GA,ch1221) Categorization and selection of level of care designation
150.5(135,77GA,ch1221) Recommendation by the statewide perinatal care program
150.6(135,77GA,ch1221) Level I hospitals
150.7(135,77GA,ch1221) Level II hospitals
150.8(135,77GA,ch1221) Level II regional centers
150.9(135,77GA,ch1221) Level II regional neonatology centers
150.10(135,77GA,ch1221) Level III centers
150.11(135,77GA,ch1221) Grant or denial of certificate of verification; and offenses and penalties
150.12(135,77GA,ch1221) Prohibited acts
150.13(135,77GA,ch1221) Construction of rules

CHAPTER 151
TOBACCO USE PREVENTION AND CONTROL
COMMUNITY PARTNERSHIP INITIATIVE

151.1(142A) Scope
151.2(142A) Community partnership areas
151.3(142A) Community partnerships
151.4(142A) Application requirements for community partnerships

151.5(142A) Performance indicators
151.6(142A) Application deadline
151.7(142A) Distribution of funding
151.8(142A) Gifts

CHAPTER 152
TOBACCO USE PREVENTION AND CONTROL FUNDING PROCESS

152.1(78GA,HF2565) Scope and purpose
152.2(78GA,HF2565) Funding
152.3(78GA,HF2565) Appeals

CHAPTER 153
SMOKEFREE AIR

153.1(82GA,HF2212) Purpose and scope
153.2(82GA,HF2212) Definitions
153.3(82GA,HF2212) Prohibition of smoking
153.4(82GA,HF2212) Areas where smoking not regulated
153.5(82GA,HF2212) Duties of employers, owners, operators, managers, and persons having custody or control of a public place, place of employment, area declared nonsmoking pursuant to 2008 Iowa Acts, House File 2212, section 5, or outdoor areas where smoking is prohibited
153.6(82GA,HF2212) Duties of other state agencies and political subdivisions
153.7(82GA,HF2212) Leases
153.8(82GA,HF2212) Complaints and enforcement
153.9(82GA,HF2212) Limitation of rules

CHAPTER 154
Reserved

CHAPTER 155
LICENSURE STANDARDS FOR SUBSTANCE ABUSE TREATMENT PROGRAMS

155.1(125) Definitions
155.2(125) Licensing
155.3(125) Type of licenses
155.4(125) Nonassignability
155.5(125) Application procedures
155.6(125) Application review
155.7(125) Inspection of licensees
155.8(125) Licenses—renewal
155.9(125) Corrective action plan
155.10(125) Grounds for denial of initial license
155.11(125) Suspension, revocation, or refusal to renew a license
155.12(125) Contested case hearing
155.13(125) Rehearing application
155.14(125) Judicial review
155.15(125) Reissuance or reinstatement
155.16(125) Complaints and investigations
155.17 Reserved
155.18(125) Deemed status
155.19(125) Funding
155.20(125) Inspection
155.21(125) General standards for all substance abuse treatment programs
155.22(125) Inpatient, residential, and halfway house safety

155.23(125) Specific standards for inpatient, residential, and halfway house service
155.24(125) Specific standards for inpatient, residential, and halfway house substance abuse service admitting juveniles
155.25(125) Specific standards for assessment and evaluation programs
155.26 to 155.34 Reserved
155.35(125) Specific standards for opioid treatment programs

CHAPTER 156
LICENSURE STANDARDS FOR SUBSTANCE ABUSE TREATMENT PROGRAMS IN CORRECTIONAL FACILITIES

156.1(125) Definitions
156.2(125) Inspection
156.3(125) General standards for all correctional substance abuse treatment programs

CHAPTER 157
STANDARDS FOR SUBSTANCE ABUSE TREATMENT AND ASSESSMENT PROGRAMS AND THE OPERATING A MOTOR VEHICLE WHILE INTOXICATED (OWI) LAW

157.1(125) Definitions
157.2(125) Screening, evaluation, treatment, and drinking drivers course
157.3(125) Screening, evaluation, treatment, and drinking drivers course completion
157.4(125) Cost of evaluation and treatment
157.5(125) Timeliness
157.6(125) Confidentiality
157.7(125) Records
157.8(125) Reciprocity

CHAPTER 158
REGIONS FOR SUBSTANCE ABUSE PREVENTION AND TREATMENT

158.1(125) Service areas established
158.2(125) Request for a change in service areas
158.3(125) Application
158.4(125) Notification of affected parties
158.5(125) Public hearing
158.6(125) Proposed decision
158.7(125) Change during term of contract
158.8(125) State board of health review
158.9(125) State board of health decision

CHAPTERS 159 to 161
Reserved

CHAPTER 162
LICENSURE STANDARDS FOR PROBLEM GAMBLING TREATMENT PROGRAMS

162.1(135) Definitions
162.2(135) Licensure
162.3(135) Type of licenses
162.4(135) Nonassignability
162.5(135) Application procedures
162.6(135) Application review
162.7(135) Inspection of licensees
162.8(135) Licensure renewal
162.9(135) Corrective action plans

162.10(135) On-site inspection for initial licensure
162.11(135) Denial, suspension, revocation, or refusal to renew a license
162.12(135) Contested case hearings
162.13(135) Rehearing application
162.14(135) Judicial review
162.15(135) Reissuance or reinstatement
162.16(135) Complaints and investigations
162.17(135) Funding
162.18(135) Inspection
162.19(135) Exemptions to rule 641—162.20(135)
162.20(135) General standards for all problem gambling treatment programs

CHAPTERS 163 to 169
Reserved

CHAPTER 170
DESCRIPTION OF ORGANIZATION
170.1(17A) Definitions
170.2(17A) State board of health
170.3(17A) Director of public health
170.4(17A,135) Administrative divisions of the department
170.5(17A) Central office
170.6(17A) Business hours
170.7(17A) Submission of materials
170.8(17A) Request for information

CHAPTER 171
PETITIONS FOR RULE MAKING
171.1(17A) Petition for rule making
171.2(17A) Briefs
171.3(17A) Inquiries
171.4(17A) Department consideration

CHAPTER 172
DECLARATORY ORDERS
172.1(17A) Petition for declaratory order
172.2(17A) Notice of petition
172.3(17A) Intervention
172.4(17A) Briefs
172.5(17A) Inquiries
172.6(17A) Service and filing of petitions and other papers
172.7(17A) Consideration
172.8(17A) Action on petition
172.9(17A) Refusal to issue order
172.10(17A) Contents of declaratory order—effective date
172.11(17A) Copies of orders
172.12(17A) Effect of a declaratory order

CHAPTER 173
CONTESTED CASES
173.1(17A) Scope and applicability
173.2(17A) Definitions
173.3(17A) Time requirements

173.4(17A) Requests for contested case proceeding
173.5(17A) Notice of hearing
173.6(17A) Presiding officer
173.7(17A) Waiver of procedures
173.8(17A) Telephone proceedings
173.9(17A) Disqualification
173.10(17A) Consolidation—severance
173.11(17A) Pleadings
173.12(17A) Service and filing of pleadings and other papers
173.13(17A) Discovery
173.14(17A,135) Subpoenas
173.15(17A) Motions
173.16(17A) Prehearing conference
173.17(17A) Continuances
173.18(17A) Withdrawals
173.19(17A) Intervention
173.20(17A) Hearing procedures
173.21(17A) Evidence
173.22(17A) Default
173.23(17A) Ex parte communication
173.24(17A) Recording costs
173.25(17A) Interlocutory appeals
173.26(17A) Final decision
173.27(17A) Appeals and review
173.28(17A) Applications for rehearing
173.29(17A) Stays of department actions
173.30(17A) No factual dispute contested cases
173.31(17A) Emergency adjudicative proceedings

CHAPTER 174
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

174.3(17A) Public rule-making docket
174.4(17A) Notice of proposed rule making
174.5(17A) Public participation
174.6(17A) Regulatory flexibility analysis
174.11(17A) Concise statement of reasons
174.13(17A) Agency rule-making record

CHAPTER 175
FAIR INFORMATION PRACTICES AND PUBLIC RECORDS

175.1(17A,22) Definitions
175.2(17A,22) Statement of policy
175.3(17A,22) Requests for access to records
175.4(17A,22) Access to confidential records
175.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination
175.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
175.7(17A,22) Consent to disclosure by the subject of a confidential record
175.8(17A,22) Notice to suppliers of information
175.9(17A,22) Disclosures without the consent of the subject
175.10(17A,22) Routine use

175.11(17A,22) Consensual disclosure of confidential records
175.12(17A,22) Release to subject
175.13(17A,22) Availability of records
175.14(17A,22) Personally identifiable information
175.15(17A,22) Other groups of records
175.16(17A,22) Data processing systems
175.17(17A,22) Applicability

CHAPTER 176
CRITERIA FOR AWARDS OR GRANTS

176.1(135,17A) Purpose
176.2(135,17A) Definitions
176.3(135,17A) Exceptions
176.4(135,17A) Requirements
176.5(135,17A) Review process (competitive applications only)
176.6 Reserved
176.7(135,17A) Public notice of available funds
176.8(135,17A) Appeals

CHAPTER 177
HEALTH DATA

177.1(76GA,ch1212) Purpose
177.2(76GA,ch1212) Definitions
177.3(76GA,ch1212) Description of data to be submitted
177.4(76GA,ch1212) Department studies
177.5(76GA,ch1212) Fees
177.6(76GA,ch1212) Patient confidentiality
177.7(76GA,ch1212) Department contracting
177.8(76GA,ch1212) Address and specification for data submissions

CHAPTER 178
VARIANCES AND WAIVERS OF PUBLIC HEALTH
ADMINISTRATIVE RULES

178.1(17A,135) Waivers
178.2(17A,135) Sample petition for waiver

CHAPTERS 179 to 190
Reserved

CHAPTER 191
ADVISORY BODIES OF THE DEPARTMENT

191.1(135) Definitions
191.2(135) Purpose
191.3(135) Appointment
191.4(135) Officers
191.5(135) Meetings
191.6(135) Subcommittees
191.7(135) Expenses of advisory body members
191.8(135) Gender balance

CHAPTER 192
CHILD SUPPORT NONCOMPLIANCE

192.1(252J) Issuance or renewal of a license—denial
192.2(252J) Suspension or revocation of a license
192.3(17A,22,252J) Sharing of information

CHAPTER 193
IMPAIRED PRACTITIONER REVIEW COMMITTEE

193.1(272C) Impaired practitioner review committee

CHAPTER 194
Reserved

CHAPTER 195
STUDENT LOAN DEFAULT/NONCOMPLIANCE WITH
AGREEMENT FOR PAYMENT OF OBLIGATION

195.1(261) General definitions
195.2(261) Issuance or renewal of a license—denial
195.3(261) Suspension or revocation of a license
195.4(17A,22,261) Sharing of information

CHAPTERS 196 to 200
Reserved

CHAPTER 201
ORGANIZED DELIVERY SYSTEMS

LICENSURE AND REGULATION

201.1(135,75GA,ch158) Purpose and scope
201.2(135,75GA,ch158) Definitions
201.3(135,75GA,ch158) Application
201.4(135,75GA,ch158) Governing body
201.5(135,75GA,ch158) Service area/geographic access
201.6(135,75GA,ch158,78GA,ch41) Provider network and contracts; treatment and services
201.7(135,75GA,ch158) Complaints
201.8(135,75GA,ch158) Accountability
201.9(135,75GA,ch158) Reporting
201.10(135,75GA,ch158) Evaluation
201.11(135,75GA,ch158) Annual report
201.12(135,75GA,ch158) Finance and solvency
201.13(135,75GA,ch158) Investment
201.14(135,75GA,ch158) Rating practices
201.15(135,75GA,ch158) Name
201.16(135,75GA,ch158) Change in organizational documents or control
201.17(135,75GA,ch158) Appeal
201.18(135,78GA,ch41) External review
201.19 Reserved

ANTITRUST

201.20(135,75GA,ch158) Purpose
201.21(135,75GA,ch158) Definitions
201.22(135,75GA,ch158) Scope
201.23(135,75GA,ch158) Application
201.24(135,75GA,ch158) Notice and comment
201.25(135,75GA,ch158) Procedure for review of applications

201.26(135,75GA,ch158) Criteria for decision
201.27(135,75GA,ch158) Decision
201.28(135,75GA,ch158) Appeal
201.29(135,75GA,ch158) Supervision after approval
201.30(135,75GA,ch158) Revocation

CHAPTER 202
CERTIFICATE OF NEED PROGRAM

202.1(135) Definitions
202.2(135) Letter of intent
202.3(135) Preliminary review
202.4(135) Submission of application
202.5(135) Organizational procedures
202.6(135) Public hearing on application
202.7(135) Summary review
202.8(135) Extension of review time
202.9(135) Rehearing of certificate of need decision
202.10(135) Status reports to affected persons
202.11(135) Finality
202.12(135) Project progress reports
202.13(135) Request for extension of certificate
202.14(135) Application changes after approval
202.15(135) Sanctions

CHAPTER 203
STANDARDS FOR CERTIFICATE OF NEED REVIEW

203.1(135) Acute care bed need
203.2(135) Cardiac catheterization and cardiovascular surgery standards
203.3(135) Radiation therapy or radiotherapy standards
203.4(135) Computerized tomography standards
203.5(135) Long-term care
203.6(135) Bed need formula for mentally retarded
203.7(135) End-stage renal disease standards
203.8(135) Financial and economic feasibility
203.9(135) Obstetrical services and neonatal intensive care unit standards
203.10(135) Designated pediatric units standards
203.11(135) Designated inpatient substance abuse treatment unit standards
203.12(135) Magnetic resonance imaging services standards
203.13(135) Positron emission tomography services standards

CHAPTER 204
UNIFORM REPORTING REQUIREMENTS

204.1(135) Reporting requirements
204.2(135) Initial reporting period

CHAPTERS 47 to 49
Reserved

CHAPTER 50
ORAL HEALTH

641—50.1(135) Purpose. The purpose of establishing the state public health dental director position and the oral health bureau within the Iowa department of public health is to create a strong oral health unit with sufficient leadership and capacity to determine priorities, develop plans, make funding decisions, and establish policies that improve the oral health of all Iowans. These rules will enhance the efficiency of state government, strengthen relationships with federal and local authorities, and improve interrelationships between the public and private sectors.

641—50.2(135) Definitions. For purposes of this chapter, the following definitions apply:

"Core public health functions" means the functions of health assessment, policy development, and assurance.

1. Assessment: regular collection, analysis, interpretation, and communication of information about health conditions, risks, and assets.
2. Policy development: development, implementation, and evaluation of plans and policies, for public health in general and priority health needs in particular, in a manner that incorporates scientific information and community values and is in accordance with state public health policy.
3. Assurance: ensuring, by encouragement, regulation, or direct action, that programs and interventions which maintain and improve health are carried out.

"Dental care for persons with disabilities program" means the department program to provide dental services to low-income children and young adults with special health care needs.

"Dental home" means a network of dental and nondental public and private health care professionals providing individualized care based on risk assessment. Services include oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services.

"Dental sealant program" means the department program implemented through public or private nonprofit agencies to provide dental examinations or screenings and dental sealants to children in a school-based setting.

"Department" means the Iowa department of public health.

"Direct dental services" means those services generally delivered one-on-one between a health professional and a client.

"Enabling services" means services that allow or provide for access to and the derivation of benefits from the array of basic health care services and includes activities such as outreach, case management, health education, transportation, translation, home visits, support services, and other services.

"EPSDT" means the Early and Periodic Screening, Diagnosis, and Treatment program which provides for regular preventive health care services for children aged 0 to 21 as authorized by Title XIX of the Social Security Act.

"Fluoride mouth rinse program" means the department program implemented through elementary schools and middle schools, which includes oral health education and weekly rinsing with fluoride. The program targets schools with children at high risk for tooth decay.

"Gap filling" means direct health services supported by public health staff or resources that are needed but are not otherwise accessible in the community.

"Infrastructure building" means activities directed at improving and maintaining the health status of all clients by providing support for the development and maintenance of comprehensive health service systems, including development and maintenance of health service standards or guidelines, training, data, and planning systems.

"I-Smile program" means the department program implemented through public and private nonprofit agencies and private health care providers to increase access to dental care for children and to ensure a dental home.

"Medicaid" means the Medicaid program authorized by Title XIX of the Social Security Act and funded through the Iowa department of human services from the United States Department of Health and Human Services.

"Oral health education" means information provided by a health professional about dental disease, prevention, and anticipatory guidance, including oral habits, oral development, fluoride exposure, and dietary counseling.

"Population-based services" means preventive interventions and personal health services developed for and available to populations of the state rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components.

"Senior smiles program" means the department program implemented through public and nonprofit private agencies to provide oral screenings and interventions for older Iowans.

"Title V" means Title V of the Social Security Act and the federal requirements contained in the Omnibus Reconciliation Act of 1989 (Public Law 101-239) which address the Maternal and Child Health and Children with Special Health Care Needs programs.

"Title V maternal and child health program" means the department program implemented through local public or private nonprofit agencies for the assurance of access to preventive and primary child and maternal health services and services to children with special health care needs in accordance with 641—Chapter 76, Maternal and Child Health Program. Through this program, agencies are responsible for ensuring access to dental services, with an emphasis on early intervention and preventive oral health care beginning at or near the age of 12 months and continuing into adulthood.

"Title XIX" means the Medicaid program authorized by Title XIX of the Social Security Act and funded through the Iowa department of human services from the United States Department of Health and Human Services.

"Vulnerable populations" means individuals and groups whose needs are not addressed by traditional dental service providers and health care systems.

641—50.3(135) Dental director responsibilities. The state public health dental director shall provide overall leadership of the state oral health program and shall be responsible for the following duties:

1. Plan and direct all work activities of the statewide public health dental program.
2. Develop comprehensive initiatives for oral health prevention and improved access to dental care.
3. Evaluate the effectiveness of the statewide public health dental program and of program personnel.
4. Manage the oral health bureau, including direction, supervision, and fiscal management of bureau staff.
5. Represent the department to external stakeholders, including public and private organizations, providers, and the general public.
6. Other related work as required.

641—50.4(135) Oral health bureau functions. The bureau shall be responsible for the core public health functions of assessment, policy development, and assurance of oral health services in Iowa.

50.4(1) *Assessment.* The bureau shall develop and implement an ongoing oral health surveillance system to evaluate and monitor the oral health status of children and other vulnerable population groups in Iowa. Assessment activities may include the following:

a. Assess oral health status and needs so that problems can be identified and addressed.

b. Assess determinants of identified oral health needs, including resources.

c. Assess the fluoridation status of water systems and other sources of fluoride.

d. Identify, investigate, and monitor oral health problems and health hazards.

50.4(2) *Policy development.* The bureau shall facilitate ongoing strategic planning and application of evidence-based research in oral health policy development to improve access to care and the overall oral health of all Iowans. Policy development activities may include the following:

a. Develop plans and policies through a collaborative process that supports individual and community oral health efforts to address oral health needs.

b. Provide leadership to address oral health problems by maintaining a strong oral health unit within the department.

c. Mobilize partnerships with policymakers, professionals, organizations, groups, the public and others to identify and implement solutions to oral health problems.

50.4(3) *Assurance.* The bureau shall assist Iowans in maintaining optimal oral health throughout all stages of life by providing or ensuring infrastructure-building, population-based, and enabling services at the state and local level. Infrastructure-building and enabling services shall target the improvement of access to dental care and prevention. Population-based services shall include public health training and technical assistance, educational activities that increase oral health awareness, and activities that improve dental support systems for families.

The bureau shall leverage federal, state, and local resources to administer grant programs which include Title V maternal and child health, including the Medicaid and EPSDT programs; I-Smile program; dental sealant program; fluoride mouth rinse program; dental care for persons with disabilities program; senior smiles program; and other new and existing programs. Assurance activities may include the following:

a. Provide assistance and resources to local public health programs for community capacity-building efforts to identify vulnerable populations and to develop innovative approaches that link people to needed oral health services, including gap-filling direct dental services.

b. Inform, educate, and empower the public regarding oral health problems and solutions.

c. Promote and enforce laws and regulations that protect and improve oral health, ensure safety, and assure public accountability for the public's well-being.

d. Assure that the public health and personal health workforce has the capacity and expertise to effectively address oral health needs.

e. Evaluate the effectiveness, accessibility, and quality of population-based and personal oral health services.

f. Conduct research and support projects to gain new insights and promote innovative solutions to oral health problems.

641—50.5(135) Funding. The oral health bureau and the state public health dental director shall be funded through federal Title V funds and state matching funds, state general funds, department of human services funding, and other funds as available.

These rules are intended to implement Iowa Code Supplement sections 135.14 and 135.15.

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CHAPTER 51
DENTAL SCREENING

641—51.1(82GA,ch146,SF2111) Purpose. The purpose of the dental screening requirement is to improve the oral health of Iowa's children. Dental screenings will facilitate early detection and referral for treatment of dental disease; reduce the incidence, impact, and cost of dental disease; inform parents and guardians of their children's dental problems; encourage the establishment of effective oral health practices early in life; promote the importance of oral health as an integral component of preparation for school and learning; and contribute to statewide surveillance of oral health. These rules will enhance the I-Smile dental home concepts of prevention, education, care coordination, and treatment to provide a critical step in closing the gap in access to dental care for underserved children.

641—51.2(82GA,ch146,SF2111) Definitions. For purposes of this chapter, the following definitions apply:

"Admitting official" means the superintendent of schools or the superintendent's designated representative if a public school; if an accredited nonpublic school, the governing official of the school.

"Applicant" means any person seeking first-time enrollment in an Iowa elementary school or high school.

"Dental hygienist" means a person licensed to practice as a dental hygienist pursuant to Iowa Code chapter 153.

"Dentist" means a person licensed to practice as a dentist pursuant to Iowa Code chapter 153.

"Department" means the Iowa department of public health.

"Electronic signature" means a confidential personalized digital key, code, or number that is used for secure electronic data transmission and that identifies and authenticates the signatory.

"Elementary school" means kindergarten, if provided, and grades one through six in an Iowa school district or accredited nonpublic school.

"High school" means grades 9 through 12 in an Iowa school district or accredited nonpublic school.

"Infection or injury" means soft tissue laceration, bleeding or swelling, or a broken or dislodged tooth.

"I-Smile" means the department program designed to increase access to dental care for children and to ensure a dental home.

"I-Smile coordinator" means a designated dental hygienist who is employed by or under contract with a local public health agency to administer the I-Smile dental home program.

"Local board of health" means a county, city, or district board of health as defined in Iowa Code section 137.2.

"No obvious problems" means a child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

"Nurse" means a person licensed to practice as a nurse pursuant to Iowa Code chapter 152.

"Physician" means a person licensed to practice medicine and surgery or osteopathic medicine and surgery pursuant to Iowa Code chapter 148, 150, or 150A.

"Physician assistant" means a person licensed to practice as a physician assistant pursuant to Iowa Code chapter 148C.

"Requires dental care" means that tooth decay or a white spot lesion is suspected in one or more teeth.

"Requires urgent dental care" means that obvious tooth decay is present in one or more teeth, the child is experiencing pain, or there is evidence of infection or injury.

"Signature" means an original signature, or authorized use of stamped signature, or electronic signature of a dentist, dental hygienist, physician, physician assistant, or nurse.

"Tooth decay" means a visible cavity or hole in a tooth with brown or black coloration, or a retained root.

"Transfer student" means an applicant from an elementary school or a high school outside Iowa who is seeking enrollment in an elementary school or a high school located in Iowa.

"White spot lesion" means a demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gum line. A white spot lesion is considered an early indicator of tooth decay, especially in primary teeth.

641—51.3(82GA,ch146,SF2111) Persons included. The dental screening requirements specified in this chapter apply to all persons newly enrolled or attempting to enroll for the first time in a public or accredited nonpublic elementary school or high school in Iowa.

641—51.4(82GA,ch146,SF2111) Persons excluded. Exclusions to these rules are permitted on an individual basis for religious and financial hardship reasons. Applicants approved for a religious or financial hardship exemption shall submit to the admitting official a valid Iowa department of public health certificate of dental screening exemption.

51.4(1) Religious exemption. A religious exemption may be granted to an applicant if the dental screening conflicts with a genuine and sincere religious belief.

a. The certificate of dental screening exemption for religious reasons shall attest that the dental screening conflicts with a genuine and sincere religious belief and that the belief is in fact religious and not based merely on philosophical, scientific, moral, personal, or medical opposition to dental screenings.

b. The certificate of dental screening exemption for religious reasons shall be signed and dated by the applicant or, if the applicant is a minor, by the parent or guardian.

c. The certificate of dental screening exemption for religious reasons is valid only when notarized.

d. To be valid, the certificate of dental screening exemption for religious reasons shall be the department certificate or a form approved in writing by the department.

51.4(2) Financial hardship exemption. A financial hardship exemption may be granted to an applicant who is unduly burdened by the cost of a dental screening.

a. The certificate of dental screening exemption for financial hardship reasons shall attest that dental screening would cause a genuine financial burden to the applicant.

b. The certificate of dental screening exemption for financial hardship reasons shall be signed and dated by a dentist, dental hygienist, physician, physician assistant, or nurse.

c. The certificate of dental screening exemption for financial hardship reasons shall include the provider type and the provider's name, business address, and telephone number.

d. To be valid, the certificate of dental screening exemption for financial hardship reasons shall be the department certificate or a form approved in writing by the department.

51.4(3) A faxed copy, photocopy, or electronic copy of the valid certificate of dental screening exemption is acceptable.

641—51.5(82GA,ch146,SF2111) Dental screening components.

51.5(1) A dental screening is a visual assessment and is noninvasive and nondiagnostic.

51.5(2) Dental instrumentation is not required for a dental screening.

51.5(3) A dental screening can identify obvious or suspected oral health conditions that require or that might require examination by a dentist.

51.5(4) The dental screening shall include the following steps:

a. Visual inspection of the soft tissues, including the lips, cheeks, gums, tongue, floor of mouth, and roof of mouth, to assess infection or injury.

b. Visual inspection of all tooth surfaces to assess tooth decay, white spot lesions, or injury.

c. Documentation of the screening and treatment needs according to 51.9(82GA,ch146,SF2111).

641—51.6(82GA,ch146,SF2111) Dental screening providers.

51.6(1) *Elementary school.* A dental screening for elementary school enrollment shall be performed by a licensed dentist, a licensed dental hygienist, a licensed physician, a licensed physician assistant, or a licensed nurse.

51.6(2) *High school.* A dental screening for high school enrollment shall be provided by a licensed dentist or a licensed dental hygienist.

641—51.7(82GA,ch146,SF2111) Time line for valid dental screening.

51.7(1) Elementary school. To be valid, a minimum of one dental screening shall be performed on an applicant no earlier than three years of age but prior to reaching six years of age.

51.7(2) High school. To be valid, a minimum of one dental screening shall be performed on an applicant within one year prior to the enrollment date.

51.7(3) A dental screening may also be deemed valid by the department if the department determines that the applicant has substantially complied with the dental screening requirements.

641—51.8(82GA,ch146,SF2111) Proof of dental screening. The applicant or, if a minor, the parent or guardian of a child enrolled in elementary school or high school shall submit a valid Iowa department of public health certificate of dental screening to the admitting official of the school district or accredited nonpublic elementary school in which the applicant wishes to enroll.

51.8(1) To be valid, the certificate of dental screening shall be the department certificate or a form approved in writing by the department.

a. The Certificate of Dental Screening form is available on the department's Web site at http://www.idph.state.ia.us/hpcdp/oral_health.asp or is available by calling the department at (866)528-4020.

b. Elementary school. The certificate of dental screening shall be signed by a dentist, dental hygienist, physician, physician assistant, or nurse.

c. High school. The certificate of dental screening shall be signed by a dentist or dental hygienist.

d. The certificate of dental screening shall include all information required by 51.9(82GA,ch146,SF2111).

51.8(2) A faxed copy, photocopy, or electronic copy of the valid certificate of dental screening is acceptable.

641—51.9(82GA,ch146,SF2111) Dental screening documentation. A person performing a dental screening required by this chapter shall record the following student information on the certificate of dental screening provided or approved in writing by the department of public health in cooperation with the department of education:

1. Name (first and last);
2. Birth date;
3. Parent or guardian name;
4. Telephone numbers (home or mobile);
5. Address (street, city, and county);
6. School;
7. Grade level;
8. Gender;
9. Treatment needs (no obvious problems, requires dental care, requires urgent dental care);
10. Date of dental screening;
11. Provider type;
12. Provider name, business address, and telephone number; and
13. Provider signature.

641—51.10(82GA,ch146,SF2111) Assuring dental screening services. Each public and accredited nonpublic school, in collaboration with the department, shall assure that the parent or guardian of a student enrolled in the school has complied with the dental screening requirement. Parents or guardians of students who do not have a valid certificate of dental screening shall be provided with community dental screening referral resources, including contact information for the I-Smile coordinator, the department, or a dental society.

641—51.11(82GA,ch146,SF2111) Records. It shall be the duty of the admitting official of an elementary school or a high school to ensure that a valid certificate of dental screening or certificate of dental screening exemption is on file for each child enrolled.

51.11(1) The admitting official shall ensure that all certificates of dental screening are properly completed according to 51.8(82GA,ch146,SF2111).

51.11(2) The admitting official shall ensure that all certificates of dental screening exemption are properly completed according to 51.4(1) and 51.4(2).

51.11(3) The admitting official shall keep the certificates of dental screening or certificates of dental screening exemption on file at the school in which the applicant is enrolled and assist the applicant or the applicant's parent or guardian in the transfer of the certificate to another school upon the transfer of the applicant to another school.

51.11(4) The local board of health or its designee, the department of education, and the department or its designee shall have the right to have access to the certificates of dental screening and certificates of dental screening exemption of students enrolled in elementary schools and high schools.

641—51.12(82GA,ch146,SF2111) Reporting.

51.12(1) It shall be the duty of each local board of health or its designee to audit the certificates of dental screening and certificates of dental screening exemption in the schools within the local board's jurisdiction to determine compliance with 2007 Iowa Acts, chapter 146, and 2008 Iowa Acts, Senate File 2111.

51.12(2) By June 30 annually, each local board of health shall furnish the department with evidence for the preceding school year that each child enrolled in any public or accredited nonpublic school within the local board's jurisdiction met the dental screening requirement.

51.12(3) The evidence shall be in the form of a report that includes:

a. Name of school, and

b. Enrollments by grade, and

c. The number of valid certificates of dental screening by grade, and

d. The number of valid certificates for religious exemptions by grade, and

e. The number of valid certificates for financial hardship exemptions by grade.

641—51.13(82GA,ch146,SF2111) Iowa's dental screening database. The department may develop and maintain a statewide dental screening database to ensure that students receive the required dental screening and to monitor oral health.

51.13(1) The database may consist of information from the valid certificates of dental screening and certificates of dental screening exemption, including identifying and demographic data.

51.13(2) The database may be updated, at a minimum, annually.

51.13(3) Database reporting shall comply with 51.13(82GA,ch146,SF2111).

51.13(4) Restricted uses of database. The database information shall not be used to:

a. Market services to students or nonstudents,

b. Assist in bill collection services, or

c. Locate or identify students or nonstudents for any purpose other than those expressly provided in this rule.

51.13(5) Confidentiality of database information. Dental screening information, including identifying and demographic data maintained in the database, is confidential and may not be disclosed except under the following limited circumstances:

a. The department may release information from the database to the following:

(1) The person who received the dental screening or the parent or guardian of the person who received the dental screening;

(2) Users of the database who complete an agreement with the department that specifies the conditions under which the database can be accessed and who have been issued an identification code or password by the department;

(3) Persons or entities requesting dental screening data in an aggregate form that does not identify an individual either directly or indirectly;

(4) Agencies that complete an agreement with the department which specifies conditions for access to database information and how that information will be used. Agencies shall not use information obtained from the database to market services to students or nonstudents, to assist in bill collection services, or to locate or identify students or nonstudents for any purposes other than those expressly provided in this rule; or

(5) A representative of a state or federal agency, or an entity bound by that state or federal agency, to the extent that the information is necessary to perform a legally authorized function of that agency or the department. The state or federal agency is subject to confidentiality regulations that are the same as or more stringent than those in the state of Iowa. State or federal agencies shall not use information obtained from the database to market services to students or nonstudents, to assist in bill collection services, or to locate or identify students or nonstudents for any purposes other than those expressly provided in this rule.

b. Approved database users shall not release dental screening data except to the person who received the dental screening, the parent or guardian of the person who received the dental screening, health records staff of schools, medical, dental, or health care providers providing continuity of care, and other approved users of the database.

641—51.14(82GA,ch146,SF2111) Release of dental screening information.

51.14(1) *Between a dentist, dental hygienist, physician, physician assistant, or nurse, and the elementary school or high school that the child attends.* A dentist, dental hygienist, physician, physician assistant, or nurse shall disclose a student's dental screening information, including the student's name, date of birth, name of parent or guardian, demographic information, the month, day and year of the screening, and the screening results and treatment needs to an elementary school or a high school upon written or verbal request from the elementary school or high school. Written or verbal permission from a student or the student's parent or guardian is not required to release this information to an elementary school or a high school.

51.14(2) *Among dentists, dental hygienists, physicians, physician assistants, or nurses.* Dental screening information, including the student's name, date of birth, name of parent or guardian, demographic information, the month, day and year of the screening, and the screening results and treatment needs shall be provided by one dentist, dental hygienist, physician, physician assistant, or nurse to another health care provider without written or verbal permission from the student or the student's parent or guardian.

641—51.15(82GA,ch146,SF2111) Referral requirements. Parents or guardians of students who require dental care or require urgent dental care shall be referred to the parent's or guardian's dentist of choice. Students without a dentist or who have difficulty accessing dental care shall be referred to a local I-Smile coordinator or local public health agency for assistance with completion of dental care. This assistance may include locating dentists, scheduling appointments, and identifying payment sources.

641—51.16(82GA,ch146,SF2111) Provider training. For the purpose of quality assurance and consistency, the department shall make training and training materials available for dental screening providers.

These rules are intended to implement 2007 Iowa Acts, chapter 146, and 2008 Iowa Acts, Senate File 2111.

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CHAPTERS 52 to 54
Reserved

CHAPTERS 57 to 66
Reserved

CHAPTER 67
BLOOD LEAD TESTING

641—67.1(135) Purpose. The purpose of the blood lead testing requirement is to improve the health of Iowa's children. Blood lead testing will facilitate early detection and referral for treatment of lead poisoning; reduce the incidence, impact, and cost of lead poisoning; inform parents and guardians of their children's exposure to lead; promote the importance of reducing exposure to lead as an integral component of preparation for school and learning; and contribute to statewide surveillance of childhood lead poisoning.

641—67.2(135) Definitions. For purposes of this chapter, the following definitions apply:

"Applicant" means any person seeking first-time enrollment in kindergarten in a public or accredited nonpublic elementary school in Iowa.

"Blood lead database" means the database maintained by the department that includes the results of all blood lead testing reported to the department as required by 641—Chapter 1.

"Blood lead testing" means taking a capillary or venous sample of blood and sending it to a laboratory to determine the level of lead in the blood.

"Capillary" means a blood sample taken from the finger or heel for lead analysis.

"Department" means the Iowa department of public health.

"Elementary school" means an Iowa school district or accredited nonpublic school offering kindergarten.

"Health care provider" means a physician licensed under Iowa Code chapter 148, 150, or 150A, a physician assistant licensed under Iowa Code chapter 148C, or an advanced registered nurse practitioner licensed under Iowa Code chapter 152.

"Laboratory" means a laboratory certified to perform either waived or non-waived blood lead analysis according to the federal Clinical Laboratory Improvement Act of 1988 (CLIA).

"Transfer student" means an applicant from any elementary school outside Iowa who is seeking enrollment in kindergarten in an elementary school in Iowa.

"Venous" means a blood sample taken from a vein in the arm for lead analysis.

"Very low risk" means that a child has not (1) lived in, visited, or spent time in any building built before 1960, including but not limited to the child's home, a daycare center, a preschool, a baby-sitter's home or a relative's home; (2) eaten nonfood items; (3) lived with or frequently come in contact with an adult who works with lead on the job or as part of a hobby, including but not limited to painting, welding, foundry work, renovating old homes, working at a shooting range, manufacturing or recycling batteries, working with ceramics or stained glass, working with sheet metal or scrap metal, or plumbing; (4) lived near a battery manufacturing plant, battery recycling plant, lead smelter, or other source of lead emissions; (5) been born in or spent more than three months in Mexico, Central America, eastern Europe, or southeast Asia; (6) ingested food, candy, or remedies containing lead; (7) played with toys, jewelry, or other items that the U.S. Consumer Product Safety Commission has recalled due to lead contamination; or (8) been exposed to any other products or substances determined by the department, the U.S. Environmental Protection Agency, the U.S. Department of Housing and Urban Development, the Centers for Disease Control and Prevention, or the U.S. Food and Drug Administration to contain lead.

641—67.3(135) Persons included. The blood lead testing requirement specified in this chapter applies to all applicants and transfer students as defined in this chapter.

641—67.4(135) Persons excluded. Exclusions to these rules are permitted on an individual basis for religious reasons and for children determined by the department to be at very low risk for elevated blood lead levels. The parent or guardian of an applicant or transfer student approved for a religious exemption or an exemption for very low risk shall submit to the board of directors of each school district and the authorities in charge of each nonpublic school a valid Iowa department of public health certificate of

blood lead testing exemption. To be valid, the certificate shall be the certificate of blood lead testing exemption provided or approved by the department.

67.4(1) Religious exemption. A religious exemption may be granted to an applicant or transfer student if the blood lead testing conflicts with a genuine and sincere religious belief.

a. The certificate of blood lead testing exemption for religious reasons shall attest that the blood lead testing conflicts with a genuine and sincere religious belief and that the belief is in fact religious and not based merely on philosophical, scientific, moral, personal, or medical opposition to blood lead testing.

b. The certificate of blood lead testing exemption for religious reasons shall be signed and dated by the applicant's or transfer student's parent or guardian.

c. The certificate is valid only when notarized.

67.4(2) Exemption for very low risk. The department may grant to an applicant or transfer student an exemption for very low risk if the parent or guardian provides evidence satisfactory to the department that the applicant or transfer student meets the definition of very low risk.

a. The certificate of blood lead testing exemption for very low risk shall be signed and dated by the applicant's or transfer student's parent or guardian and by the chief of the bureau of lead poisoning prevention.

b. The certificate of blood lead testing exemption for very low risk is valid only when notarized.

67.4(3) A faxed copy, photocopy, or electronic copy of the valid certificate of blood lead testing exemption is acceptable.

641—67.5(135) Blood lead testing requirement.

67.5(1) Each applicant and transfer student shall meet the requirements of subrule 67.6(1).

67.5(2) The board of directors of each school district and the authorities in charge of each nonpublic school shall, in collaboration with the department, ensure that applicants and transfer students comply with the blood lead testing requirement according to subrule 67.6(1).

641—67.6(135) Time line for valid blood lead testing.

67.6(1) To be valid, a blood lead test shall be performed on an applicant or transfer student before the applicant or transfer student reaches six years of age, or in cases in which the applicant or transfer student has already reached six years of age, as soon as the department notifies the parent or guardian that a blood lead test has not yet been performed.

67.6(2) Desirable age for blood lead testing. A parent or guardian of a child under two years of age is strongly encouraged to have the child tested for elevated blood lead levels by the time that the child reaches two years of age.

641—67.7(135) Proof of blood lead testing.

67.7(1) The board of directors of each school district and the authorities in charge of each nonpublic school shall furnish the department, in the format specified by the department, within 60 days after the start of the school calendar, an electronic list of the children enrolled in kindergarten, including the names of children who have filed certificates of blood lead testing exemption.

67.7(2) The department shall match these electronic lists of children with the department's blood lead database and shall notify the school districts and nonpublic schools of the children who have and who have not met the blood lead testing requirement set forth in this chapter.

67.7(3) If the parent or guardian cannot provide evidence that the child received a blood lead test in accordance with subrule 67.5(1), the board of directors of the school district or the authorities in charge of the nonpublic school shall, in collaboration with the department, provide the parent or guardian with community blood lead testing program information, including contact information for the department. The department shall provide this information to and shall work with the school districts, nonpublic schools, and the local childhood lead poisoning prevention programs to ensure that children who have not met the blood lead testing requirement are tested as required by subrule 67.5(1).

641—67.8(135) Referral requirements. Parents or guardians of children who require a blood lead test shall be referred to a health care provider of choice. The parents or guardians of children without a health care provider or who have difficulty accessing blood lead testing shall be referred to a local childhood lead poisoning prevention program, local child health center, or local public health agency for assistance with completion of blood lead testing. This assistance may include locating health care providers, scheduling appointments, identifying payment sources, and providing blood lead testing.

641—67.9(135) Blood lead testing documentation. A health care provider performing a blood lead test required by this chapter shall ensure that the results of the blood lead test are reported to the department as required by 641—Chapter 1.

641—67.10(135) Records. The board of directors of each school district and the authorities in charge of each nonpublic school shall, in collaboration with the department, ensure that each applicant and transfer student complies with the blood lead testing requirement according to subrule 67.6(1) or has a valid certificate of blood lead testing exemption on file.

67.10(1) The board of directors of each school district and the authorities in charge of each nonpublic school shall ensure that the certificate of blood lead testing exemption is properly completed according to rule 641—67.4(135).

67.10(2) Within the constraints of the privacy rights of the parents or guardians and students, the local board of health, the department of education, and the department or its designee shall have the right to have access to the department's determination that a child has received a blood lead test and to the certificates of blood lead testing exemption of children enrolled in kindergarten.

641—67.11(135) Provider training. For the purpose of quality assurance and consistency, the department shall make training and training materials available for health care providers who will be performing blood lead testing and for school officials, school health personnel, local childhood lead poisoning prevention programs, local child health centers, and local public health agencies.

These rules are intended to implement Iowa Code Supplement section 135.105D and 2008 Iowa Acts, Senate File 2111.

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CHAPTER 109
PRESCRIPTION DRUG DONATION REPOSITORY PROGRAM

641—109.1(135M) Definitions. For purposes of this chapter, the following definitions apply:

"Centralized repository" means a distributor approved by the contractor and licensed pursuant to 657 IAC Chapter 17 that accepts donated drugs, conducts a safety inspection of the drugs, and ships the donated drugs to a local repository to be dispensed in compliance with this chapter and federal and state laws, rules and regulations.

"Contractor" means the third party approved by the department to implement and administer the prescription drug donation repository program.

"Controlled substance" means the same as defined in Iowa Code section 124.101.

"Department" means the Iowa department of public health.

"Indigent" means a person with an income that is below 200 percent of the federal poverty level (FPL) as defined by the most recently revised poverty income guidelines published by the United States Department of Health and Human Services.

"Local repository" means a pharmacy or medical facility that elects to accept and dispense donated drugs and that meets the eligibility requirements of rule 641—109.3(135M).

"Medical facility" means any of the following:

1. A physician's office.
2. A hospital.
3. A health clinic.
4. A nonprofit health clinic, including a federally qualified health center as defined in 42 U.S.C. § 1396d(l)(2)(B); a rural health clinic as defined in 42 U.S.C. § 1396d(l)(1); and a nonprofit health clinic that provides medical care to patients who are indigent, uninsured, or underinsured.
5. A free clinic as defined in Iowa Code section 135.24.
6. A charitable organization as defined in Iowa Code section 135.24.
7. A nursing facility as defined in Iowa Code section 135C.1.

"NDC #" means the unique national drug code number that identifies a specific approved drug.

"Nurse practitioner" means an advanced registered nurse practitioner as defined in 655 IAC Chapter 7.

"Pharmacist" means a pharmacist as defined in Iowa Code section 155A.3.

"Pharmacy" means a pharmacy as defined in Iowa Code section 155A.3.

"Physician" means an individual licensed under Iowa Code chapter 148, 150, or 150A.

"Prescription drug" means the same as defined in Iowa Code section 155A.3 and includes cancer drugs and antirejection drugs, but does not include controlled substances.

"Supplies" means the supplies necessary to administer the prescription drugs donated.

"USP" means United States Pharmacopoeia.

641—109.2(135M) Purpose. The overall purpose of this chapter is to establish administrative rules in accordance with Iowa Code chapter 135M relative to the following:

1. Requirements for medical facilities and pharmacies to accept and dispense donated prescription drugs and supplies.
2. Eligibility criteria for individuals to receive donated prescription drugs and supplies.

641—109.3(135M) Eligibility criteria for program participation by medical facilities and pharmacies.

109.3(1) To be eligible for participation in the prescription drug donation repository program, a medical facility or pharmacy shall be in compliance with all applicable federal and state laws, including laws applicable to the storage and distribution of drugs and the appropriate licensure standards, and shall hold active, nonrestricted, state-issued licenses or registrations in good standing.

109.3(2) Participation in the prescription drug donation repository program is voluntary.

109.3(3) A pharmacy or medical facility may elect to participate in the prescription drug donation repository program by providing, on a form prescribed by the department and available on the program's Web page, written notification to the centralized repository of all of the following:

a. The name, street address, and telephone number of the pharmacy or medical facility, and any state-issued license or registration number issued to the pharmacy or medical facility, including the name of the issuing agency.

b. The name and telephone number of the responsible pharmacist, physician or nurse practitioner who is employed by or under contract with the pharmacy or medical facility.

c. A statement, signed and dated by the responsible pharmacist, physician or nurse practitioner, indicating that the pharmacy or medical facility meets the eligibility requirements under this rule and shall comply with the requirements of this chapter.

109.3(4) Withdrawal from participation. A pharmacy or medical facility may withdraw from participation in the prescription drug donation repository program at any time by providing written notice to the centralized repository on a form prescribed by the department and available on the program's Web page.

641—109.4(135M) Standards and procedures for accepting donated prescription drugs and supplies.

109.4(1) Any individual who is 18 years of age or older may donate legally obtained prescription drugs or supplies to the centralized repository or a local repository if the drugs or supplies meet the requirements of this rule, as determined by a pharmacist who is employed by or under contract with a drug repository.

109.4(2) No drugs that require storage temperatures other than normal room temperature as specified by the manufacturer or United States Pharmacopoeia shall be donated or accepted as part of the prescription drug donation repository program. Drugs that require storage temperatures other than normal room temperature as specified by the manufacturer or USP shall not be donated or accepted because of the increased potential for these drugs to become adulterated. Excluded from this restriction are drugs donated directly from a drug manufacturer.

109.4(3) Controlled substances shall not be donated or accepted. Pursuant to federal and state laws, a controlled substance cannot be returned or reused once the drug has been dispensed to a patient.

109.4(4) The centralized repository or a local repository may accept a prescription drug only if all of the following requirements are met:

a. The drug is in its original sealed and tamper-evident packaging. However, a drug in a single-unit dose or blister pack with the outside packaging opened may be accepted if the single-unit-dose packaging is undisturbed;

b. The drug has been stored according to manufacturer or USP storage requirements;

c. The packaging contains the lot number and expiration date of the drug. If the lot number is not retrievable, all specified medications will be destroyed in the event of a recall, pursuant to Iowa board of pharmacy rules;

d. The drug has an expiration date that is more than six months after the date that the drug was donated. However, a donated prescription drug bearing an expiration date that is six months or less after the date the prescription drug was donated may be accepted and distributed if the drug is in high demand and can be dispensed for use prior to the drug's expiration date;

e. The drug does not have any physical signs of tampering or adulteration, and there is no reason to believe that the drug is adulterated;

f. The packaging does not have any physical signs of tampering, misbranding, deterioration, compromised integrity or adulteration; and

g. All drugs shall be inventoried at the centralized repository or a local repository. The inventory shall include the name of the drug, strength of the drug, quantity of the drug, and the date of donation if the drug has been continually under the control of a health care professional. If the drug has not been continually under the control of a health care professional, the repository shall collect a donation form

provided by the prescription drug donation repository program that is signed by the person making the donation or that person's authorized representative.

109.4(5) A repository may accept supplies necessary to administer the prescription drugs donated only if all of the following requirements are met:

a. The supplies are in their original, unopened, sealed packaging;

b. The supplies are not adulterated or misbranded; and

c. All supplies shall be inventoried at the centralized repository or a local repository. The inventory shall include a description of the supplies and the date donated. Such inventory shall be recorded on a form provided by the prescription drug donation repository program.

109.4(6) Drugs and supplies may be donated on the premises of a participating centralized repository or a local repository to a person designated by the repository. A drop box may not be used to deliver or accept donations.

641—109.5(135M) Standards and procedures for inspecting and storing donated prescription drugs and supplies.

109.5(1) A licensed pharmacist employed by or under contract with the centralized repository or a local repository shall inspect donated prescription drugs and supplies to determine, to the extent reasonably possible in the judgment of the pharmacist, that the drugs and supplies are not adulterated or misbranded, are safe and suitable for dispensing, and are not ineligible drugs or supplies. The pharmacist who inspects the drugs shall sign an inspection record stating the above and attach it to the copy of the inventory or donor record provided with the drugs. If a local repository receives drugs and supplies from the centralized repository, the local repository does not need to reinspect the drugs and supplies.

109.5(2) The centralized repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drugs or supplies being stored. Donated drugs and supplies may not be stored with nondonated inventory. When donated drugs are not inspected immediately upon receipt, a repository shall quarantine the donated drugs separately from all dispensing stock until the donated drugs have been inspected and approved for dispensing under the program.

109.5(3) Repositories shall destroy donated noncontrolled substances that are not suitable for dispensing and make a record of such destruction according to board of pharmacy rule 657—8.8(124,155A). The destruction record shall be made in the same manner as prescribed for the record of return or destruction of a controlled substance in subrule 109.5(4).

109.5(4) Controlled substances shall not be accepted for donation.

a. Controlled substances submitted for donation shall be documented and returned immediately to the donor or the donor's representative that provided the drugs.

b. In the event controlled substances enter the centralized repository or a local repository and it is not possible or practicable to return the controlled substances to the donor or the donor's representative due to inability to identify the donor or the donor's representative or due to refusal by the donor or the donor's representative to receive them, abandoned controlled substances shall be documented and destroyed beyond reclamation pursuant to rules of the board of pharmacy examiners. Such destruction shall be performed by a pharmacist or other person that has authority to dispense controlled substances and shall be witnessed by another responsible adult employee of the repository.

109.5(5) If a repository receives a recall notification, the repository shall perform a uniform destruction of all of the recalled prescription drugs in the repository and complete the destruction information form for all donated drugs destroyed. If a recalled drug has been dispensed, the repository shall immediately notify the recipient of the recalled drug pursuant to established drug recall procedures.

641—109.6(135M) Standards and procedures for dispensing donated prescription drugs and supplies.

109.6(1) Donated drugs and supplies may be dispensed only if the drugs or supplies are prescribed by a health care practitioner for use by an eligible individual and are dispensed by a licensed pharmacist, physician or nurse practitioner.

109.6(2) A repository shall prioritize dispensing to an individual requesting drugs through the program as follows:

a. First, to an indigent individual;

b. Second, to an individual who has no active third-party prescription drug reimbursement coverage for the drug prescribed; and

c. Third, to any other individual if an indigent or uninsured individual is unavailable.

109.6(3) A repository shall dispense donated prescription drugs in compliance with applicable federal and state laws and regulations for dispensing prescription drugs, including all requirements relating to packaging, labeling, record keeping, drug utilization review, and patient counseling.

109.6(4) The centralized repository and a local repository shall remove the original donor's identification and the name of the dispensing pharmacy from the package prior to dispensing the drugs or supplies.

109.6(5) The centralized repository and a local repository shall be responsible for drug recalls and shall have an established mechanism to notify recipients in the event of a drug recall.

109.6(6) Prescription drugs or supplies donated under this program shall not be resold.

109.6(7) The participating centralized repository and local repositories may distribute drugs and supplies donated under this program to other participating repositories for use pursuant to the program. The repository distributing the drugs or supplies shall complete a transfer form.

641—109.7(135M) Eligibility criteria for individuals to receive donated prescription drugs and supplies.

109.7(1) An individual who requests drugs from the prescription drug donation repository program shall certify to the repository that the individual is a resident of Iowa and meets one or both of the following criteria:

a. Is indigent;

b. Has no active third-party prescription drug reimbursement coverage for the drug prescribed.

109.7(2) The local repository shall collect from each individual recipient a signed intake collection form provided by the department or its contractor.

a. The intake collection form shall attest that:

(1) The individual is a resident of the state of Iowa;

(2) The individual's income does not exceed 200 percent of the FPL;

(3) The individual is uninsured and has no prescription coverage or is underinsured and has no prescription coverage;

(4) The individual acknowledges that the drugs may have been donated; and

(5) The individual consents to a waiver of the requirement for child resistant packaging of the Poison Prevention Packaging Act.

b. The intake collection form will include an identification card to be given to the recipient for continued use for one year.

109.7(3) The identification card is valid for one year or until the new federal poverty guidelines have been published for all prescriptions and supplies.

109.7(4) A summary of data taken from the intake collection form is to be sent via regular mail, E-mail or facsimile to the centralized repository for data collection.

641—109.8(135M) Forms and record keeping.

109.8(1) The following forms developed for the administration of this program shall be utilized by participants of the program and are available on the program's Web page on the department's Web site, www.idph.state.ia.us.

a. Prescription drug donation repository program notice of participation or withdrawal.

b. Prescription drug donation repository program donation, transfer, inventory or destruction record.

c. A record of medications dispensed.

109.8(2) The prescription drug donation repository program recipient data collection form and identification card are given to the recipient by the local repository, and the completed data collection form is collected from the recipient by the local repository.

109.8(3) Record-keeping requirements.

a. All records required to be maintained as a part of the prescription drug donation repository program shall be maintained for a minimum of five years by participating pharmacies and medical facilities.

b. Records required as part of this program shall be maintained pursuant to all current applicable practice acts.

c. Data collected by the prescription drug donation repository program from all participating repositories shall be submitted quarterly or upon request to the centralized repository. The data will consist of the information collected in accordance with 641—109.8(135M), Forms and record keeping.

d. The centralized repository and the contractor shall submit reports to the department as required by the contract or upon request of the department.

641—109.9(135M) Handling fee. A repository may charge the recipient of a donated drug a handling fee, not to exceed a maximum of 200 percent of the Medicaid professional dispensing fee as established by rule of the department of human services, to cover stocking and dispensing costs. A prescription drug dispensed through the prescription drug donation repository program shall not be eligible for reimbursement under the medical assistance program.

641—109.10(135M) List of drugs and supplies program will accept. All prescription drugs, excluding controlled substances, that have been approved for medical use in the United States, that are listed in the USP or National Formulary (USP/NF), and that meet the criteria for donation established by these rules may be accepted for donation under the prescription drug donation repository program.

641—109.11(135M) Exemption from disciplinary action, civil liability and criminal prosecution.

109.11(1) A drug manufacturer acting reasonably and in good faith is not subject to criminal prosecution or civil liability for injury, death, or loss to a person or property for matters related to the donation, acceptance, or dispensing of a prescription drug manufactured by the drug manufacturer that is donated under this chapter, including liability for failure to transfer or communicate product or consumer information or the expiration date of the donated prescription drug.

109.11(2) Except as provided in subrule 109.11(3), a person other than a drug manufacturer subject to subrule 109.11(1), acting reasonably and in good faith, is immune from civil liability and criminal prosecution for injury to or the death of an individual to whom a donated prescription drug is dispensed under this chapter and shall be exempt from disciplinary action related to the person's acts or omissions related to the donation, acceptance, distribution, or dispensing of a donated prescription drug under this chapter.

109.11(3) The immunity and exemption provided in subrule 109.11(2) does not extend to any of the following:

a. The donation, acceptance, distribution, or dispensing of a donated prescription drug under this chapter by a person if the person's acts or omissions are not performed reasonably and in good faith.

b. Acts or omissions outside the scope of the program.

These rules are intended to implement Iowa Code chapter 135M.

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CHAPTER 114
PREPAREDNESS ADVISORY COMMITTEE

641—114.1(135) Definitions. For the purpose of these rules, the following definitions shall apply:

"Chairperson" means the chairperson of the preparedness advisory committee, who has been elected by a majority of advisory committee members.

"Department" means the Iowa department of public health.

"Designee" means the individual designated by the director.

"Director" means the director of public health.

"PAC" means the preparedness advisory committee.

"Quorum" means a simple majority of the voting membership of the preparedness advisory committee.

"Regions" means the six multicounty geographic areas of the state as identified by the preparedness advisory committee or the department to provide support services to the public health and hospital preparedness programs.

641—114.2(135) Purpose. The preparedness advisory committee (PAC) shall provide technical assistance and make recommendations for the planning and implementation of the public health emergency preparedness program for the department. The committee shall advise the department on matters of policy, plan development, funding allocations, and coordination of state, regional and local entities that are responsible for promoting and protecting the health and safety of all Iowans prior to, during, or after a public health emergency or disaster.

641—114.3(135) Appointment.

114.3(1) The voting members of the PAC shall be appointed by the director or designee as nominated by the member organizations.

114.3(2) The appointments shall be for three-year staggered terms which shall expire on June 30.

114.3(3) Vacancies shall be filled in the same manner in which the original appointments were made for the balance of the unexpired term.

114.3(4) Absences.

a. If a member is unable to attend a scheduled meeting, an alternate may be designated by the member organization to serve in the absence of the regular member.

b. Three consecutive unexcused absences shall be grounds for the director or designee to request nomination of an alternate representative to fill the position.

c. The chairperson of the preparedness advisory committee shall be charged with providing notification of absences to the department.

641—114.4(135) Membership.

114.4(1) The voting membership of the PAC shall consist of one representative nominated by each of the following organizations and approved by the director or the director's designee:

a. American Red Cross,

b. Indian Health Services,

c. Upper Midwest Center for Public Health Preparedness,

d. Center for Food Security and Public Health,

e. Iowa Counties Public Health Association,

f. Iowa Environmental Health Association,

g. Iowa Emergency Management Association,

h. Iowa Emergency Medical Services Association,

i. Iowa Hospital Association,

j. Iowa Medical Society,

k. Iowa/Nebraska Primary Care Association,

l. Iowa Nurses Association,

m. Iowa Osteopathic Medical Association,
n. Iowa Pharmacy Association,
o. Iowa Poison Control Center,
p. Iowa National Guard,
q. University Hygienic Laboratory,
r. Veterans Health Administration,
s. Safeguard Iowa Partnership,
t. School Administrators of Iowa, and
u. A mental health association.

114.4(2) The preparedness advisory committee shall also include as voting members:
a. One public health representative from each of the six public health preparedness regions, and
b. One hospital representative from each of the six health care preparedness regions.

114.4(3) Contributions and representation to the PAC shall consist of the following entities:
a. The Iowa department of public health,
b. The Iowa department of human services,
c. The Iowa homeland security and emergency management division,
d. The Iowa department of natural resources,
e. The Iowa department of agriculture and land stewardship,
f. The Iowa department of elder affairs, and
g. The Iowa department of education.

641—114.5(135) Officers.

114.5(1) Officers of the PAC shall consist of a chairperson and a vice chairperson, who shall be elected at the first meeting of each fiscal year.
a. Vacancies in the office of chairperson shall be filled by elevation of the vice chairperson.
b. Vacancies in the office of vice chairperson shall be filled by election at the next meeting after the vacancy occurs.

114.5(2) Duties of officers.
a. The chairperson shall:
(1) Preside at all meetings of the advisory committee,
(2) Appoint such subcommittees as deemed necessary, and
(3) Ratify the chairperson of each subcommittee following elections.
b. The vice chairperson shall:
(1) Perform the duties of the chairperson if the chairperson is absent or unable to act. When so acting, the vice chairperson shall have all the powers of and be subject to all restrictions upon the chairperson.
(2) Perform such other duties as may be assigned by the chairperson.

641—114.6(135) Meetings.

114.6(1) The PAC shall establish a meeting schedule on an annual basis to conduct its business.
a. Meetings may be scheduled as business requires, but notice to members must be at least five working days prior to the meeting date unless action is required by the PAC on an emergency basis.
b. A four-week notice is encouraged to accommodate the schedules of professional members.

114.6(2) Robert's Rules of Order shall govern all meetings.

641—114.7(135) Subcommittees.

114.7(1) The PAC may designate one or more subcommittees pertinent to the priorities and activities of the public health and hospital preparedness program. Subcommittee members shall perform such duties as may be deemed necessary.
a. Each subcommittee shall include one voting member of the PAC.
b. The chairperson of each subcommittee shall be elected by the subcommittee membership and ratified by the PAC.

114.7(2) The designated subcommittees shall include but are not limited to:

a. Planning,

b. Epidemiology,

c. Lab,

d. Communications/information technology,

e. Risk communication, and

f. Education/exercises.

114.7(3) The PAC may establish ad hoc subcommittees for a specified time of duration for special projects or where special expertise is needed.

641—114.8(135) Expenses of preparedness advisory committee voting members. The following may be considered necessary expenses for reimbursement of PAC members when incurred on behalf of advisory committee business and are subject to established state reimbursement rates:

1. Reimbursement for travel in a private car.
2. Actual lodging and meal expenses, including sales tax on lodging and meals.
3. Actual expense of public transportation.

641—114.9(135) Gender balance. All advisory committees of the department appointed by the governor, director or designee, if not otherwise provided by law, shall be gender-balanced.

These rules are intended to implement Iowa Code chapter 135.

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CHAPTERS 115 to 120
Reserved

CHAPTER 127
COUNTY MEDICAL EXAMINERS
[Prior to 7/29/87, Health Department [470] Ch 127]

641—127.1(144,331,691) Definitions.

"Autopsy" means the external and internal postmortem examination of a deceased person.

"Cause of death" means the disease or injury which sets in motion the chain of events which eventually result in the death of a person. The physician shall consider "but for" this injury or disease the person would still be living.

"County medical examiner" or *"CME"* means a medical or osteopathic physician or surgeon licensed in the state of Iowa and appointed by the board of supervisors to serve in this capacity.

"County medical examiner investigator" or *"CME-I"* means an individual appointed by a county medical examiner, with approval by the board of supervisors and the state medical examiner, to serve under the supervision of a county medical examiner to assist in death investigations.

"County of appointment" means the county which requests a medical examiner to conduct an investigation, perform or order an autopsy, or prepare a report(s) in a death investigation case. The request may be authorized by the county attorney or the county medical examiner. The county of appointment shall be the county in which the death occurred.

"Cremation" means the technical process, using heat and flame, that reduces human remains to bone fragments.

"Day" means calendar day.

"Death" means the condition as described in Iowa Code section 702.8.

"Death affecting the public interest" means any death of a human being in which the circumstances are sudden, unexpected, violent, suspicious, or unattended, including but not limited to those deaths listed at Iowa Code section 331.802(3) and described as follows:

1. Violent death. Violent death includes homicide, suicide, or accidental death resulting from physical, mechanical, thermal, chemical, electrical, or radiation injury. A medical examiner's investigation and report are required irrespective of the period of survival following injury.

2. Death caused by criminal abortion, including self-induced.

3. Death related to disease thought to be virulent or contagious which may constitute a public hazard. Any such case investigated by a medical examiner shall be reported to the department and to the local health authority.

4. Death that has occurred unexpectedly or from an unexplained cause. This term includes the following situations:

- Death without prior medical conditions accounting for the death.
- Apparently instantaneous death without obvious cause.
- Death during or following an unexplained syncope or coma.
- Death during an unexplained, acute, or rapidly fatal illness.

5. Death of a person confined in a prison, jail, or correctional institution.

6. Death of a person when unattended by a physician during the period of 36 hours immediately preceding death.

- This term includes the following situations:

— Persons found dead without obvious or probable cause.

— Death when the person was unattended by a physician during a terminal illness.

— Fetal death unattended by a physician. A fetal death is a fetus born dead after a gestation period of 20 completed weeks or greater or a fetus which weighs 350 grams or more (Iowa Code section 144.29).

- This term does not include a prediagnosed terminal or bedfast case in which a physician has been in attendance within 30 days preceding the death.
- This term does not include a terminally ill patient who was admitted to and received services from a hospice program as defined in Iowa Code section 135J.1, if a physician or registered nurse employed by the program was in attendance within 30 days preceding the death.

7. Death of a person if the body is not claimed by a relative or friend.

8. Death of a person if the identity of the deceased is unknown.

9. Death of a child under the age of two years if death results from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death.

"Department" means the Iowa department of public health.

"Deputy county medical examiner" or *"DCME"* means an individual appointed by a county medical examiner, with approval by the board of supervisors and the state medical examiner, to assist the county medical examiner in the performance of the county medical examiner's duties.

"External examination" means a close inspection of the exterior of a deceased human body for the purpose of locating, describing, and delineating any and all injuries or other abnormalities. External examination of a body does not constitute an autopsy, even if toxicology samples are obtained.

"Fee" means an amount to be paid to a county medical examiner's office as determined by the board of supervisors of the county of appointment for completion of an investigation, autopsy, or report(s). Fees for services provided by the state medical examiner's office are established at 641—126.3(691).

"Form ME-1" means the Preliminary Report of Investigation by Medical Examiner form.

"Form ME-2" means the Medical Examiner Embalming Certificate form.

"Form ME-3" means the Permit by Medical Examiner for Autopsy form.

"Form ME-4" means the Preliminary Report of Child/Infant Death Scene Investigation form.

"Form ME-5" means the Cremation Permit by Medical Examiner form.

"Form ME-6" means the Iowa State Medical Examiner's Office Personal Effects form.

"Form ME-7" means the Medication List form.

"Form ME-8" means the Body Identification Record form.

"Manner of death" means the circumstances under which the cause of death occurred and may be specified as follows: natural, accident, suicide, homicide, undetermined, or pending.

"Medical care provider" means an individual licensed or certified in any medical profession, including but not limited to a physician, physician assistant, nurse, emergency medical care provider, certified nurse's aide, pharmacist, physical therapist, and medical technologist.

"Medical examiner" means the state medical examiner, deputy state medical examiner, county medical examiner, or deputy county medical examiner.

641—127.2(331,691) Duties of medical examiners—jurisdiction over deaths which affect the public interest.

127.2(1) *Jurisdiction.* Upon receiving notification of a death which affects the public interest, a medical examiner shall notify any appropriate law enforcement agency not otherwise notified and shall take charge of the body of the decedent. The body shall not be disturbed or removed from the position in which it was found without authorization from the medical examiner except for the purpose of preserving the body from loss or destruction or permitting the passage of traffic on a highway, railroad, or airport, or unless the failure to remove the body might endanger life, safety, or health.

127.2(2) *Investigation.* A county medical examiner shall conduct a preliminary investigation of the cause and manner of death and shall utilize the investigative protocol outlined in the most current edition of the County Medical Examiner's Handbook, available from the state medical examiner's office. A medical examiner may perform or authorize performance of any scientific study to assist in identifying the cause, circumstances, and manner of death. A medical examiner shall cooperate with other investigating officials and agencies involved and shall share reports, information, and conclusions with these officials and agencies.

127.2(3) *Reports required.*

a. Form ME-1.

(1) Preparation and filing. A county medical examiner shall prepare a written report of the examiner's findings on the Preliminary Report of Investigation by Medical Examiner, Form ME-1. A county medical examiner shall file the original Form ME-1 with the state medical examiner's office within 14 days of the date of death and shall file a copy of the Form ME-1 with the county attorney within 14 days of the date of the death and shall retain a copy for the medical examiner's records.

(2) Content. Form ME-1 shall be completed as fully as possible in light of all available information and may be signed by either a county medical examiner or a county medical examiner investigator acting under the supervision of a county medical examiner. If the cause or manner of death, identity of the decedent, or other information is unknown or pending at the time of filing, "unknown" or "pending" may be written in the appropriate area of the form. If additional information becomes available, this information shall be forwarded to the state medical examiner in written form at such time as it becomes available to be added as a supplement to the file.

b. Jurisdiction declined or terminated. A form designated by the office of the state medical examiner shall be completed and filed in accordance with subparagraphs (1) and (2) of paragraph *"a"* above in cases reported to the county medical examiner where jurisdiction is terminated or declined.

127.2(4) *Disposition of body.* After an investigation, including an autopsy if one was performed, the body of the decedent shall be made available to the funeral home designated by a relative or friend of the decedent for burial or appropriate disposition. A medical examiner shall not use influence in favor of a particular funeral director or funeral home. If no one claims a body, it shall be disposed of as provided in Iowa Code chapter 142.

127.2(5) *Coverage.*

a. When an individual is required to report a death to a medical examiner and the county medical examiner cannot be located or is not available, the individual shall contact a county medical examiner from any adjacent Iowa county to perform those duties outlined in this chapter. The responding medical examiner shall have full authority to conduct any procedures necessary to the investigation of the cause and manner of death. If an adjacent county medical examiner is not available, the state medical examiner shall be contacted and may act in the capacity of a county medical examiner.

b. The responding county medical examiner shall be reimbursed by the county for which the service is provided for all fees and expenses at the rate which is customarily paid by the county for which the service is provided or at a rate agreed upon by the medical examiner and the board of supervisors of the county for which the service is provided.

641—127.3(331,691) Autopsies.

127.3(1) *Autopsy required.* A county medical examiner shall perform an autopsy or order that an autopsy be performed in the following cases:

a. All cases of homicide or suspected homicide, irrespective of the period of survival following injury.

b. All cases in which the manner of death is undetermined.

c. All cases involving unidentified bodies.

d. All deaths of children under the age of two when there is not a clear cause of death, including suspected cases of sudden infant death syndrome. A summary of the findings of the autopsy shall be transmitted by the physician who performed the autopsy to the county medical examiner within two days of completion of the report. Autopsies performed on children under the age of two when the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death or the cause of death is not clearly explained by known medical history shall conform to Form ME-4.

e. All work- and farm-related deaths unless there is an obvious natural cause of death.

f. All drowning deaths.

g. All deaths of commercial vehicle drivers that occur during the performance of their job duties.

h. Deaths due to poisoning.

i. Deaths of airplane pilots who die as a result of an airplane crash. The National Transportation Safety Board and the Federal Aviation Administration should be contacted prior to the autopsy to request specimen kit(s).

j. Deaths due to a natural disaster, including tornadoes and floods.

k. Deaths in a prison, jail or correctional institution or under police custody, where there is not a natural disease process that accounts for the death.

127.3(2) *Autopsy recommended.* It is recommended that a county medical examiner should perform an autopsy or order that an autopsy be performed in the following cases:

a. Deaths of adolescents less than 18 years of age when there is not a natural cause of death.

b. All cases which involve a motor vehicle crash, unless it is a single motor vehicle accident with no potential for litigation and there is an obvious cause of death or the injuries have been clearly documented by hospitalization.

c. Rescinded IAB 3/29/06, effective 5/3/06.

d. Deaths from suicide.

e. All pedestrian, bicycle, motorcycle, snowmobile, boating, watercraft, three- or four-wheeler or all-terrain vehicle fatalities.

f. Deaths due to failure of a consumer product.

g. Deaths due to a possible public health hazard.

h. Deaths due to drug or alcohol abuse or overdose.

i. Electrical- and lightning-related deaths.

j. Deaths from burns or smoke or soot inhalation.

k. All deaths related to exposure, such as hypothermia and hyperthermia.

l. All sport-related deaths, including but not limited to deaths from auto racing and deaths resulting from injuries sustained in football, basketball, baseball, softball, soccer, or other games or sports.

127.3(3) *Other deaths.* For those deaths not listed in subrule 127.3(1) or 127.3(2), a county medical examiner shall determine whether the public interest requires an autopsy and may perform an autopsy or order that an autopsy be performed. A county medical examiner may consult with the state medical examiner to assist in determining the need for an autopsy.

127.3(4) *Performance of autopsy.*

a. *Who may authorize.* Autopsies may be authorized by the state medical examiner, the county medical examiner for the county in which the death occurred or the county where any injury contributing to or causing the death was sustained, or the county attorney who would have jurisdiction in any criminal proceeding related to the death.

b. *Who may perform.* An autopsy shall be performed by a pathologist trained or with experience in forensic pathology, licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa and board-certified by the American Board of Pathology, or under the direct supervision of a physician with these qualifications. If an autopsy is performed by a physician who does not satisfy these criteria and who is not performing under the direct supervision of a physician who satisfies these criteria, the physician shall submit a supplemental report with the Permit by Medical Examiner for Autopsy, Form ME-3, which details the specific training, education, and experience which qualify the physician to perform an autopsy. The following cases/types of deaths shall be transported to the office of the state medical examiner for autopsy unless otherwise approved by the state medical examiner:

(1) Deaths of adolescents through 18 years of age when there is not a known or preexisting natural cause of death.

(2) All cases of homicide or suspected homicide, irrespective of the period of survival following injury.

(3) Deaths of children under the age of 2 years if death results from an unknown cause or if the circumstances surrounding the death indicate that Sudden Infant Death Syndrome may be the cause of death.

(4) All suspicious suicides.

(5) All high-profile deaths including, but not limited to, deaths of elected officials in municipal, state or federal government.

(6) All deaths of inmates occurring in any institutions under the department of corrections as outlined in Iowa Code section 904.102, excluding those deaths that result from a pre-existing medical condition.

c. *Permit required—Form ME-3.* A medical examiner shall complete the Permit by Medical Examiner for Autopsy, Form ME-3. All reasonable efforts shall be made to complete the Form ME-3

prior to the performance of an autopsy and to submit the form with the body of the decedent or to submit the form via facsimile to the state medical examiner.

127.3(5) *Autopsy report.* A complete record of the findings of the autopsy shall be submitted to the state medical examiner's office, the county attorney of the county where the death occurred and the county attorney of the county where the injury contributing to or causing the death was sustained within 90 days following the date of death, unless unusual circumstances requiring further investigation or testing exist. The report filed shall include all diagrams, transcriptions of the autopsy observations and opinions, and toxicology reports.

127.3(6) *Out-of-state autopsy.* The body of a decedent may be sent out of state for an autopsy or postmortem examination only if the county medical examiner certifies in writing that the out-of-state autopsy or examination is necessary for any of the following reasons:

a. A forensic pathologist practicing in the state of Iowa is unavailable;

b. Requiring an in-state autopsy would cause financial hardship; or

c. Requiring an in-state autopsy would delay the funeral or burial more than three days.

127.3(7) *Retention and disposal of tissues, organs, and bodily fluids.* The office of the state medical examiner shall retain tissues, organs, and bodily fluids as necessary to determine the cause and manner of death or as deemed advisable by the state medical examiner for medical or public health investigation, teaching, or research. Tissues, organs, and bodily fluids shall be retained at a minimum for the time periods established by the National Association of Medical Examiners and may be retained for a longer time period at the discretion of the state medical examiner. Tissues, organs, and bodily fluids retained under this subrule shall be disposed of without the specific consent or notification of the legal next of kin and in accordance with applicable federal and state regulations including but not limited to OSHA-recommended biohazard and blood-borne pathogen standards. The anatomical material shall be removed from the laboratory premises through use of a contracted, licensed, and bonded medical waste removal service to a medical waste processing center for final disposition.

641—127.4(331,691) Fees.

127.4(1) *Payment of fee and expenses.*

a. A medical examiner shall receive from the county of appointment a fee for each preliminary investigation and report submitted in a case in which a death affects the public interest. A county medical examiner shall also receive from the county of appointment the examiner's actual expenses.

b. A pathologist or other physician who performs an autopsy under medical examiner authorization shall be paid for the services by the county of appointment.

127.4(2) *Reimbursement.*

a. *County of residence different from county of appointment—Iowa resident.* The county of the decedent's residence shall reimburse the county of appointment for the fee and expenses paid by the county of appointment.

b. *Death caused by criminal defendant.* If the person's death is caused by a criminal defendant who has been convicted and sentenced for murder, voluntary manslaughter, involuntary manslaughter, or homicide by vehicle, the county of the person's residence may recover from the defendant the fee and expenses.

c. *Out-of-state resident—law enforcement involvement.* The fee and expenses of a county medical examiner who performs an investigation or autopsy of a person who dies after being brought into the state for emergency medical treatment by or at the direction of an out-of-state law enforcement officer or public authority shall be paid by the state. A claim for payment shall be filed with the department.

d. *Out-of-state resident—no law enforcement involvement.* The fee and expenses of a county medical examiner who performs an investigation or autopsy of an out-of-state resident shall be paid by the county of appointment.

e. *Child under the age of two.* If the death of a child under the age of two results from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death, the department shall reimburse the county of appointment up to $400 toward the expense of the autopsy. A county auditor may submit a copy of the bill and the autopsy report to Iowa

SIDS Program, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319. A request for reimbursement shall be submitted within one year after the date of death.

641—127.5(144,331,691) Death certificates—deaths affecting the public interest.

127.5(1) *Completion.* The funeral director to whom the body is released shall complete the personal data on the death certificate. The medical examiner shall complete the manner of death and cause of death sections of the death certificate within 72 hours after determination of the cause of death. If an autopsy is performed by the state medical examiner, the death certificate shall be submitted to the state medical examiner's office for completion. All information included on the certificate shall be typewritten.

127.5(2) *Filing.* The funeral director shall file the certificate with the county registrar in the county in which the death occurred. A death certificate shall be filed prior to the issuance of a burial transit permit and prior to disposal of the body.

127.5(3) *Extension of time.* If a medical examiner is unable to complete the manner of death and cause of death sections of the death certificate within the 24-hour time period, the funeral director shall file a death certificate form completed with all available information. Such certificate shall be authority for the issuance of a burial transit permit. Within 15 days, a supplemental report shall be filed with the local registrar which provides the information missing from the original certificate.

127.5(4) *Additional standards.* Additional rules relative to death certificates may be found at 641—Chapter 101.

641—127.6(331,691) Cremation.

127.6(1) *Permit obtained prior to cremation—Form ME-5.* A permit for cremation shall be obtained from a county medical examiner prior to cremation of a body of a decedent. For purposes of this requirement, a facsimile or electronic copy of the cremation permit has the same legal effect as the original. Cremation permits shall be issued on the Cremation Permit by Medical Examiner, Form ME-5.

127.6(2) *Requirements for issuance of permit.* A county medical examiner shall direct an inquiry into the cause and manner of death and shall determine whether the death is one which affects the public interest prior to issuing a cremation permit.

a. *Death which affects the public interest.* If the death occurred in a manner specified in Iowa Code section 331.802(3) or if reasonable suspicion that the death occurred in such a manner exists, a medical examiner shall view the body, make a personal inquiry into the cause and manner of death, and complete or cause to be completed all necessary autopsy or postmortem examinations prior to issuing a cremation permit.

b. *Death which does not affect the public interest.* If, following an inquiry into the cause and manner of death, the county medical examiner determines that the death did not occur in a manner specified in Iowa Code section 331.802(3), a medical examiner is not required to view the body prior to issuing a cremation permit. A county medical examiner shall certify on the Cremation Permit by Medical Examiner, Form ME-5, that the medical examiner's inquiry into the cause and manner of death did not disclose evidence that the death occurred in a manner specified in Iowa Code section 331.802(3).

127.6(3) *Fee.* A fee for the Cremation Permit by Medical Examiner, Form ME-5, shall be paid by the family, next of kin, guardian of the decedent, or other person authorized to act on behalf of the decedent.

641—127.7(331,691) County medical examiner investigators.

127.7(1) *Appointment.* A county medical examiner may appoint one or more county medical examiner investigators upon approval by the board of supervisors and the state medical examiner.

127.7(2) *Qualifications.*

a. Prior to appointment, a CME-I should possess a minimum of two years of experience as a licensed or certified nurse or medical care provider. A certified peace officer may be appointed to the position of CME-I if a nurse or medical care provider is not available.

b. A CME-I shall satisfy the following criteria:

(1) Prior to or within two years of appointment, attend the St. Louis University School of Medicine Basic Medicolegal Death Investigation Course or its state medical examiner-approved equivalent; and

(2) Prior to or within five years of appointment, obtain certification at the registry-level as a death investigator by the American Board of Medicolegal Death Investigators.

c. A CME-I is not required to meet the requirements of paragraph *"a"* or *"b"* if the individual has functioned in the capacity of a CME-I for a period of five years as of January 1, 2002.

d. If a CME is unable to appoint a CME-I who possesses the qualifications required by paragraph *"a," "b,"* or *"c,"* the CME may request a waiver. Waiver requests shall be submitted in writing to the state medical examiner and shall include the efforts undertaken by the CME to locate a CME-I who meets the above qualifications; the qualifications of the individual willing to serve in the capacity of CME-I; and the period of time for which the waiver is requested, not to exceed two years. The state medical examiner has sole discretion to waive the requirements of this rule and may withdraw or modify a waiver request upon a finding that the CME-I has failed to adequately perform the duties of the position or for other good cause.

127.7(3) *Duties.* A CME-I shall assist in death investigations. A CME-I acting under the supervision of a county medical examiner may sign the Form ME-1. A CME-I shall not sign a certificate of death or a Form ME-5.

127.7(4) *Supervision.* A CME-I shall serve under the supervision of a county medical examiner. A CME-I provides services under the direction of a county medical examiner or state medical examiner's office. A CME-I shall at all times perform services in a manner which is consistent with the protocol outlined in the most current edition of the County Medical Examiner's Handbook and any policies or protocols of the supervising county medical examiner.

127.7(5) *Fees.* Fees for the services provided by a CME-I shall be paid by the county of appointment.

641—127.8(331,691) Deputy county medical examiners.

127.8(1) *Appointment.* A county medical examiner may appoint one or more deputy county medical examiners upon approval by the board of supervisors and the state medical examiner.

127.8(2) *Qualifications.* A DCME shall be licensed in the state of Iowa as a medical or osteopathic physician or surgeon.

127.8(3) *Duties.* A DCME shall serve at the direction of the county medical examiner and may perform any duty of a county medical examiner which is delegated by the county medical examiner to the DCME.

127.8(4) *Fees.* Fees for the services provided by a DCME shall be paid by the county of appointment.

641—127.9(331,691) Failure to comply with rules. If a county medical examiner, deputy county medical examiner, county medical examiner investigator, pathologist, or other physician fails to comply with these rules, the state medical examiner may provide written notice of the failure to comply to that individual, the appropriate county medical examiner, and the appropriate county board of supervisors. Within 30 days of the date of the notice, the individual to whom the notice was provided shall submit a written response to the state medical examiner, outlining a proposed corrective action plan. If no response is received within the 30 days or if the proposed corrective action plan is unacceptable, the state medical examiner shall forward copies of the notice and all pertinent correspondence and information to the board of supervisors for the county which appointed the individual, notifying the board of the individual's failure to comply with these rules.

641—127.10(331,691,22) Confidentiality. Records and reports of a medical examiner may be confidential records pursuant to Iowa Code sections 22.7(2), 22.7(5), and 22.7(41) and other provisions of Iowa law. Prior to releasing a medical examiner record or report to a member of the public, a county medical examiner may inform the appropriate law enforcement agency, the county attorney, and the state medical examiner to determine whether release is authorized under Iowa law.

641—127.11(331,691,670) Indemnification. A board of supervisors shall defend, hold harmless, and indemnify a county medical examiner and any properly appointed staff members to the extent provided in Iowa Code chapter 670.

These rules are intended to implement Iowa Code chapters 331 and 691.

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CHAPTER 128
DOGS FOR SCIENTIFIC RESEARCH
Rescinded IAB 7/30/08, effective 9/3/08.

CHAPTER 129
Reserved

CHAPTER 153
SMOKEFREE AIR

641—153.1(82GA,HF2212) Purpose and scope. The purpose of these rules is to implement Iowa's Smokefree Air Act, enacted to reduce the level of exposure by the general public and employees to environmental tobacco smoke in order to improve the public health of Iowans. These rules apply to public places, places of employment, and certain outdoor areas in the state.

641—153.2(82GA,HF2212) Definitions. For the purposes of this chapter, the following definitions shall apply:

"Ashtray" means any receptacle, including a can, bottle, bowl, tray, or other vessel that is used for extinguishing or disposing of any lighted cigar, cigarette, pipe, or other tobacco product in any manner or form including ash, cigarette butts or filters, or cigar stubs. However, "ashtray" shall not include any receptacle located outdoors and on the perimeter of any public place, the perimeter of the grounds of any public building, the perimeter of school grounds, or the perimeter of any other outdoor space subject to the prohibition in 2008 Iowa Acts, House File 2212, section 3, and rule 641—153.3(82GA,HF2212).

"Bar" means an establishment where one may purchase alcoholic beverages, as defined in Iowa Code section 123.3, for consumption on the premises and in which the serving of food is only incidental to the consumption of those beverages.

"Child care facility" means child care facility as defined by the department of human services pursuant to Iowa Code section 237A.1.

"Child care home" means child care home as defined by the department of human services pursuant to Iowa Code section 237A.1.

"Department" means the Iowa department of public health.

"Entrance" means any doorway to an enclosed area used by the public or employees for ingress or egress to or from any public place or place of employment. "Entrance" also includes the commonly understood points of entry and exit to and from an outdoor area such as a driveway, sidewalk, pathway, access road, gate, or dedicated point of entry.

"Gaming floor" means gaming floor as defined by the state racing and gaming commission pursuant to Iowa Code section 99F.1.

"Grounds of any public building" means an outdoor area of a public building that is used in connection with the building, including but not limited to a sidewalk immediately adjacent to the building; a sitting or standing area immediately adjacent to the building; a patio; a deck; a curtilage or courtyard; a swimming or wading pool; a beach; or any other outdoor area as designated by the person having custody or control of the public building. A person having custody or control of a public building may exclude from the designated grounds of any public building the following: a parking lot, the course of play at a golf course, a hiking trail, locations of an individual campsite or campfire, or a lake, river, or other body of water. Nothing in this definition prohibits any owner, operator, manager, or other person having custody or control of an area that is exempt from the prohibitions of 2008 Iowa Acts, House File 2212, section 3, and rule 641—153.3(82GA,HF2212) from declaring the entire area or property a nonsmoking place.

"Hotel and motel" means any building or structure equipped, used, advertised as, or held out to the public to be an inn, hotel, motel, motor inn, or place where sleeping accommodations are furnished for hire to transient guests.

"Incidental to the sale of tobacco products" means that the gross revenue of a retail tobacco store derived from the sale of products other than tobacco products is not more than 20 percent of the retail tobacco store's total gross revenue.

"Infiltrate" means to permeate an area where smoking is prohibited by passing through a wall, ceiling, floor, window, door, or ventilation system to the extent that an individual can smell secondhand smoke.

"Public or private educational facility" means a public school and nonpublic school as defined in Iowa Code section 280.2, a community college as defined in Iowa Code section 260C.2, an accredited

private institution as defined in Iowa Code section 261.9, and an institution governed by the board of regents pursuant to Iowa Code section 262.7.

"Restaurant" means eating establishments, including private and public school cafeterias, which offer food to the public, guests, or employees, including the kitchen and catering facilities in which food is prepared on the premises for serving elsewhere, and including a bar area within a restaurant.

"Retail tobacco store" means a retail store utilized primarily for the sale of tobacco products and accessories and in which the sale of other products is incidental to the sale of tobacco products.

"Seating areas of outdoor sports arenas, stadiums, amphitheaters, or other entertainment venues" means areas designated by the owner, operator, manager, or other person having custody or control of the area to be used primarily to witness entertainment events and shall include, but not be limited to, all chairs, seats, and bleachers whether permanent or temporary; standing room only; general admission or festival-style seating; and any other areas where individuals congregate to witness entertainment events.

"Serving of food incidental to the consumption of alcoholic beverages" means food preparation that is limited to the service of ice, prepackaged snack foods, popcorn, peanuts, and the reheating of commercially prepared foods that do not require assembly, such as frozen pizza, prepackaged sandwiches, or other prepackaged, ready-to-serve products.

"Smoking cessation program" means a course of treatment that is capable of clinical review for evidence-based outcomes that verify that individuals in the program stop smoking and that has been approved for coverage by a private or managed health care plan, Medicaid, Medicare, the Veterans Health Administration, or the United States military.

641—153.3(82GA,HF2212) Prohibition of smoking.

153.3(1) *Public places, places of employment.* Smoking is prohibited and a person shall not smoke in either of the following areas:

a. Public places, as defined in 2008 Iowa Acts, House File 2212.

b. All enclosed areas within places of employment including but not limited to work areas, private offices, conference and meeting rooms, classrooms, auditoriums, employee lounges and cafeterias, hallways, medical facilities, restrooms, elevators, stairways and stairwells, and vehicles owned, leased, or provided by the employer unless otherwise provided under these rules and 2008 Iowa Acts, House File 2212.

153.3(2) *Outdoor areas.* Smoking is prohibited and a person shall not smoke in or on any of the following outdoor areas:

a. The seating areas of outdoor sports arenas, stadiums, amphitheaters and other entertainment venues where members of the general public assemble to witness entertainment events.

b. Outdoor seating or serving areas of restaurants.

c. Public transit stations, platforms, and shelters under the authority of the state or its political subdivisions.

d. School grounds, including parking lots, athletic fields, playgrounds, tennis courts, and any other outdoor area under the control of a public or private educational facility, including inside any vehicle located on such school grounds.

e. The grounds of any public buildings owned, leased, or operated by or under the control of the state government or its political subdivisions, including the grounds of a private residence of any state employee any portion of which is open to the public with the following exceptions:

(1) This paragraph shall not apply to the Iowa state fairgrounds, or fairgrounds as defined in Iowa Code section 174.1.

(2) This paragraph shall not apply to institutions administered by the department of corrections, except that smoking on the grounds shall be limited to designated smoking areas.

(3) This paragraph shall not apply to facilities of the Iowa National Guard as defined in Iowa Code section 29A.1, except that smoking on the grounds shall be limited to designated smoking areas.

641—153.4(82GA,HF2212) Areas where smoking not regulated. Notwithstanding any provision of these rules and 2008 Iowa Acts, House File 2212, to the contrary, the following areas are exempt from the prohibitions of 2008 Iowa Acts, House File 2212, section 3:

153.4(1) Private residences, unless used as a child care facility, child care home, or a health care provider location.

153.4(2) Hotel and motel rooms that are rented to guests and are designated as smoking rooms; provided that not more than 20 percent of the rooms of a hotel or motel rented to guests are designated as smoking rooms, all smoking rooms on the same floor are contiguous, and smoke from smoking rooms does not infiltrate into areas in which smoking is otherwise prohibited under these rules. The status of smoking and nonsmoking rooms shall not be changed, except to provide additional nonsmoking rooms.

153.4(3) Retail tobacco stores, provided that smoke from these locations does not infiltrate into areas in which smoking is otherwise prohibited under these rules.

153.4(4) Private and semiprivate rooms in long-term care facilities, occupied by one or more individuals, all of whom are smokers and have requested in writing to be placed in a room where smoking is permitted, provided that smoke from these locations does not infiltrate into areas in which smoking is otherwise prohibited under these rules and 2008 Iowa Acts, House File 2212.

153.4(5) Private clubs that have no employees, except when being used for a function to which the general public is invited, provided that smoke from these locations does not infiltrate into areas in which smoking is otherwise prohibited under these rules and 2008 Iowa Acts, House File 2212. This exemption shall not apply to any entity that is established for the purpose of avoiding compliance with these rules and 2008 Iowa Acts, House File 2212.

153.4(6) Outdoor areas that are places of employment except those areas where smoking is prohibited pursuant to 2008 Iowa Acts, House File 2212, section 3, subsection 2.

153.4(7) Limousines under private hire; vehicles owned, leased, or provided by a private employer that are for the sole use of the driver and are not used by more than one person in the course of employment either as a driver or passenger; privately owned vehicles not otherwise defined as a place of employment or public place; and cabs of motor trucks or truck tractors if no nonsmoking employees are present.

153.4(8) An enclosed area within a place of employment or public place that provides a smoking cessation program or a medical or scientific research or therapy program, if smoking is an integral part of the program.

153.4(9) Farm tractors, farm trucks, and implements of husbandry when being used for their intended purposes.

153.4(10) Only the gaming floor of premises licensed pursuant to Iowa Code chapter 99F exclusive of any bar or restaurant located within the gaming floor which is an enclosed area and subject to the prohibitions of 2008 Iowa Acts, House File 2212, section 3.

153.4(11) The Iowa veterans home.

641—153.5(82GA,HF2212) Duties of employers, owners, operators, managers, and persons having custody or control of a public place, place of employment, area declared nonsmoking pursuant to 2008 Iowa Acts, House File 2212, section 5, or outdoor areas where smoking is prohibited.

153.5(1) The employer, owner, operator, manager, or person having custody or control of a place where smoking is prohibited under 2008 Iowa Acts, House File 2212, shall:

a. Not permit smoking in a public place, place of employment, outdoor area where smoking is prohibited, or an area declared nonsmoking pursuant to 2008 Iowa Acts, House File 2212, section 5.

b. Inform all current employees and all prospective employees upon application for employment of the prohibitions of 2008 Iowa Acts, House File 2212.

c. Not retaliate against any employee, applicant for employment, or customer that exercises any rights under 2008 Iowa Acts, House File 2212, registers a complaint, or attempts to prosecute a violation of 2008 Iowa Acts, House File 2212.

d. Post signs in and at every entrance to the public place, place of employment, area declared nonsmoking, and outdoor area where smoking is prohibited that clearly and conspicuously inform persons that they are entering a no smoking facility or area.

(1) The signs shall be clear and conspicuous in or at the entrance where posted.

(2) The signs shall be at least 24 square inches in size and shall be in legible font type.

(3) The signs shall contain the words "No Smoking" or the international "no smoking" symbol; the telephone number for reporting complaints, 1-888-944-2247; and the department of public health Web site, www.IowaSmokefreeAir.gov.

e. Place no smoking signs in every vehicle that constitutes a public place, place of employment, or area declared nonsmoking pursuant to 2008 Iowa Acts, House File 2212, section 5.

(1) Such signs shall be clear and conspicuous from the exterior of the vehicle.

(2) The signs shall be at least 24 square inches, and in legible font type.

(3) The signs shall contain the words "No Smoking" or the international "no smoking" symbol; the telephone number for reporting complaints, 1-888-944-2247; and the department of public health Web site, www.IowaSmokefreeAir.gov.

(4) Nothing in this rule requires the placement of a sign in any vehicle that the director of the department of administrative services or the director of transportation orders to receive a regular registration plate pursuant to Iowa Code section 321.19.

f. Remove all ashtrays from areas where smoking is prohibited.

153.5(2) The owner or operator of a building or facility that contains more than one public place, place of employment, or area declared nonsmoking pursuant to 2008 Iowa Acts, House File 2212, section 5, which is controlled by other employers, owners, or operators shall comply with the provisions of subrule 153.5(1) for the area of the building or facility under the owner or operator's control.

153.5(3) An employer, owner, or operator of a public place, place of employment or area declared nonsmoking pursuant to 2008 Iowa Acts, House File 2212, section 5, that is within a public place that is owned or operated by another person shall comply with the provisions of subrule 153.5(1) for the area under the control of the employer, owner, or operator within that public place.

153.5(4) An employer, owner, operator, manager, or person having custody or control of a place where smoking is prohibited under 2008 Iowa Acts, House File 2212, shall inform any individual smoking in a place where smoking is prohibited that the individual is violating the smokefree air Act and shall request that the individual stop smoking immediately.

a. If the individual refuses to stop smoking, the employer, owner, operator, manager, or person having custody or control of the place where smoking is prohibited may discontinue service to that individual.

b. If the individual refuses to stop smoking, the employer, owner, operator, manager, or person having custody or control of the place where smoking is prohibited may request that the individual leave the area where smoking is prohibited.

c. If the individual refuses to leave the area where smoking is prohibited, the employer, owner, operator, manager, or person having custody or control of the place where smoking is prohibited may notify the state or local law enforcement agency with jurisdiction over the area where smoking is prohibited.

641—153.6(82GA,HF2212) Duties of other state agencies and political subdivisions. A state agency or political subdivision which inspects public places shall assess compliance with the requirements of these rules and 2008 Iowa Acts, House File 2212, during any inspection process and shall report any violations of 2008 Iowa Acts, House File 2212, to the department.

641—153.7(82GA,HF2212) Leases. Any lease entered into by the state or its political subdivisions on or after July 1, 2008, shall require that all areas where smoking is prohibited in 2008 Iowa Acts, House File 2212, section 3, comply with the provisions of 2008 Iowa Acts, House File 2212.

641—153.8(82GA,HF2212) Complaints and enforcement.

153.8(1) *Duties of department.* The department shall maintain a system for receiving and investigating complaints against persons who own, operate, manage, or otherwise have custody or

control of a place where smoking is prohibited and who fail to comply with the provisions of 2008 Iowa Acts, House File 2212.

a. Pursuant to 2008 Iowa Acts, House File 2212, section 9, subsection 7, the department may designate one or more public agencies through a 28E agreement or other written contract to assist with the enforcement of 2008 Iowa Acts, House File 2212.

b. The department may refer complaints regarding a violation of 2008 Iowa Acts, House File 2212, to the law enforcement authorities of the state or of the political subdivision of the state in which the alleged violation occurred.

153.8(2) *Enforcement against a person who smokes in an area where smoking is prohibited.* Pursuant to 2008 Iowa Acts, House File 2212, section 9, subsection 7, the department designates the law enforcement authorities of the state and of each political subdivision of the state to assist with the enforcement of 2008 Iowa Acts, House File 2212. A peace officer may issue a citation in lieu of arrest pursuant to Iowa Code chapter 805 against a person who smokes in an area where smoking is prohibited pursuant to 2008 Iowa Acts, House File 2212, and such person shall pay a civil penalty pursuant to Iowa Code section 805.8C(3)*"a"* for each violation.

153.8(3) *Enforcement against a person who owns, operates, manages, or otherwise has control of a place where smoking is prohibited.* Pursuant to 2008 Iowa Acts, House File 2212, section 9, subsection 7, the department designates the law enforcement authorities of the state and of each political subdivision of the state to assist with the enforcement of 2008 Iowa Acts, House File 2212. The department or its designee may initiate a civil action against an owner, operator, manager, or person who otherwise has custody or control of a place where smoking is prohibited pursuant to 2008 Iowa Acts, House File 2212, and such person shall pay the applicable civil penalty pursuant to 2008 Iowa Acts, House File 2212, section 9.

153.8(4) *Manner of filing a complaint.* Any person may register a complaint with the department by calling the toll-free number, 1-888-944-2247, or registering a complaint on the department's Web site, www.IowaSmokefreeAir.gov, or downloading a complaint form from the department's Web site and mailing the complaint form to the department at Department of Public Health, Division of Tobacco Use Prevention and Control, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319.

153.8(5) *Contents of the complaint.* A complaint filed with the department shall include:

a. The name and contact information of the person making the complaint;

b. The name or location of the public place, place of employment, area declared a nonsmoking place pursuant to 2008 Iowa Acts, House File 2212, section 5, or outdoor area where smoking is prohibited which is the subject of the complaint;

c. A description of the occurrence that prompted the complaint; and

d. Any other information relevant to the occurrence.

153.8(6) *Review of complaint by department.* Upon receipt of a complaint, the department or its designee may contact the individual making the complaint to confirm the details of the complaint and obtain any additional information.

153.8(7) *Information from inspections.* Information received by the department pursuant to rule 641—153.6(82GA,HF2212) of one or more violations of 2008 Iowa Acts, House File 2212, as a result of an inspection of a public place by the state or political subdivision of the state shall be considered a credible complaint under this rule.

153.8(8) *Notice of violation.* If the department determines that a complaint against a public place, place of employment, area declared nonsmoking pursuant to 2008 Iowa Acts, House File 2212, section 5, or outdoor areas where smoking is prohibited is credible, the department shall:

a. For the first complaint.

(1) Issue a written notice of violation to the owner, operator or person having custody or control including the details of the complaint.

(2) The notice shall include educational materials about how to comply with 2008 Iowa Acts, House File 2212, and information on whom to contact for further information and assistance for compliance.

b. For the second complaint in one year.

(1) Issue a second notice of violation to the owner, operator, or person having custody and control.

(2) In addition, the department may authorize one or more public agencies to conduct a compliance check of the location.

(3) In addition, the department may pursue the civil penalties provided for in 2008 Iowa Acts, House File 2212, section 9, subsection 2; may refer the complaint to the appropriate authority for enforcement of the civil penalties provided for in 2008 Iowa Acts, House File 2212, section 9, subsection 2; or may pursue any other remedy authorized by 2008 Iowa Acts, House File 2212.

c. For the third and subsequent complaints of a violation within one year.

(1) Issue a subsequent notice of violation and authorize one or more public agencies to conduct a compliance check of the location.

(2) In addition, the department may pursue the civil penalties provided for in 2008 Iowa Acts, House File 2212, section 9, subsection 2; may refer the complaint to the appropriate authority for enforcement of the civil penalties provided for in 2008 Iowa Acts, House File 2212, section 9, subsection 2; or may pursue any other remedy authorized by 2008 Iowa Acts, House File 2212.

641—153.9(82GA,HF2212) Limitation of rules. Nothing in these rules is intended to limit any other state administrative rule or federal regulation that prohibits smoking.

These rules are intended to implement 2008 Iowa Acts, House File 2212.

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CHAPTER 154
Reserved

CHAPTER 175
FAIR INFORMATION PRACTICES AND PUBLIC RECORDS

641—175.1(17A,22) Definitions. For purposes of this chapter, the following definitions apply:

"Agency" or *"department"* means the Iowa department of public health.

"Confidential record" means a record which is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records include records or information contained in records that the department is prohibited by law from making available for examination by members of the public, and records or information contained in records that are specified as confidential by Iowa Code section 22.7, or other provision of law, but that may be disclosed upon order of a court, the lawful custodian of the record, or by another person duly authorized to release the record. Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

"Custodian" means the department or a person lawfully delegated authority by the department to act for the department in implementing Iowa Code chapter 22.

"Open record" means a record other than a confidential record.

"Personally identifiable information" means information about or pertaining to an individual in a record which identifies the individual and which is contained in a record system.

"Record" means the whole or a part of a "public record" as defined in Iowa Code section 22.1 that is owned by or in the physical possession of the department.

"Record system" means any group of records under the control of the department from which a record may be retrieved by a personal identifier such as the name of an individual, number, symbol, or other unique retriever assigned to an individual.

641—175.2(17A,22) Statement of policy. The purpose of this chapter is to facilitate broad public access to open records and to facilitate sound department determinations with respect to the maintenance of confidential records and the implementation of the fair information practices Act. The department is committed to the policies set forth in Iowa Code chapter 22, and department staff shall cooperate with members of the public in implementing the provisions of that chapter.

641—175.3(17A,22) Requests for access to records.

175.3(1) *Location of record.* A request for access to a record should be directed to the division where the record is maintained. If the location of the record is not known by the requester, the request shall be directed to the Iowa Department of Public Health, Public Information Officer, Lucas State Office Building, Des Moines, Iowa 50319-0075, Attention: Record Request. The department will forward the request to the appropriate person.

175.3(2) *Office hours.* Open records shall be made available during all customary office hours, which are 8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays and legal holidays.

175.3(3) *Request for access.* Requests for access to open records may be made in writing, in person, by telephone, or by electronic means. A person requesting a record shall identify the particular record sought by name or description in order to facilitate the location of the record. A person requesting a record by mail, telephone, or by electronic means shall include the name, address, and telephone number of the person requesting the information in order to facilitate delivery of the record. A person shall not be required to give a reason for requesting an open record.

175.3(4) *Response to requests.* The custodian shall provide prompt access to an open record upon request unless the size or nature of the request makes prompt access infeasible. If the size or nature of the request for access to an open record requires time for compliance, the custodian shall comply with the request as soon as feasible. The custodian may delay access to an open record for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4). The custodian shall promptly give notice to the requester of the reason for any delay in access to an open record and an estimate of the length of that delay and, upon request, shall promptly provide that notice to the requester in writing.

The custodian of a record may deny access to the record by members of the public only on the grounds that such a denial is warranted under Iowa Code sections 22.8(4) and 22.10(4), or that it is a confidential record, or that its disclosure is prohibited by a court order.

175.3(5) *Security of record.* No person may, without permission from the custodian, search or remove any record from the department files. The custodian or a designee of the custodian shall supervise examination and copying of department records. Records shall be protected from damage and disorganization.

175.3(6) *Copying.* A reasonable number of copies of an open record may be made in the department's office. If photocopy equipment is not available in the department office where an open record is kept, the custodian shall permit its examination in that office and shall arrange to have copies promptly made elsewhere.

175.3(7) *Fees.*

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

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

c. Search and supervisory fee. An hourly fee may be charged for actual department expenses in searching for and supervising the examination and copying of requested records. The fee shall be based upon the actual costs incurred. The department shall post the hourly fees to be charged in routine cases for search and supervision of records. Except as provided in Iowa Code section 144.46, no fee shall be charged if the records are not made available for inspection, or if the time required does not exceed one hour in duration, or if the time required for the search was the result of department error or record-keeping problems. Iowa Code section 144.46 specifically allows for fees for vital record searches when the record is not copied or is not found, and this Iowa Code section is implemented by 641—96.4(144).

d. Advance deposits.

(1) Fulfillment of a request for a copy of a public record may be contingent upon receipt of payment of expenses to be incurred in fulfilling the request, and such estimated expenses shall be communicated to the requester prior to fulfillment of the request. When the estimated total fee chargeable under this subrule exceeds $25, the custodian may require a requester to make an advance payment to cover all or a part of the estimated fee.

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

641—175.4(17A,22) Access to confidential records. Under Iowa Code section 22.7 or other applicable provisions of law, the lawful custodian may disclose certain confidential records to particular persons under certain limited circumstances if the person is legally entitled to the record. In requesting the custodian to permit the examination and copying of such a confidential record, the following procedures apply and are in addition to those specified for requests for access to records in rule 175.3(17A,22).

175.4(1) *Proof of identity.* A person requesting access to a confidential record may be required to provide proof of identity or authority to secure access to the record.

175.4(2) *Requests.* The custodian may require a request to examine and copy a confidential record to be in writing. A person requesting access to such a record may be required to sign a certified statement or affidavit enumerating the specific reasons justifying access to the confidential record and to provide any proof necessary to establish relevant facts.

175.4(3) *Notice to subject of record and opportunity to obtain injunction.* After the custodian receives a request for access to a confidential record, and before the custodian releases such a record, the custodian may make reasonable efforts to notify promptly any person who is a subject of that record, is identified in that record, and whose address or telephone number is contained in that record. To the extent such a delay is practicable and in the public interest, the custodian may give the subject of such confidential record to whom notification is transmitted a reasonable opportunity to seek an injunction under Iowa Code section 22.8, and indicate to the subject of the record the specific period of time during which disclosure will be delayed for that purpose. The department is not required to provide notification or an opportunity to seek an injunction under this subrule and retains sole discretion as to whether to pursue such action.

175.4(4) *Requests denied.* When the custodian denies a request for access to a confidential record, the custodian shall promptly notify the requester. If the requester indicates to the custodian that a written notification of the denial is desired, the custodian shall promptly provide such a notification that is signed by the custodian and that includes:

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

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

175.4(5) *Request granted.* When the custodian grants a request for access to a confidential record to a particular person, the custodian shall notify that person and indicate any lawful restrictions imposed by the custodian on that person's examination and copying of the record.

641—175.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination. The custodian may treat a record as a confidential record and withhold it from examination only to the extent that the custodian is authorized by Iowa Code section 22.7, another applicable provision of law, or a court order to refuse to disclose that record to members of the public.

175.5(1) *Persons who may request.* Any person who would be aggrieved or adversely affected by disclosure of a record and who asserts that Iowa Code section 22.7, another applicable provision of law, or a court order authorizes the custodian to treat the record as a confidential record may request the custodian to treat that record as a confidential record and to withhold it from public inspection.

175.5(2) *Request.* A request that a record be treated as a confidential record and be withheld from public inspection shall be in writing and shall be filed with the custodian. The request must set forth the legal and factual basis justifying such confidential treatment for that record, and the name, address, and telephone number of the person authorized to respond to any inquiry or action of the custodian concerning the request. A person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit enumerating the specific reasons justifying the treatment of that record as a confidential record and to provide any proof necessary to establish relevant facts. Requests for treatment of a record as a confidential record for a limited time period shall also specify the precise period of time for which that treatment is requested.

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

175.5(3) *Failure to request.* Failure of a person to request confidential record treatment for a record does not preclude the custodian from treating it as a confidential record. However, if a person who has submitted business information to the department does not request that it be withheld from public inspection under Iowa Code sections 22.7(3) and 22.7(6), the custodian of records containing that information may proceed as if that person has no objection to its disclosure to members of the public.

175.5(4) *Timing of decision.* A decision by the custodian with respect to the disclosure of a record to members of the public may be made when a request for its treatment as a confidential record is filed or when the custodian receives a request for access to the record by a member of the public.

175.5(5) *Request granted or deferred.* If a request for such confidential record treatment is granted, or if action on such a request is deferred, a copy of the record from which the matter in question has been deleted and a copy of the decision to grant the request or to defer action upon the request will be made available for public inspection in lieu of the original record. If the custodian subsequently receives a request for access to the original record, the custodian will make reasonable and timely efforts to notify any person who has filed a request for its treatment as a confidential record that is not available for public inspection of the pendency of that subsequent request.

175.5(6) *Request denied and opportunity to seek injunction.* If a request that a record be treated as a confidential record and be withheld from public inspection is denied, the custodian shall notify the requester in writing of that determination and the reasons therefor. On application by a requester, the custodian may engage in a good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief under the provisions of Iowa Code section 22.8 or other applicable provision of law. However, such a record shall not be withheld from public inspection for any period of time if the custodian determines that the requester had no reasonable ground to justify the treatment of that record as a confidential record. The custodian shall notify requester in writing of the time period allowed to seek injunctive relief or the reasons for the determination that no reasonable grounds exist to justify the treatment of that record as a confidential record. The custodian may extend the period of good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief only if no request for examination of that record has been received, or if a court directs the custodian to treat it as a confidential record, or to the extent permitted by another applicable provision of law, or with the consent of the person requesting access.

641—175.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records. Except as otherwise provided by law, a person may file a request with the custodian to review, and to have a written statement of additions, dissents, or objections entered into a record containing personally identifiable information pertaining to that person. However, a person who is a subject of such a record shall not be authorized to alter the original copy of that record or to expand the official record of any agency proceeding. A requester shall send the request to review such a record or the written statement of additions, dissents, or objections to the custodian or to the division in which the record is maintained. The request to review such a record or the written statement of such a record of additions, dissents, or objections must be dated and signed by requester, and shall include the current address and telephone number of the requester or the requester's representative.

641—175.7(17A,22) Consent to disclosure by the subject of a confidential record. Except as otherwise provided by law, a person who is the subject of a confidential record may have a copy of the portion of that record concerning the subject disclosed to a third party. A request for such a disclosure must be in writing and must identify the particular record or records that may be disclosed, and the particular person or class of persons to whom they may be disclosed. The person who is the subject of the record and, where applicable, the person to whom the record is to be disclosed, may be required to provide proof of identity. Appearance of counsel before the department on behalf of a person who is the subject of a confidential record is deemed to constitute consent for the department to disclose records about that person to the person's attorney.

641—175.8(17A,22) Notice to suppliers of information. When the department requests a person to supply information about that person, the department may notify the person of the use that will be made of the information, which persons outside the department might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested. This notice may be given in these rules, on the written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, verbally, or by other appropriate means.

641—175.9(17A,22) Disclosures without the consent of the subject.

175.9(1) The department shall routinely disclose open records without the consent of the subject.

175.9(2) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject. Following are instances where disclosure, if lawful, will generally occur without notice to the subject:

a. For a routine use as defined in rule 175.10(17A,22) or in the notice for a particular record system.

b. To a recipient who has provided the department with advance written assurance that the record will be used solely as a statistical research or reporting record. The department shall not release confidential data or information pursuant to this chapter unless the department and the recipient have executed an agreement which includes the conditions under which the confidential data or information may be used and a restriction on the further disclosure of the data or information.

c. To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil, administrative, or criminal law enforcement activity if the activity is authorized by law, and if an authorized representative of such government agency or instrumentality has submitted a written request to the department specifying the record desired and the law enforcement activity for which the record is sought.

d. To an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual if a notice of the disclosure is transmitted to the last-known address of the subject.

e. To the legislative services agency under Iowa Code section 2A.3.

f. Disclosures in the course of employee disciplinary proceedings.

g. In response to a court order or subpoena.

h. To the office of citizens' aide pursuant to Iowa Code section 2C.9.

641—175.10(17A,22) Routine use.

175.10(1) Defined. "Routine use" means the disclosure of a record without the consent of the subject for a purpose which is compatible with the purpose for which the record was collected. "Routine use" includes disclosures required or authorized by statute or rule.

175.10(2) To the extent allowed by law, the following uses are considered routine uses of all department records:

a. Disclosure to those officers, employees, and agents of the department who have a need for the record in the performance of their duties.

b. Disclosure to employees of federal, state and local agencies and other researchers for purposes of bona fide research. The department shall not release data or information pursuant to this paragraph unless the department and the researcher have executed an agreement which includes the conditions under which the confidential data or information may be used and restrictions on further disclosure of the data or information.

c. Disclosure of information indicating an apparent violation of the law to appropriate law enforcement authorities for investigation and possible criminal prosecution, civil court action, or regulatory order.

d. Disclosure to the department of inspections and appeals for matters in which it is performing services or functions on behalf of the department.

e. Transfers of information within the department, to other state or federal agencies, or to local units of government as necessary to administer the program for which the information is collected or as necessary to administer a program within the other governmental agency. Confidential information transferred within the department or provided to other agencies pursuant to this paragraph shall continue to maintain its confidential status and shall not be rereleased by the receiving agency.

f. Information released to staff of federal and state entities for audit purposes or for purposes of determining whether the department is operating a program lawfully.

g. Any disclosure specifically authorized by the statute or rule under which the record was collected or maintained.

641—175.11(17A,22) Consensual disclosure of confidential records.

175.11(1) *Consent to disclosure by a subject individual.* To the extent permitted by law, the subject may consent in writing to department disclosure of confidential records as provided in rule 175.7(17A,22).

175.11(2) *Complaints to public officials.* A letter from a subject of a confidential record to a public official which seeks the official's intervention on behalf of the subject in a matter that involves the department may to the extent permitted by law be treated as an authorization to release sufficient information about the subject to the official to resolve the matter.

641—175.12(17A,22) Release to subject.

175.12(1) The subject of a confidential record may file a written request to review confidential records about that person as provided in rule 175.6(17A,22). However, the department need not release the following records to the subject:

a. The identity of a person providing information to the department need not be disclosed directly or indirectly to the subject of the information when the information is authorized to be held confidential pursuant to Iowa Code section 22.7(18) or other provision of law.

b. Records need not be disclosed to the subject when they are the work product of an attorney or are otherwise privileged.

c. Peace officers' investigative reports may be withheld from the subject, except as required by the Iowa Code.

d. As otherwise authorized by law.

175.12(2) Where a record has multiple subjects with interest in the confidentiality of the record, the department shall take reasonable steps to protect confidential information relating to another subject.

641—175.13(17A,22) Availability of records.

175.13(1) *General.* Department records are open for public inspection and copying subject to supervision unless otherwise provided by statute or rule.

175.13(2) *Confidential records.* The following records shall be withheld from public inspection. Records are listed by department division and include the legal authority for withholding the record from public inspection.

a. Division of acute disease prevention and emergency response.

(1) Records which identify a person infected with or exposed to a reportable disease or other disease or health condition collected pursuant to Iowa Code chapter 139A, and maintained as confidential pursuant to Iowa Code section 139A.3(2)*"b"* and Iowa Code section 22.7(16).

(2) Records which identify a business involved in a reportable disease or other disease or health condition investigation collected pursuant to Iowa Code chapter 139A, and maintained as confidential pursuant to Iowa Code section 139A.3(2)*"c."*The identity of a business may be disclosed pursuant to this authority only if the state epidemiologist or the director of the department determines such a release of information necessary for the protection of the health of the public.

(3) Records which identify a person infected with or exposed to a reportable sexually transmitted disease or infection collected pursuant to Iowa Code chapter 139A, and maintained as confidential pursuant to Iowa Code section 139A.30 and Iowa Code section 22.7(16).

(4) Records which identify a person infected with or exposed to HIV/AIDS collected pursuant to Iowa Code chapter 141A, and maintained as confidential pursuant to Iowa Code section 141A.9.

(5) Data and records received or developed by the trauma system evaluation and quality improvement committee, including patient and emergency medical care service program identifying information, collected pursuant to Iowa Code chapter 147A, and maintained as confidential pursuant to Iowa Code section 147A.25.

(6) Data collected by and furnished to the statewide trauma registry which identifies a patient or former patient collected pursuant to Iowa Code section 147A.26, and maintained as confidential pursuant to Iowa Code section 147A.26.

(7) All information in complaint and investigative files maintained by the bureau of emergency medical services collected pursuant to Iowa Code chapter 147A, and maintained as confidential pursuant to Iowa Code section 272C.6(4), except that the information may be released to the provider or the service once a disciplinary proceeding has been initiated by the filing of a notice of proposed action. A notice of proposed action and final agency action are public documents.

(8) Immunization information which identifies a patient maintained on the statewide immunization registry collected pursuant to Iowa Code section 22.7(2), and maintained as confidential pursuant to Iowa Code section 22.7(2) and 641—subrule 7.11(4). The department's rules regarding sharing of immunization information are contained at 641—7.12(22).

b. Division of administration and professional licensure.

(1) Vital records maintained pursuant to Iowa Code chapter 144, including records of births, deaths, fetal deaths, adoptions, marriages, divorces, annulments and related data and correspondence, and maintained as confidential pursuant to Iowa Code section 144.43.

(2) Licensing and disciplinary records of the professional licensing boards may be confidential in accordance with Iowa Code section 272C.6(4) and 645—10.13(17A,22).

c. Division of behavioral health.

(1) Records which identify a person named in a report to the central registry for brain or spinal cord injuries collected pursuant to Iowa Code section 135.22, and maintained as confidential pursuant to Iowa Code section 135.22 and 641—21.6(135).

(2) Information contained in a complaint regarding a licensed substance abuse program collected pursuant to Iowa Code chapter 125, and maintained as confidential pursuant to Iowa Code sections 22.7(2), 22.7(18), and 125.37. Investigative reports, written plans of corrective action, and all notices and orders issued by the board of health shall refer to clients and patients by number and shall not include any other client or patient identifying information. Investigative reports, written plans of corrective action, and all notices and orders issued by the board of health shall be available to the public as open records in accordance with 641—subrule 155.16(5).

(3) Records which identify the victim of a domestic abuse death collected or maintained by the Iowa domestic abuse death review team pursuant to Iowa Code section 135.110, and maintained as confidential pursuant to Iowa Code section 135.111.

d. Division of environmental health.

(1) Drafts of proposed regulations released to the department from the federal government which constitute essential information needed by the department to ensure compliance with federal regulations collected pursuant to Iowa Code chapter 136C, and maintained as confidential pursuant to Iowa Code section 22.9 and 641—subrule 38.7(2).

(2) Applications and documents submitted to the department pursuant to Iowa Code chapter 136C, which may be maintained as confidential pursuant to 641—subrule 39.4(24) if disclosure of their contents is not required in the public interest and would adversely affect the interest of a person concerned.

(3) Records which identify a person infected with or exposed to a reportable disease or other disease or health condition, including lead and other heavy metal poisonings, collected pursuant to Iowa Code chapter 139A, and maintained as confidential in accordance with Iowa Code section 139A.3(2)*"b."*

(4) Records which identify a business involved in a reportable disease or other disease or health condition investigation, including a lead or other heavy metal poisoning investigation, collected pursuant to Iowa Code chapter 139A, and maintained as confidential pursuant to Iowa Code section 139A.3(2)*"c."* The identity of a business may be disclosed pursuant to this authority only if the state epidemiologist or the director of the department determines such a release of information necessary for the protection of the health of the public or if the release is required by federal, state, or local law.

e. Division of health promotion and chronic disease prevention.

(1) All medical, health and nutrition information which identifies a WIC program participant collected pursuant to federal law and Iowa Code chapter 135, and maintained as confidential in accordance with 7 CFR 246, Iowa Code section 22.7(2), and 641—subrule 73.7(7).

(2) Records which identify the victim of a child death collected or maintained by the Iowa child death review team pursuant to Iowa Code section 135.43, and maintained as confidential pursuant to Iowa Code section 135.43.

(3) Records which identify a child subject to a newborn and infant hearing screening collected pursuant to Iowa Code section 135.131, and maintained as confidential pursuant to Iowa Code section 135.131 and 641—3.10(80GA,ch102).

(4) Records which identify a person named in a report to the central registry for congenital and inherited disorders collected pursuant to Iowa Code section 136A.7, and maintained as confidential in accordance with Iowa Code section 136A.7 and 641—subrule 4.3(7).

(5) Records which identify a person infected with or exposed to a reportable disease or other disease or health condition, including a congenital or inherited disorder, collected pursuant to Iowa Code chapter 139A, and maintained as confidential pursuant to Iowa Code section 139A.3(2)*"b."*

f. Sections which govern all divisions.

(1) Records which contain medical information collected pursuant to Iowa Code chapters 135, 139A, and 147A, and maintained as confidential pursuant to Iowa Code section 22.7(2).

(2) Records collected from any person, hospital, or other organization related to the condition and treatment of any person to be used in the course of any study for the purpose of reducing morbidity or mortality collected pursuant to Iowa Code section 135.40, and maintained as confidential pursuant to Iowa Code sections 135.40, 135.41, and 135.42.

(3) Records concerning security procedures or emergency preparedness developed and maintained by the department or other federal or state agency for the protection of governmental employees, visitors to the department, persons in the care, custody, or under the control of the department, or property under the jurisdiction of the department, if disclosure could reasonably be expected to jeopardize such employees, visitors, or property. Pursuant to Iowa Code section 22.7(50), the department has adopted a policy which identifies all specific records or classes of records to which this protection applies.

175.13(3) Minutes of closed meetings of a government body shall be kept confidential in accordance with Iowa Code section 21.5.

175.13(4) Identifying details in final orders, decisions and opinions shall be kept confidential to the extent required to prevent a clearly unwarranted invasion of personal privacy or trade secrets under Iowa Code section 17A.3(1)*"e."*

175.13(5) Portions of department staff manuals, instructions or other statements issued shall be kept confidential when such documents set forth criteria or guidelines to be used by department staff in auditing, in making inspections, in settling commercial disputes or negotiating commercial arrangements, or in the selection or handling of cases, such as operational tactics or allowable tolerances or criteria for the defense, prosecution or settlement of cases, when disclosure of these statements would:

a. Enable law violators to avoid detection;

b. Facilitate disregard of requirements imposed by law; or

c. Give a clearly improper advantage to persons who are in an adverse position to the department.

175.13(6) Records which constitute attorney work product or attorney-client communications or which are otherwise privileged shall be kept confidential. Attorney work product is confidential under Iowa Code sections 22.7(4), 622.10 and 622.11, Iowa R.C.P. 1.503, Fed. R. Civ. P. 26(b)(3), and case law. Attorney-client communications are confidential under Iowa Code sections 622.10 and 622.11, the rules of evidence, the Code of Professional Responsibility, and case law.

175.13(7) Records exempted from public inspection under Iowa Code section 22.7 or any other provision of law shall be kept confidential.

641—175.14(17A,22) Personally identifiable information. This rule describes the nature and extent of personally identifiable information which is collected, maintained, and retrieved by the department by personal identifiers in record systems as defined in rule 175.1(17A,22). For each record system, this rule describes the legal authority for the collection of that information and the means of storage of that information. A data processing system does not match, collate, or permit the comparison of personally

identifiable information in one record system with personally identifiable information in another record system unless so indicated. The record systems maintained by the department are as follows:

175.14(1) *Division of acute disease prevention and emergency response.*

a. Records of reportable diseases and other diseases and health conditions collected pursuant to Iowa Code chapter 139A. These records are stored on paper, electronically, or both, depending on the specific type of record. Except for statistical reports, these records are confidential as outlined in 175.13(2)*"a."*

b. Records of reportable sexually transmitted diseases or infections collected pursuant to Iowa Code chapter 139A. These records are stored on paper, electronically, or both, depending on the specific type of record. Except for statistical reports, these records are confidential as outlined in 175.13(2)*"b."*

c. Records of the veterinary public health program collected pursuant to Iowa Code chapter 139A. These records are stored on paper. Certain medical information in these records may be confidential as outlined in 175.13(2)*"a."*

d. Records of the emergency medical services program collected pursuant to Iowa Code chapter 147A. These records are stored on paper, electronically, or both, depending on the specific type of record. Some of these records are confidential as outlined in 175.13(2)*"a."*

e. Records of the AIDS drug reimbursement program collected for purposes of implementing a federal grant program authorized by HR 1827. These records are stored on paper. Certain patient records are confidential as outlined in 175.13(2)*"a."*

f. Personnel records containing information about employees, families and dependents, and applicants for positions with the department. Some of this information is confidential under Iowa Code sections 22.7(11) and 22.7(18).

g. Records of the certificate of need program collected pursuant to Iowa Code sections 135.61 to 135.83. These records are stored on paper.

h. Annual hospital surveys collected pursuant to Iowa Code sections 135.74 and 135.75. These records are stored on paper and electronically.

175.14(2) *Division of administration and professional licensure.*

a. Vital records collected pursuant to Iowa Code chapter 144, including records of births, deaths, fetal deaths, adoptions, marriages, divorces, annulments and related data and correspondence. These records are stored on paper, on microfiche, and electronically. These records are confidential as noted in 175.13(2)*"b."*

b. Licensing records of the professional licensing boards. These records are identified in rules filed by the individual licensing boards (see Professional Licensure Division, IAC 645). They contain information about individuals, some of which is confidential.

c. An electronic inventory of records maintained by the department, which indicates the type of information contained in the record, contact person for the record, how the record is stored, whether the record is confidential, and whether it contains personally identifiable information. This inventory is maintained by the information management bureau.

d. Fiscal records, including itemized vouchers collected from individuals pursuant to Iowa Code section 8A.514. These records are stored on paper and electronically.

175.14(3) *Division of behavioral health.*

a. Records of substance abuse programs of this division are identified in rules adopted by the board of health in 641—Chapter 155.

b. Records of the domestic abuse death review team collected pursuant to Iowa Code section 135.110. These records are stored on paper, electronically, or both. Except for statistical reports, these records are confidential as outlined in 175.13(2)*"c."*

c. Records which identify a person named in a report to the central registry for brain or spinal cord injuries collected pursuant to Iowa Code section 135.22. These records are stored on paper, electronically, or both. Except for statistical reports, these records are maintained as confidential pursuant to Iowa Code section 135.22 and 641—21.6(135).

d. Records which identify brain injury service program recipients collected pursuant to Iowa Code section 135.22B. These records are stored on paper, electronically, or both.

175.14(4) *Division of environmental health.*

a. Records of the environmental health programs collected pursuant to Iowa Code section 135.11(1) and PL 96-510, Section 104(d)(1), 40 CFR 763 effective June 28, 1983, and 40 CFR 761 effective May 31, 1979, dealing with asbestos, PCB and other environmental health factors. These records are stored on paper, electronically, or both, depending on the specific type of record. Certain medical information in the work-related disease program file may be confidential as outlined in 175.13(2)*"d."* Certain asbestos and PCB inspection records are collected under contract with the federal Environmental Protection Agency, and requests for such records will be referred to that agency.

b. Records of the radiological health program collected pursuant to Iowa Code chapters 136B and 136C. These records are stored on paper, electronically, or both, depending on the specific record. Certain of these records are confidential as outlined in 175.13(2)*"d."*

c. Records of reportable diseases and other diseases and health conditions, including lead and other heavy metal poisonings, collected pursuant to Iowa Code chapter 139A. These records are stored on paper, electronically, or both, depending on the specific type of record. Except for statistical reports, these records are confidential as outlined in 175.13(2)*"a."*

d. Records of the childhood lead poisoning prevention program collected pursuant to Iowa Code sections 135.100 to 135.105. These records are stored on paper, electronically, or both. Certain of these records are confidential as outlined in 175.13(2)*"d."* Data processing systems will link certain client data in these programs with client data in the maternal and child health program, WIC program, and refugee health program.

175.14(5) *Division of health promotion and chronic disease prevention.*

a. Records of the maternal and child health programs collected pursuant to Iowa Code section 135.11(20). These records are stored on paper, electronically, or both, depending on the specific type of record. Data processing systems will link certain client data in these programs with client data in the WIC program.

b. Records of the nutrition and WIC (supplemental food program for women, infants and children) programs collected pursuant to Iowa Code section 135.11(1) and Chapter 17 of the federal Child Nutrition Act of 1966 as amended. These records are stored on paper, electronically, or both, depending on the specific type of record. Data processing systems will link certain client data in this program with client data in maternal and child health programs.

c. Records of the center for congenital and inherited disorders collected pursuant to Iowa Code chapter 136A. These records are stored on paper.

d. Records of the dental health programs collected pursuant to Iowa Code section 135.11(19), funded primarily by maternal and child health funds. These records are stored on paper or electronically, depending on the specific type of record.

e. Records of the newborn and infant hearing screening program collected pursuant to Iowa Code section 135.131. These records are stored on paper, electronically, or both, depending on the specific type of record. Information which identifies an individual patient is confidential as outlined in 175.13(2)*"e."*

f. Refugee health program records collected pursuant to Iowa Code section 135.11(1) and Section 412(c)(3) of the federal Immigration and Naturalization Act. These records are stored on paper, electronically, or both, depending on the specific type of record. Certain medical information in these records is confidential as outlined in 175.13(2)*"f."*

g. Records of the bureau of chronic disease prevention and management collected pursuant to Iowa Code section 135.11(1), including the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program and the Breast and Cervical Cancer Early Detection Program (BCCEDP). Certain medical information in these records is confidential as outlined in 175.13(2)*"f."* The medical information from wellness programs and screening programs is stored on paper, electronically, or both, depending on the specific type of record. Data processing systems will link certain client data in these programs with client data in the University of Iowa's health registries.

641—175.15(17A,22) Other groups of records. This rule describes groups of records maintained by the agency other than record systems as defined in rule 175.2(17A,22). These records are routinely

available to the public. However, the department's files of these records may contain confidential information as discussed in rule 175.13(17A,22). The records listed may contain information about individuals. All records are stored on paper unless otherwise noted.

175.15(1) *Rule making.* Rule-making records may contain information about individuals making written or oral comments on proposed rules. This information is collected pursuant to Iowa Code section 17A.4.

175.15(2) *Council and commission records.* Agendas, minutes, and materials presented to the councils, committees and commissions listed below, by division, are available from the department, except those records concerning closed sessions which are exempt from disclosure under Iowa Code section 21.5(4) or which are otherwise confidential by law. Council and commission records contain information about people who participate in meetings. This information is collected pursuant to Iowa Code section 21.3.

a. Division of acute disease prevention and emergency response.

(1) EMS advisory council established in Iowa Code section 147A.2.

(2) System evaluation and quality improvement committee established in Iowa Code section 147A.25.

(3) Trauma system advisory council established in Iowa Code section 147A.24.

(4) State health facilities council established in Iowa Code section 135.61.

b. Division of administration and professional licensure: professional licensing boards established in Iowa Code chapters 147 and 272C.

c. Division of behavioral health.

(1) Advisory council on brain injuries established in Iowa Code section 135.22A.

(2) Domestic abuse death review team established in Iowa Code section 135.109.

(3) State substitute medical decision-making board established in Iowa Code section 135.28.

d. Division of environmental health: technical advisory committee for radiation machines and radioactive materials established in Iowa Code section 136C.3(2).

e. Division of health promotion and chronic disease prevention.

(1) Abuse education review panel established in Iowa Code section 135.11(27).

(2) Advisory committee to the center for rural health and primary care established in Iowa Code section 135.107.

(3) Committee on maternal and child health established in Iowa Code section 235C.1.

(4) Council on chemically exposed infants and children established in Iowa Code section 235C.1.

(5) Iowa child death review team established in Iowa Code section 135.43.

f. Division of tobacco use prevention and control.

(1) Commission on tobacco use prevention and control established in Iowa Code section 142A.3(2).

(2) Commission on tobacco use prevention and control advisory council established in Iowa Code section 142A.3(9).

(3) Just Eliminate Lies executive body established in Iowa Code section 142A.9(2)*"c."*

g. Director's office.

(1) Interagency coordinating council established in Iowa Code section 691.6B.

(2) State board of health established in Iowa Code chapter 136.

(3) State medical examiner advisory council established in Iowa Code section 691.6C.

(4) Preventative health and health services block grant advisory committee.

(5) Other ad hoc and advisory committees as established by the director pursuant to Iowa Code section 135.11(26).

175.15(3) *Publications.* News releases, annual reports, project reports, and department newsletters are available from the public information office. Department news releases, project reports, and newsletters may contain information about individuals, including department staff or members of department councils or committees.

175.15(4) *Statistical reports.* Periodic reports of vital statistics records are available from the bureau of vital statistics.

175.15(5) *Appeal decisions and advisory opinions.* All final orders, decisions and opinions are open to the public except for information that is confidential according to rule 175.13(17A,22) or 175.14(17A,22). These records may contain information about individuals.

175.15(6) *Published materials.* The department uses many legal and technical publications in its work. The public may inspect these publications upon request. Some of these materials may be protected by copyright law.

175.15(7) *Policy manuals.* Policy or program manuals for various programs may be obtained by contacting the program.

175.15(8) *All other records that are not exempted from disclosure by law.* Other records used by the department include correspondence files, surveys conducted by programs, information and data files, and records used for processing purposes internally. Some of these records may contain information about individuals. Correspondence files may contain confidential information protected by statutes cited in rule 175.13(17A,22).

641—175.16(17A,22) Data processing systems. Except where otherwise noted, data processing systems used by the department do not permit the comparison of personally identifiable information in one record system with personally identifiable information in another record system.

641—175.17(17A,22) Applicability. This chapter does not:

1. Require the department to index or retrieve records which contain information about individuals by that person's name or other personal identifier.
2. Make available to the general public records which would otherwise not be available under the public records law, Iowa Code chapter 22.
3. Govern the maintenance or disclosure of, notification of, or access to records in the possession of the department which are governed by the regulations of another agency.
4. Apply to grantees, including local governments or subdivisions, that administer state-funded programs, unless otherwise provided by law or agreement.
5. Make available records compiled by the department in reasonable anticipation of court litigation or formal administrative proceedings. The availability of such records to the general public or to any individual or party subject to such litigation or proceedings shall be governed by applicable legal and constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable regulations of the department.

These rules are intended to implement Iowa Code chapters 17A and 22.

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PUBLIC SAFETY DEPARTMENT[661]

Rules transferred from agency number 680 to 661 to conform with the reorganization numbering scheme in general

CHAPTER 1
THE DEPARTMENT

1.1(17A) Establishment of the department of public safety
1.2(17A) Organization
1.3(17A) Offices
1.4(17A) Methods by which and location where the public may obtain information or make submissions or requests
1.5 Reserved
1.6(17A) Legal advice
1.7(17A) Surety companies
1.8(17A) Construction of rules

CHAPTER 2
Reserved

CHAPTER 3
SHERIFF'S UNIFORMS

3.1(17A,331) General provisions
3.2(17A,331) Trousers
3.3(17A,331) Shirts
3.4(17A,331) Hats
3.5(17A,331) Ties
3.6(17A,331) Raingear
3.7(17A,331) Shoes and boots
3.8(17A,331) Gloves
3.9(17A,331) Jackets
3.10(17A,331) Accessories

CHAPTER 4
Reserved

Division I
Rescinded IAB 5/9/07 Effective 7/1/07; see 661—Chapter 91

CHAPTER 5
FIRE MARSHAL ADMINISTRATION

GENERAL PROVISIONS

5.1(100) Description
5.2(17A,80,100,101,101A) Definitions
5.3(17A,100) Building plan approval
5.4(17A,100,101,101A) Inspections
5.5(100) Certificates and inspection fees
5.6(17A,80,100) Fire investigations
5.7(17A,101A) Explosive materials
5.8(100,101,101A) Fire drills
5.9(17A,100) Fire escapes
5.10(17A,22,100,692) Public inspection of fire marshal files and fire records
5.11(17A,80,100) Information requested before inspection
5.12(17A,80,100A) Sharing of insurance company information with the fire marshal
5.13(17A,80,100A) Release of information to an insurance company

5.14(17A,80,100A) Forms
5.15(17A,100) Waivers, variances, and exceptions
5.16 to 5.49 Reserved

MEANS OF EXIT

5.50 to 5.99 Reserved

LIFE SAFETY REQUIREMENTS FOR EXISTING BUILDINGS

5.100 to 5.249 Reserved

LIQUEFIED PETROLEUM GASES

5.250 to 5.274 Reserved

LIQUEFIED NATURAL GAS

5.275 to 5.299 Reserved

FLAMMABLE AND COMBUSTIBLE LIQUIDS CODE

5.300 to 5.349 Reserved

OIL BURNING EQUIPMENT

5.350 to 5.399 Reserved

STORAGE OF FLAMMABLE AND COMBUSTIBLE LIQUIDS ON FARMS AND ISOLATED CONSTRUCTION PROJECTS

5.400 to 5.449 Reserved

TRANSPORTATION AND DELIVERY OF FLAMMABLE AND COMBUSTIBLE LIQUIDS BY TANK VEHICLES

5.450 to 5.499 Reserved

CHILD CARE CENTERS

5.500(100) Definitions
5.501(100) Child care centers in mixed occupancies
5.502(100) Child care centers for seven or more children
5.503 to 5.509 Reserved

ADULT DAY SERVICES PROGRAMS

5.510(231D) Adult day services
5.511 to 5.606 Reserved

RESIDENTIAL FACILITIES

5.607 to 5.614 Reserved
5.615(237C) Facilities in which foster care is provided to fewer than six children by agencies
5.616 to 5.619 Reserved
5.620(100,135C) General requirements for small group homes (specialized licensed facilities) licensed pursuant to Iowa Code section 135C.2
5.621 to 5.624 Reserved
5.625(100,231B) Elder group homes
5.626(231C) Assisted living housing
5.627 to 5.649 Reserved

FIRE SAFETY RULES FOR SCHOOL AND COLLEGE BUILDINGS

5.650 Reserved

EXISTING SCHOOL BUILDINGS

5.651 to 5.674 Reserved

NEW SCHOOL BUILDINGS

5.675 to 5.699 Reserved

NEW COLLEGE BUILDINGS

5.700 to 5.748 Reserved

EXISTING COLLEGE BUILDINGS

5.749 to 5.774 Reserved

NEW COLLEGE BUILDINGS

5.775 to 5.799 Reserved

FIRE SAFETY RULES FOR RESIDENTIAL OCCUPANCIES

5.800 Reserved

NEW RESIDENTIAL OCCUPANCIES

5.801 to 5.803 Reserved

EXISTING RESIDENTIAL OCCUPANCIES

5.804 to 5.806 Reserved
5.807(100) Smoke detectors definition
5.808(100) General requirements
5.809(100) Smoke detectors—notice and certification of installation
5.810(100) Smoke detectors—new and existing construction
5.811 to 5.819 Reserved

BED AND BREAKFAST INNS

5.820(100,137C) Bed and breakfast inns
5.821 to 5.849 Reserved

EXPLOSIVE MATERIALS

5.850 Reserved
5.851(101A) Inventory
5.852 to 5.864 Reserved
5.865(101A,252J) Grounds for suspension, revocation, or denial of commercial explosives licenses
5.866(252J) Child support collection procedures

CHAPTER 6
VEHICLE IMPOUNDMENT

6.1(17A,321) Vehicle impoundment
6.2(17A,321) Vehicles which may be impounded immediately
6.3(17A,321) Vehicles which need not be impounded immediately
6.4(17A,321) Impoundment procedure
6.5(17A,321) Abandoned vehicles
6.6(321) Scope

CHAPTER 7
IGNITION INTERLOCK DEVICES

7.1 to 7.7 Reserved
7.8(321J) Breath alcohol ignition interlock device

CHAPTER 8
CRIMINAL JUSTICE INFORMATION

8.1 to 8.100 Reserved

DIVISION I
IOWA ON-LINE WARRANTS AND ARTICLES SYSTEM

8.101(80,692) Iowa on-line warrants and articles (IOWA) criminal justice information system
8.102(80,692) Information available through the IOWA system
8.103(80) Human immunodeficiency virus-related information
8.104(80,692) IOWA system security
8.105(80,692) Subpoenas and court orders

CHAPTER 9
Reserved

CHAPTER 10
PRACTICE AND PROCEDURE BEFORE THE DEPARTMENT OF PUBLIC SAFETY

10.1(17A)	Definitions
10.2 to 10.100	Reserved
10.101(17A)	Petition for declaratory order
10.102(17A)	Notice of petition
10.103(17A)	Intervention
10.104(17A)	Briefs
10.105(17A)	Inquiries
10.106(17A)	Service and filing of petitions and other papers
10.107(17A)	Consideration
10.108(17A)	Action on petition
10.109(17A)	Refusal to issue order
10.110(17A)	Contents of declaratory order—effective date
10.111(17A)	Copies of orders
10.112(17A)	Effect of a declaratory order
10.113 to 10.200	Reserved

AGENCY PROCEDURE FOR RULE MAKING

10.201(17A)	Applicability
10.202(17A)	Advice on possible rules before notice of proposed rule adoption
10.203(17A)	Public rule-making docket
10.204(17A)	Notice of proposed rule making
10.205(17A)	Public participation
10.206(17A)	Regulatory analysis
10.207(17A,25B)	Fiscal impact statement
10.208(17A)	Time and manner of rule adoption
10.209(17A)	Variance between adopted rule and published notice of proposed rule adoption
10.210(17A)	Exemptions from public rule-making procedures
10.211(17A)	Concise statement of reasons
10.212(17A)	Contents, style, and form of rule
10.213(17A)	Agency rule-making record
10.214(17A)	Filing of rules
10.215(17A)	Effectiveness of rules prior to publication
10.216(17A)	General statements of policy
10.217(17A)	Review by department of rules
10.218(17A)	Petition for rule making
10.219(17A)	Briefs
10.220(17A)	Inquiries
10.221(17A)	Agency consideration
10.222(17A)	Waivers of rules
10.223 to 10.300	Reserved

CONTESTED CASES

10.301(17A)	Scope and applicability
10.302(17A)	Definitions
10.303(17A)	Time requirements
10.304(17A)	Requests for contested case proceeding
10.305(17A)	Notice of hearing
10.306(17A)	Presiding officer

10.307(17A) Waiver of procedures
10.308(17A) Telephone proceedings
10.309(17A) Disqualification
10.310(17A) Consolidation—severance
10.311(17A) Pleadings
10.312(17A) Service and filing of pleadings and other papers
10.313(17A) Discovery
10.314(17A) Subpoenas
10.315(17A) Motions
10.316(17A) Prehearing conference
10.317(17A) Continuances
10.318(17A) Withdrawals
10.319(17A) Intervention
10.320(17A) Hearing procedures
10.321(17A) Evidence
10.322(17A) Default
10.323(17A) Ex parte communication
10.324(17A) Recording costs
10.325(17A) Interlocutory appeals
10.326(17A) Final decision
10.327(17A) Appeals and review
10.328(17A) Applications for rehearing
10.329(17A) Stays of agency actions
10.330(17A) No factual dispute contested cases
10.331(17A) Emergency adjudicative proceedings
10.332(17A) Burden of proof

CHAPTER 11
IDENTIFICATION SECTION OF THE DIVISION OF CRIMINAL INVESTIGATION

11.1(17A,690,692) Identification section
11.2(17A,690,692) Definitions
11.3(690,692) Release of information
11.4(690,692) Right of review
11.5(690,692) Review of record
11.6(17A,690,692) Inaccuracies in criminal history
11.7(17A,690,692) Fingerprint files and crime reports
11.8(690) Taking of fingerprints
11.9(17A,690,692) Arresting agency portion of final disposition form
11.10(690,692) Final disposition form
11.11 Reserved
11.12(692) Release of information to the public
11.13 Reserved
11.14(692) Scope of record checks for non-criminal justice agencies and individuals
11.15(692) Fees
11.16 Reserved
11.17(17A,22,692) Requests for criminal history data
11.18(690) Administrative sanctions
11.19(232) Juvenile fingerprints and criminal histories
11.20(135C) Release of dependent adult abuse records
11.21(692) Criminal history checks for qualified entities

CHAPTER 12
Reserved

CHAPTER 13
SPECIAL RAILWAY AGENTS

13.1(17A,80)	Appointment of railway special agents
13.2(17A,80)	Standards
13.3(17A,80)	Training requirements
13.4(17A,80)	Letter of request
13.5(17A,80)	Application form
13.6(17A,80)	Photographs
13.7(17A,80)	Vision classification
13.8(17A,80)	Surety bond
13.9(17A,80)	Background investigation
13.10(17A,80)	Weapons permit
13.11(17A,80)	Renewal of permit
13.12(17A,80)	Weapons training
13.13(17A,80)	Review of application
13.14(17A,80)	Identification card
13.15(17A,80)	Notification
13.16(17A,80)	Notice of termination of employment

CHAPTER 14
Reserved

CHAPTER 15
LAW ENFORCEMENT ADMINISTRATOR'S TELECOMMUNICATIONS
ADVISORY COMMITTEE (LEATAC)

15.1(693)	Establishment of committee
15.2(693)	Membership of committee
15.3(693)	Terms of appointment
15.4(693)	Officers
15.5(693)	Bylaws
15.6(693)	Duties

CHAPTER 16
STATE BUILDING CODE—FACTORY-BUILT STRUCTURES

16.1 to 16.609	Reserved

PART 1—MODULAR FACTORY-BUILT STRUCTURES

16.610(103A)	"Modular factory-built structures"
16.611 to 16.619	Reserved

PART 2—MANUFACTURED HOUSING

16.620(103A)	Manufactured home construction
16.621(103A)	Installation of manufactured homes
16.622	Reserved
16.623(103A)	Installation seal and certificate procedures for manufactured homes
16.624 to 16.626	Reserved
16.627(103A)	Approval of existing manufactured home tie-down systems
16.628(103A)	Procedure for governmental subdivisions for installation of factory-built structures
16.629(103A)	Support and anchoring systems submission

CHAPTER 17
Reserved

CHAPTER 18
PARKING FOR PERSONS WITH DISABILITIES

18.1(321L) Scope
18.2(321L) Location
18.3(321L) Dimensions
18.4(321L) Access aisles and loading zones
18.5(321L) Designation
18.6(321L) Numbers of parking spaces for persons with disabilities required in off-street parking facilities
18.7(321L) Persons with disabilities parking at residential facilities
18.8(321L) On-street parking

CHAPTER 19
Reserved

CHAPTER 20
GOVERNOR'S TRAFFIC SAFETY BUREAU

20.1(23USC402,ExecOrd23) Authority
20.2(23USC402,ExecOrd23) Purpose
20.3(23USC402,ExecOrd23) Responsibilities
20.4(23USC402,ExecOrd23) Funding criteria
20.5(23USC402,ExecOrd23) Program requirements

CHAPTERS 21 to 24
Reserved

CHAPTER 25
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

PREAMBLE

25.1(17A,22) Definitions
25.2(17A,22) Statement of policy
25.3(17A,22) Requests for access to records
25.4(17A,22) Procedures for access to confidential records
25.5(17A,22) Requests for treatment of a record as a confidential record
25.6(17A,22) Procedure by which a subject may have additions, dissents, or objections entered into the record
25.7(17A,22) Consent to disclosure by the subject of a confidential record
25.8 Reserved
25.9(17A,22) Disclosures without the consent of the subject
25.10(17A,22) Routine use
25.11(17A,22) Records management manual
25.12(17A,22) Data processing system
25.13(22) Confidential records
25.14(252J) Release of confidential licensing information for child support recovery purposes
25.15(22,82GA,SF457) Release of official photographs of employees

CHAPTERS 26 and 27
Reserved

CHAPTER 28
MARIJUANA ERADICATION PROCEDURES

28.1(80) Reports of marijuana
28.2(80) Cultivated marijuana

28.3(80) Uncultivated marijuana
28.4(80) Scope and limitation

CHAPTERS 29 to 34
Reserved

CHAPTER 35
COMPLAINTS AGAINST EMPLOYEES
35.1(80) Definitions
35.2(80) Filing a complaint
35.3(80) Notification to complainant

CHAPTERS 36 to 40
Reserved

CHAPTER 41
PAYMENT OF SMALL CLAIMS TO EMPLOYEES
41.1(17A,80) Authorization to reimburse

CHAPTERS 42 to 50
Reserved

CHAPTER 51
FLAMMABLE AND COMBUSTIBLE LIQUIDS
51.1(101) Definitions
51.2 to 51.149 Reserved
51.150(101) Production, storage, and handling of liquefied natural gas

CHAPTER 52
Reserved

CHAPTER 53
FIRE SERVICE TRAINING BUREAU
53.1(78GA,HF2492) Fire service training bureau
53.2(78GA,HF2492) Programs, services, and fees

CHAPTERS 54 to 80
Reserved

CHAPTER 81
CRIMINAL INTELLIGENCE INFORMATION
81.1(692) Definitions
81.2(692) Iowa law enforcement intelligence network (LEIN) information system
81.3(692) Criminal intelligence file security
81.4(692) Review of criminal intelligence files—purging
81.5(692) Subpoenas and court orders

CHAPTER 82
Reserved

CHAPTER 83
IOWA SEX OFFENDER REGISTRY
83.1(692A) Sex offender registry established
83.2(692A) Definitions
83.3(692A) Forms and procedures

83.4(692A) Availability of records
83.5(692A) Expungement of records

CHAPTERS 84 to 88
Reserved

CHAPTER 89
MISSING PERSONS

89.1 to 89.99 Reserved

DIVISION I
MISSING PERSON INFORMATION CLEARINGHOUSE

89.100(694) Missing person information clearinghouse
89.101(694) Administration of missing person information clearinghouse
89.102(694) Definitions
89.103(694) Program information
89.104(694) Prevention and education programs and materials
89.105(694) Release of information
89.106(694) Dissemination
89.107(694) Training
89.108 to 89.199 Reserved

DIVISION II
AMBER ALERT PROGRAM

89.200(694) AMBER alert program
89.201(694) Criteria
89.202(694) Activation procedures
89.203(694) Alternative alert if criteria are not satisfied

CHAPTER 90
Reserved

CHAPTER 91
WEAPONS PERMITS

91.1(724) Definitions
91.2(724) Forms
91.3(724) Training programs
91.4(724) Application procedures for a permit to carry a weapon
91.5(724) Firearm purchase or transfer—permit to acquire pistols or revolvers
91.6(724) Reports and remittance to the state
91.7(724) Offensive weapons as collector's items—method of classification

CHAPTERS 92 to 94
Reserved

CHAPTER 95
DISPOSITION OF SEIZED AND FORFEITED WEAPONS AND AMMUNITION

95.1(809,809A) Definitions
95.2(809,809A) Ammunition and firearms
95.3(809,809A) Firearms inventory
95.4(809,809A) Deposit of firearms in the firearms reference file
95.5(809,809A) Disposition of firearms (interstate)
95.6(809A) Transfer of rifles and shotguns to the department of natural resources
95.7(809,809A) Disposition of firearms (intrastate)
95.8(809,809A) Final disposition and destruction of firearms

95.9(809,809A) Claims
95.10(809,809A) Disposition of explosives
95.11(809,809A) Disposition of weapons other than firearms and explosives

CHAPTERS 96 to 120
Reserved

CHAPTER 121
BAIL ENFORCEMENT, PRIVATE INVESTIGATION, AND
PRIVATE SECURITY BUSINESSES

121.1(80A) Licensing
121.2(80A) Definitions
121.3(80A) Persons exempt
121.4(80A) Licenses
121.5(80A) License requirements
121.6(80A) Identification cards
121.7(80A) License and background investigation fees
121.8(80A) Display of license
121.9(80A) Duplicate license
121.10(80A) License renewal
121.11(80A) Employee identification cards
121.12(80A) Badges, uniforms, insignia, patches and hats
121.13(80A) Advertisement, cards, letterhead and the like
121.14(80A) Misleading statements
121.15(80A) Reports
121.16(80A) Denial, cancellation, suspension, or revocation of a license or identification card
121.17(80A) Licensee's duty regarding employees
121.18(80A) Campus weapon requirements
121.19(80A) Professional permit to carry weapons
121.20(80A) Appeals
121.21(252J) Child support collection procedures
121.22(80A) Continuing education requirements
121.23(80A) Reciprocity
121.24(80A) Replacement license

CHAPTERS 122 to 140
Reserved

CHAPTER 141
CLOSED CIRCUIT SURVEILLANCE SYSTEMS

141.1(99F) Definitions
141.2(99F) Minimum standards
141.3(99F) Surveillance departments—organizational structure
141.4(99F) Closed circuit surveillance system
141.5(99F) Required equipment
141.6(99F) Required surveillance
141.7(99F) Equipment in DCI offices
141.8(99F) Camera lenses
141.9(99F) Lighting
141.10(99F) Surveillance room
141.11(99F) Nongambling hours
141.12(99F) Waivers from requirements

CHAPTERS 142 to 149
Reserved

CHAPTER 150
DIVISION OF CRIMINAL INVESTIGATION CRIMINALISTICS LABORATORY

150.1(691) Criminalistics laboratory
150.2(691) Purpose and scope of work
150.3(691) Laboratory capabilities
150.4(691) Evidence submission to the laboratory
150.5(17A,691) Distribution of reports
150.6(17A,691) Disposition of evidence

CHAPTERS 151 to 155
Reserved

CHAPTER 156
DNA DATABASE

156.1(81GA,HF619) Establishment of DNA database
156.2(81GA,HF619) Definitions
156.3(81GA,HF619) Administration of DNA database
156.4(81GA,HF619) Collection of DNA samples
156.5(81GA,HF619) Submission of DNA samples
156.6(81GA,HF619) Analysis of DNA samples
156.7(81GA,HF619) Identification of DNA samples
156.8(81GA,HF619) Storage of DNA samples
156.9(81GA,HF619) Disposition of DNA samples
156.10(81GA,HF619) Expungement of DNA samples

CHAPTER 157
DEVICES AND METHODS TO TEST BODY FLUIDS FOR ALCOHOL OR DRUGS

157.1(321J) Approval of devices and methods to test for alcohol or drug concentration
157.2(321J) Breath testing
157.3(321J) Urine collection
157.4(321J) Submission of samples for alcohol and drug testing to the criminalistics laboratory
157.5(321J) Preliminary breath screening test
157.6(123) Chemical test—alcohol concentration—public intoxication
157.7(321J) Detection of drugs other than alcohol

CHAPTERS 158 to 173
Reserved

CHAPTER 174
RETAIL SALES OF PSEUDOEPHEDRINE

174.1(81GA,SF169) Electronic logbooks
174.2(81GA,SF169) Reporting of civil penalties

CHAPTERS 175 to 200
Reserved

CHAPTER 201
GENERAL FIRE SAFETY REQUIREMENTS

201.1(100) Scope
201.2(100) General provisions
201.3(100) Electrical installations

201.4(100) Existing buildings or structures
201.5(100) Recognition of local fire ordinances and enforcement

CHAPTER 202
REQUIREMENTS FOR SPECIFIC OCCUPANCIES

202.1(100) Scope
202.2(237) Facilities in which foster care is provided by agencies to fewer than six children
202.3(137C) Bed and breakfast inns
202.4(100) Existing jails and correctional facilities

CHAPTERS 203 and 204
Reserved

CHAPTER 205
FIRE SAFETY REQUIREMENTS FOR HOSPITALS AND HEALTH CARE FACILITIES

205.1(100) Definitions
205.2 to 205.4 Reserved
205.5(100) Hospitals
205.6 to 205.9 Reserved
205.10(100) Nursing facilities and hospices
205.11 to 205.14 Reserved
205.15(100) Intermediate care facilities for the mentally retarded and intermediate care facilities for persons with mental illness
205.16 to 205.19 Reserved
205.20(100) Ambulatory health care facilities
205.21 to 205.24 Reserved
205.25(100) Religious nonmedical health care institutions
205.26 to 205.99 Reserved
205.100(135C) Residential care facilities

CHAPTERS 206 to 209
Reserved

CHAPTER 210
SMOKE DETECTORS

210.1(100) Definition
210.2(100) General requirements
210.3(100) Smoke detectors—notice and certification of installation
210.4(100) Smoke detectors—new and existing construction

CHAPTERS 211 to 220
Reserved

CHAPTER 221
FLAMMABLE AND COMBUSTIBLE LIQUIDS

221.1(101) Scope
221.2(101) Definitions
221.3(101) Flammable and combustible liquids
221.4(101) Motor fuel dispensing facilities and repair garages
221.5(101) Aircraft fueling
221.6(101) Helicopter fueling
221.7(101) Fuel-fired appliances
221.8(101) Stationary combustion engines and gas turbines

CHAPTERS 222 and 223
Reserved

CHAPTER 224
ABOVEGROUND PETROLEUM STORAGE TANKS

224.1(101) Scope
224.2(101) Definition
224.3(101) Compliance
224.4(101) Registration of existing and new tanks—fees
224.5(101) Approval of plans
224.6(101) Inspections and orders
224.7(101) Leaks, spills, or damage
224.8(101) Civil penalty
224.9(17A,101) Appeals

CHAPTER 225
Reserved

CHAPTER 226
LIQUEFIED PETROLEUM GAS

226.1(101) General requirements
226.2(101) Transfer into container
226.3(101) Prohibition of certain refrigerants
226.4(101) Qualifications of personnel
226.5(101) Pressure testing
226.6(101) Damages—reporting

CHAPTERS 227 to 230
Reserved

CHAPTER 231
MANUFACTURING, STORAGE, HANDLING, AND
USE OF EXPLOSIVE MATERIALS

231.1(101A) Explosive materials

CHAPTERS 232 to 250
Reserved

CHAPTER 251
FIRE FIGHTER TRAINING AND CERTIFICATION

251.1(100B) Definitions
251.2 to 251.100 Reserved

MINIMUM TRAINING STANDARDS

251.101(100B) Minimum training standard
251.102(100B) Other training
251.103(100B) Continuing training
251.104(100B) Record keeping
251.105 to 251.200 Reserved

FIRE FIGHTER CERTIFICATION

251.201(100B) Fire fighter certification program
251.202(100B) Certification standards
251.203(100B) Fees
251.204(100B) Certification, denial, and revocation of certification

CHAPTERS 252 to 258
Reserved

CHAPTER 259
FIRE FIGHTER TRAINING AND EQUIPMENT FUNDS

259.1 to 259.100 Reserved

DIVISION I
VOLUNTEER FIRE FIGHTER TRAINING AND EQUIPMENT FUND

259.101(17A,77GA,ch1222) Establishment of fund
259.102(17A,77GA,ch1222) Allocations
259.103(17A,77GA,ch1222) Awards to private providers of training
259.104(100B) Paul Ryan memorial fire fighter safety training fund
259.105(80GA,ch1175) Volunteer fire fighter preparedness fund
259.106 to 259.200 Reserved

DIVISION II
FIRE FIGHTING EQUIPMENT REVOLVING LOAN FUND

259.201(80GA,ch177) Fire fighting equipment revolving loan fund
259.202(80GA,ch177) Purpose and scope
259.203(80GA,ch177) Definitions
259.204(80GA,ch177) Application process
259.205(80GA,ch177) Allowable acquisitions
259.206(80GA,ch177) Eligibility requirements and restrictions
259.207(80GA,ch177) Loan origination fee and repayment schedule
259.208 to 259.300 Reserved

DIVISION III
REGIONAL TRAINING FACILITY FUNDS

259.301(100B) Regional training center program
259.302(100B) Definitions
259.303(100B) Availability of funds
259.304(100B) Application process
259.305(100B) Processing of submitted applications

CHAPTERS 260 to 274
Reserved

CHAPTER 275
CERTIFICATION OF AUTOMATIC FIRE EXTINGUISHING SYSTEM CONTRACTORS

275.1(100C) Establishment of program
275.2(100C) Definitions
275.3(100C) Responsible managing employee
275.4(100C) Certification requirements
275.5(100C) Application and fees
275.6(100C) Complaints
275.7(100C) Denial, suspension, or revocation of certification; civil penalties; and appeals

CHAPTERS 276 to 290
Reserved

CHAPTER 291
VOLUNTEER EMERGENCY SERVICES PROVIDER DEATH BENEFITS

291.1(100B) Volunteer emergency services provider death benefit program
291.2(100B) Eligibility
291.3(100B) Determination

CHAPTERS 292 to 299
Reserved

CHAPTER 300
STATE BUILDING CODE—ADMINISTRATION

300.1(103A) State building code promulgated
300.2(103A) Building code commissioner
300.3(103A) Building code advisory council
300.4(103A) Plan reviews
300.5(103A) Inspections
300.6(103A) Local code enforcement

CHAPTER 301
STATE BUILDING CODE—GENERAL PROVISIONS

301.1(103A) Scope and applicability
301.2(103A) Definitions
301.3(103A) General provisions
301.4(103A) Mechanical requirements
301.5(103A) Electrical requirements
301.6(103A) Plumbing requirements
301.7(103A) Existing buildings
301.8(103A) Residential construction requirements

CHAPTER 302
STATE BUILDING CODE—ACCESSIBILITY OF BUILDINGS AND FACILITIES AVAILABLE TO THE PUBLIC

302.1(103A,104A) Purpose and scope
302.2(103A,104A) Definitions
302.3(103A,104A) Plan review procedures
302.4(103A,104A) Site development
302.5(103A,104A) Building elements and spaces accessible to the physically handicapped
302.6(103A,104A) Restaurants and cafeterias
302.7(103A,104A) Medical care facilities
302.8(103A,104A) Business and mercantile facilities
302.9(103A,104A) Libraries
302.10(103A,104A) Transient lodging facilities
302.11(103A,104A) Transportation facilities
302.12 to 302.19 Reserved
302.20(103A,104A) Making apartments accessible and functional for persons with disabilities

CHAPTER 303
STATE BUILDING CODE—REQUIREMENTS FOR ENERGY CONSERVATION IN CONSTRUCTION

303.1(103A) Scope and applicability of energy conservation requirements
303.2(103A) Residential energy code
303.3(103A) Adoption of nonresidential energy code
303.4(470) Life cycle cost analysis
303.5(103A) Energy review fee

CHAPTERS 304 to 321
Reserved

CHAPTER 322
STATE BUILDING CODE —
MANUFACTURED HOUSING SUPPORT AND ANCHORAGE SYSTEMS

322.1	Reserved
322.2(103A)	Definitions
322.3 to 322.10	Reserved
322.11(103A)	Support and anchorage of manufactured homes
322.12(103A)	Suspension of installation requirements in proclaimed disaster emergencies
322.13 to 322.19	Reserved
322.20(103A)	Fees

CHAPTER 323
TEMPORARY EMERGENCY USE OF FACTORY-BUILT STRUCTURES—COMMERCIAL USE

323.1(103A)	Temporary factory-built structures for commercial use

CHAPTERS 324 to 349
Reserved

CHAPTER 350
STATE HISTORIC BUILDING CODE

350.1(103A)	Scope and definition

CHAPTERS 351 to 371
Reserved

CHAPTER 372
MANUFACTURED OR MOBILE HOME RETAILERS,
MANUFACTURERS, AND DISTRIBUTORS

372.1(103A)	Definitions
372.2(103A)	Criteria for obtaining a manufactured or mobile home retailer's license
372.3(103A)	Operation under distinct name
372.4(103A)	Supplemental statements
372.5(103A)	Denial, suspension, or revocation—civil penalties
372.6(103A,321)	Sale or transfer of manufactured or mobile homes
372.7(103A)	Right of inspection
372.8(103A)	Criteria for obtaining a manufactured or mobile home manufacturer's or distributor's license
372.9(17A,103A)	Waivers

CHAPTER 373
Reserved

CHAPTER 374
MANUFACTURED HOUSING INSTALLER CERTIFICATION

374.1(103A)	Certification program
374.2(103A)	Certified installer required
374.3(103A)	Requirements for installer certification
374.4(103A)	Certification fee
374.5(103A)	Certification period
374.6(103A)	Review of application for certification
374.7(103A)	Certification renewal and continuing education
374.8(103A)	Suspension or revocation of certification
374.9(103A)	Civil penalties

374.10(103A) Inspections
374.11(103A) Temporary certification during proclaimed disaster emergencies

CHAPTERS 375 to 399
Reserved

CHAPTER 400
PEACE OFFICERS' RETIREMENT, ACCIDENT, AND
DISABILITY SYSTEM—GOVERNANCE AND ADMINISTRATION

400.1(97A) Establishment of system
400.2(97A) Definitions
400.3(97A) Governance
400.4(97A) Meetings of board of trustees
400.5(97A) Administrative support
400.6(97A) Forms and information
400.7(97A) Annual statements
400.8(97A) Books of account
400.9(97A) Investments
400.10(97A) Medical board

CHAPTER 401
PEACE OFFICERS' RETIREMENT, ACCIDENT, AND
DISABILITY SYSTEM—ADMINISTRATIVE PROCEDURES

401.1(97A) Applications
401.2(97A) Determination on initial review
401.3 to 401.100 Reserved

PROCEDURE FOR RULE MAKING

401.101(17A) Applicability
401.102(17A) Advice on possible rules before notice of proposed rule adoption
401.103(17A) Public rule-making docket
401.104(17A) Notice of proposed rule making
401.105(17A) Public participation
401.106(17A) Regulatory analysis
401.107(17A,25B) Fiscal impact statement
401.108(17A) Time and manner of rule adoption
401.109(17A) Variance between adopted rule and published notice of proposed rule adoption
401.110(17A) Concise statement of reasons
401.111(17A,97A) Agency rule-making record
401.112(17A,97A) Petitions for rule making
401.113(17A,97A) Waivers of rules
401.114 to 401.200 Reserved

DECLARATORY ORDERS

401.201(17A) Petition for declaratory order
401.202(17A) Notice of petition
401.203(17A) Intervention
401.204(17A) Briefs
401.205(17A) Inquiries
401.206(17A) Service and filing of petitions and other papers
401.207(17A) Consideration
401.208(17A) Action on petition
401.209(17A) Refusal to issue order
401.210(17A) Contents of declaratory order—effective date

401.211(17A) Copies of orders
401.212(17A) Effect of a declaratory order
401.213 to 401.300 Reserved

CONTESTED CASES

401.301(17A) Contested case proceeding
401.302(17A) Discovery
401.303(17A) Subpoenas in a contested case
401.304(17A) Motions
401.305(17A) Settlements
401.306(17A) Prehearing conference
401.307(17A) Continuances
401.308(17A) Withdrawals
401.309(17A) Hearing procedures
401.310(17A) Evidence
401.311(17A) Ex parte communication
401.312(17A) Decisions
401.313(17A) No factual dispute contested cases
401.314(17A) Applications for rehearing

CHAPTER 402
PEACE OFFICERS' RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM—
ELIGIBILITY, BENEFITS, AND PAYMENTS

402.1 to 402.99 Reserved

DIVISION I
ELIGIBILITY

402.100(97A) Age of qualification
402.101(97A) Date of retirement
402.102(97A) Application of Iowa Code Supplement section 97A.6, subsection 12
402.103(97A) Date of death
402.104(97A) Age of spouse
402.105 to 402.199 Reserved

DIVISION II
BENEFITS AND PAYMENTS

402.200(97A) Computation of average final compensation
402.201(97A) Workers' compensation—effect on benefit payment
402.202(97A) Errors in payments
402.203(97A) Initial benefit for a child
402.204(97A) Computation for partial month
402.205(97A) One year of service
402.206(97A) Termination prior to retirement
402.207(97A) Optional retirement benefits
402.208(97A) Options not reversible once payments begin—exceptions
402.209(97A) Method of calculating annual adjustments when optional retirement benefits are selected
402.210(97A) Termination of benefits when optional retirement benefits are selected
402.211(97A) Impact of optional benefit selections on child benefits
402.212 to 402.299 Reserved

DIVISION III
SERVICE PURCHASES

402.300(97A) Purchase of eligible service credit
402.301(97A) Determination of eligible service

402.302(97A) Determination of cost to member
402.303(97A) Application process
402.304(97A) Service adjustment irrevocable
402.305(97A) Board review
402.306(97A) Other provisions

CHAPTER 403
PEACE OFFICERS' RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM—
LINE-OF-DUTY DEATH BENEFIT

403.1(97A) Member death benefit program
403.2(97A) Application
403.3(97A) Determination

CHAPTER 404
PEACE OFFICERS' RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM—
TEMPORARY INCAPACITY

404.1(97A) Temporary incapacity defined
404.2(97A) Application for temporary incapacity status
404.3(97A) Processing applications for temporary incapacity status
404.4(97A) Actions by the board
404.5(97A) Sick leave
404.6(97A) Recurrences
404.7(97A) Review
404.8(97A) Discontinuance of temporary incapacity status
404.9(97A) Appeals

CHAPTERS 405 to 499
Reserved

CHAPTER 500
ELECTRICIAN AND ELECTRICAL CONTRACTOR LICENSING PROGRAM—
ORGANIZATION AND ADMINISTRATION

500.1(82GA,ch197) Establishment of program
500.2(82GA,ch197) Definitions

CHAPTER 501
ELECTRICIAN AND ELECTRICAL CONTRACTOR LICENSING PROGRAM—
ADMINISTRATIVE PROCEDURES

501.1(82GA,ch197) Board meetings and agenda
501.2 to 501.4 Reserved
501.5(17A) Waivers

CHAPTER 502
ELECTRICIAN AND ELECTRICAL CONTRACTOR LICENSING PROGRAM—LICENSING
REQUIREMENTS, PROCEDURES, AND FEES

502.1(82GA,ch197) License categories and licenses required
502.2(82GA,ch197) License requirements
502.3(82GA,ch197) License terms and fees
502.4(82GA,ch197) Disqualifications for licensure
502.5(82GA,ch197) License application
502.6(82GA,ch197) Restriction of use of class B licenses by political subdivisions
502.7(82GA,ch197) Financial responsibility

CHAPTER 503
ELECTRICIAN AND ELECTRICAL CONTRACTOR LICENSING PROGRAM—
COMPLAINTS AND DISCIPLINE

503.1(82GA,ch197) Complaints
503.2(82GA,ch197) Discipline
503.3(82GA,ch197) Action against an unlicensed person
503.4(82GA,ch197) Appeals
503.5(252J,82GA,ch197) Suspension or revocation for nonpayment of child support

CHAPTER 504
STANDARDS FOR ELECTRICAL WORK

504.1(82GA,ch197) Installation requirements

CHAPTER 6
VEHICLE IMPOUNDMENT

[Ch 6 as appeared before 6/27/79 rescinded]
[Prior to 4/20/88, see Public Safety Department[680] Ch 6]

661—6.1(17A,321) Vehicle impoundment. The patrol division and other peace officer members of the department may impound any vehicle determined to be "abandoned" as defined in Iowa Code section 321.89(1)*"b,"* provided that:

1. The officer shall first attempt to determine the owner through department of transportation records and request communications division advise an owner found thereby that the vehicle must be moved within a reasonable time or it will be impounded, and

2. Either the owner cannot be found or the owner fails to remove the vehicle within a reasonable time.

661—6.2(17A,321) Vehicles which may be impounded immediately.

6.2(1) Vehicles which an officer has reason to believe are wrongfully possessed by the person then having control of such vehicles or on which the vehicle identification number or the identification numbers of any component part have been altered or defaced, or on which an attempt to alter or deface has been made.

6.2(2) Vehicles which are involved in an accident when immediate impoundment is necessary:

a. To preserve evidence which will be used in an administrative or judicial proceeding; or

b. To protect the vehicle from theft or further damage when the legal custodian is unavailable or incapable to give consent to such impoundment; or

c. To prevent further accidents when the vehicle is so situated as to appear to constitute a hazard to traffic.

6.2(3) Vehicles which an officer has reason to believe are being used to transport contraband.

6.2(4) Vehicles involved in a person's death when the medical examiner or a peace officer determines:

a. That seizure is necessary to secure evidence needed in the investigation of the cause and manner of death.

b. That circumstances indicate the vehicle may be removed or tampered with before written authorization for its impoundment can be obtained.

c. That the vehicle is situated on a public highway in such a manner that it may constitute a hazard to traffic.

6.2(5) Vehicles under the control of a person at the time of arrest:

a. If the arrested person's vehicle reasonably appears to a peace officer to constitute a traffic hazard if it remains where it is situated at the time of arrest and the arrested person is unwilling or unable to have it moved; or

b. To preserve evidence which will be used in an administrative or judicial proceeding; or

c. To protect the vehicle from theft or further damage when the legal custodian is unavailable or incapable to give consent to such impoundment.

6.2(6) Vehicles positioned upon a public highway in such a location as to indicate that they constitute a hazard to traffic.

661—6.3(17A,321) Vehicles which need not be impounded immediately.

6.3(1) If a vehicle is unattended, an officer shall tag it. A record is kept by the officer at the district to which the officer is assigned. After the period of time prescribed in Iowa Code section 321.89, the unattended vehicle shall be declared an abandoned vehicle.

6.3(2) If the vehicle is thought to be abandoned, the officer shall attempt to determine the owner through department of transportation records, and request that the communications division advise the owner that the vehicle must be moved within a reasonable time or it will be impounded. If the owner cannot be contacted, or if the owner does not remove the vehicle, the vehicle may be impounded.

661—6.4(17A,321) Impoundment procedure.

6.4(1) Prior to towing an impounded vehicle, the officer shall:

a. Request that a tow truck be dispatched to remove the vehicle.

b. Complete a vehicle tow-in and recovery report which includes the following information:

(1) Reason for towing;

(2) The license number and description of the vehicle including its condition at the time of impoundment;

(3) Vehicle identification number and registration information, when readily accessible.

c. Instruct the towing service to tow the vehicle to a designated location, which in the case of an abandoned vehicle shall be the towing service's storage area.

6.4(2) Within 24 hours of towing an impounded vehicle, the officer shall:

a. Complete an inventory of all property in the vehicle and a notation of any parts of the vehicle which appear to be missing or damaged. The inventory shall include a list of the contents of each container in the vehicle. Each container shall be opened unless the contents of a particular container are evident from its exterior. If keys, a locksmith, or other means of access are not reasonably available to the officer, the officer is authorized to break locks to gain access to the vehicle and its locked compartments. The inventory is a record which is intended for use in ensuring the safe return of the lawful possessor's property and resolving questions regarding the condition or contents of the vehicle.

b. Add to the vehicle tow-in and recovery report information indicating the circumstances of recovery of the vehicle and notification of the owner if the vehicle is believed to be stolen or operated without the consent of the owner.

EXCEPTION: The inventory and completion of the report may be delayed beyond 24 hours after towing of the impounded vehicle has occurred if completion within a 24-hour period is rendered impracticable by road or weather conditions or by the volume of impounded vehicles requiring processing during a limited period of time. Such an extension of time shall be granted automatically if the office processing the vehicles is affected by a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6 and may otherwise be granted by written permission of the commander of the district or zone office or another supervisor designated by the commander of the officer responsible for processing an impounded vehicle. The reason for any delay in completing the inventory and report beyond 24 hours after towing a vehicle shall be noted in the report. In any event, the inventory and report shall be completed as soon as practicable after towing the vehicle.

This rule is intended to implement Iowa Code sections 80.9(2)*"a"* and 321.89.

661—6.5(17A,321) Abandoned vehicles. If the vehicle is impounded pursuant to rule 661—6.1(17A,321):

6.5(1) The district officer in charge of abandoned vehicles shall notify, within 20 days of impoundment, by certified mail, the last known registered owner of the vehicle and all lienholders of record, addressed to their last known address of record, that the abandoned vehicle has been impounded. Such notice shall state:

a. The location of the vehicle.

b. That the person or persons notified have the right to reclaim the vehicle within 21 days of notice upon payment of all towing, preservation and storage charges resulting from impoundment.

c. That failure to reclaim the vehicle within 21 days will constitute a waiver of all right, title, claim and interest in the vehicle and will also constitute the giving of consent to sale or disposal of the vehicle.

d. That a written objection to the impoundment may be filed in accordance with subrule 6.5(3).

6.5(2) When the district officer in charge of abandoned vehicles is unable to determine the identity or address of the last known registered owner or of any lienholders of record, the officer shall cause to be published once in a newspaper of general circulation in the area where the abandoned vehicle was found, a notice containing all the information otherwise required by subrule 6.5(1).

6.5(3) Registered owners or lienholders of record may, within the 21-day reclamation period, submit a written objection to the initial impoundment or to any procedure followed by the patrol officer or towing

agent. Such objection shall contain an explanation of why the objector believes the impoundment was not authorized by law. When an objection is received by the district officer in charge of abandoned vehicles, such officer shall:

a. Immediately consider the objection and make an initial decision as to the legality of the impoundment,

b. Immediately thereafter notify the objector of the decision. Such notice shall state either:

(1) That the impoundment was authorized by law, and explain the basis of such decision, or

(2) That the impoundment was not authorized by law, that the vehicle will be released to the objector upon presentation of proof of ownership at district headquarters, and that no towing or storage fees will be assessed for 21 days, and

c. File a copy of the notice required by subrule 6.5(3), paragraph *"b,"* with other documents kept in connection with the impoundment.

6.5(4) The registered owner and any lienholders of record have 21 days in which to reclaim the vehicle after mailing or date of publication of notice as prescribed in subrules 6.5(1) and 6.5(2), except where written objection to impoundment has been made in accordance with subrule 6.5(3), in which case the 21-day period shall begin when notice of the district officer's response to the objection is mailed. An additional 14 days will be allowed if the owner or any lienholder submits a written request for an extension of the 21-day reclamation period.

6.5(5) If the reclamation period has expired, and either the registered owner or any lienholder of record has made no written objection to the impoundment, or an objection has been filed and the district officer has determined that the impoundment was authorized by law, then all rights of the owner or of any lienholders of record with regard to the impounded vehicle are forfeited and the vehicle will be either:

a. Sold for use upon the highway after an inspection and certification that it is safe for such use in accordance with Iowa Code section 321.238; or

b. Sold for junk, demolished, and sold as scrap, or

c. Sold as provided in Iowa Code section 321.88 with a restricted certificate of title and not for use on the highways.

6.5(6) When the vehicle is sold:

a. The circumstances of the sale shall be entered in appropriate records kept by the district officer in charge of abandoned vehicles.

b. The required department of transportation forms shall be completed by the officer, given to the purchaser, and mailed to the abandoned vehicle section of the motor vehicle division of the department of transportation. The motor vehicle division shall then take action regarding the funds collected or expended.

6.5(7) If the registered owner or any lienholders of record have filed written objection to the impoundment in accordance with subrule 6.5(3) and the district officer has determined that the impoundment was not authorized by law, towing and storage fees will not be assessed unless the objector, after receipt of notice of such determination, fails to reclaim the vehicle within the reclamation period provided in subrule 6.5(4). If the vehicle is not reclaimed during the reclamation period, said fees shall be deemed "abandoned," and subject to forfeiture and sale if not claimed within 60 days of receipt of notice from the district officer pursuant to subrule 5.4(3).

661—6.6(321) Scope. Nothing in this chapter shall be construed to limit an officer's authority to seize or search an individual, vehicle, or location upon probable cause or as otherwise justified by law.

These rules are intended to implement Iowa Code sections 80.9(2)*"a"* and 321.89 and *Florida v. Wells,* 110 Sup. Ct. 1632.

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CHAPTER 11
IDENTIFICATION SECTION OF THE DIVISION OF CRIMINAL INVESTIGATION

[Rules 11.1 to 11.7 appeared as 4.3 prior to 6/27/79]
[Prior to 4/20/88, see Public Safety Department[680] Ch 11]

661—11.1(17A,690,692) Identification section. The identification section maintains information necessary to identify persons with criminal histories. It collects, files and disseminates criminal history data to authorized criminal justice agencies and the public upon request and updates criminal history records as a continual process.

661—11.2(17A,690,692) Definitions.

"Authorized agency" means a division or office of the state of Iowa designated by a state to report, receive, or disseminate information under Iowa state law, administrative rule or Public Law 103-209.

"Criminal identification records" shall mean either of the following records, the forms for which are provided by the department to law enforcement agencies:

1. Department of public safety arrest fingerprint cards.
2. State of Iowa final disposition reports.

"Dependent adult abuse registry" means the official registry kept by the department of human services, established pursuant to Iowa Code chapter 235B.

"Employee" means a person who provides services to a qualified entity and is compensated for those services.

"Fee" means any cost associated with conducting a state or national criminal history record check.

"Felony" and *"misdemeanor"* shall have the same meaning and classifications as described in Iowa Code sections 701.7 and 701.8.

"Fitness determination" means an analysis of criminal history information to determine whether or not it disqualifies an individual from holding a particular position either as an employee or a volunteer.

"National record check" means a criminal history record check from the FBI that is fingerprint-based and is transmitted through the state central repository.

"Nonlaw enforcement agency" means an agency authorized by law to receive criminal history data from the department which is not a "criminal justice agency" as defined in Iowa Code section 692.1, subsection 10, or which is not an institution which trains law enforcement officers for certification under Iowa Code chapter 80B.

"Qualified entity" means a business or organization, whether public, private, for-profit, not-for-profit, or voluntary, that provides child care or child care placement services, including a business or organization that licenses or certifies others to provide child care or child care placement services. This definition also applies to organizations which provide care to the elderly or the disabled.

The *"taking of fingerprints"* shall mean the obtaining of a fully rolled set of inked fingerprint impressions having suitable quality for fingerprint classification and identification.

"Volunteer" means a person who provides services to a qualified entity without compensation.

This rule implements Iowa Code chapters 690 and 692.

"Working day" means any day except any of the following:

1. Saturday.
2. Sunday.
3. State holiday.
4. Federal holiday during which the administrative office of the submitting agency is closed.
5. Any day during which the administrative office of the agency is closed or relocated due to weather or road conditions or any condition related to a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6.

661—11.3(690,692) Release of information. Records maintained by the identification section are public records and are released to criminal justice agencies and the public as authorized by statute. Only the department of public safety may release criminal history information maintained by the department to non-criminal justice agencies or persons.

661—11.4(690,692) Right of review. Any person who has a criminal history record on file with the division of criminal investigation has the right to review and obtain a copy of the record. This right may be exercised by an attorney acting on behalf of the person with the criminal history record with written authorization and fingerprint identification of the person with the criminal history record. A copy of a criminal history record provided pursuant to this rule is subject to the fee provided in rule 661—11.15(692).

661—11.5(690,692) Review of record. Any individual or that individual's attorney, acting with written authorization from the individual, may review or obtain a copy of the individual's criminal history record during normal business hours at the headquarters of the division in the Wallace State Office Building in Des Moines or by submitting a request on a form provided by the department of public safety. A copy of this request form may be obtained by writing to Identification Section, Division of Criminal Investigation, Department of Public Safety, Wallace State Office Building, Des Moines, Iowa 50319, by telephoning the identification section at (515)281-8706 or by sending a request by electronic mail to cchinfo@dps.state.ia.us. The request form may also be downloaded from the division's Web site at http://www.state.ia.us/government/dps/dci/. The completed request form must be notarized, if submitted by mail, and accompanied by a set of the fingerprints of the individual whose criminal history record is being requested, along with submission of the fee established in rule 661—11.15(692). After the record check has been completed, the fingerprints submitted for verification shall be returned, upon request, or destroyed.

661—11.6(17A,690,692) Inaccuracies in criminal history. If an individual believes inaccuracies exist in the individual's criminal history, notice may be filed with the division outlining the alleged inaccuracies accompanied by any available supporting data. In all instances where a notice is so filed, the division contacts the arresting agencies, court of record and institutions to verify record accuracy. Any necessary changes shall be made to the individual's record. Any agency previously receiving a copy of the inaccurate record shall be so notified with a corrected copy. A final report shall be made to the individual who has so filed a notice of correction within 20 days of said filing. If, after notice is filed and the division makes its final report, the individual is still of the opinion that inaccuracies exist within the records, an appeal of the final decision of the division to the Polk county district court may be made.

661—11.7(17A,690,692) Fingerprint files and crime reports. This section also maintains all fingerprint files and has personnel for the entry of crime reports to the criminal system.

661—11.8(690) Taking of fingerprints. The taking of fingerprints shall be in compliance with Iowa Code sections 232.148(2), 690.2 and 690.4. Fingerprints taken pursuant to these sections shall be submitted to the identification section of the division of criminal investigation, within two working days and to the Federal Bureau of Investigation.

661—11.9(17A,690,692) Arresting agency portion of final disposition form. The sheriff of each county and the chief of police of each city shall complete the arresting agency portion of the final disposition form with the arrest information on all persons whose fingerprints are taken in accordance with the rules or Iowa Code section 690.2, and thereafter forward the form to the appropriate county attorney or to the juvenile court officer who received the referral if the case remains in juvenile court.

661—11.10(690,692) Final disposition form. The county attorney of each county or juvenile court officer who received the referral shall complete a final disposition report and submit it to the division of criminal investigation within 30 days when a preliminary information or citation is dismissed without new charges being filed, or when a case is ignored by a grand jury. When an indictment is returned or a county attorney's information filed, the final disposition form shall be forwarded by the county attorney to the clerk of the court having jurisdiction. The clerk of court shall forward a copy to the division of criminal investigation within 30 days after judgment. If a juvenile is processed through juvenile court, the juvenile court officer shall forward the disposition form to the division of criminal investigation.

661—11.11(692) Destruction of fingerprints. Rescinded IAB 11/22/95, effective 1/1/96.

661—11.12(692) Release of information to the public. The department may release criminal history information to any person, or public or private agency, upon written application. Non-criminal justice agencies may not receive information regarding arrests older than 18 months that do not have dispositions or deferred judgments where the department has received official notice of successful completion of probation, unless a waiver has been given to the requestor from the person who is the subject of the criminal history information and is presented to the department at the time the request for the information is made.

Each record released to a non-criminal justice agency shall prominently display the statement: "AN ARREST WITHOUT DISPOSITION IS NOT AN INDICATION OF GUILT."

661—11.13(692) Redissemination of criminal history information by youth service agencies. Rescinded IAB 7/3/96, effective 7/1/96.

661—11.14(692) Scope of record checks for non-criminal justice agencies and individuals. Record checks made for non-criminal justice agencies and individuals pursuant to these rules will be based upon name, including maiden name and aliases, if any, and birth date. This information is not sufficient to effect a precise identification of a subject. Persons may have the same name and birth date. Persons may use several names. The records of the department are based upon reports from other agencies. The department, therefore, cannot warrant the completeness or accuracy of the information provided. Agencies and individuals receiving criminal history information are therefore advised to verify all information received from the department to the extent possible (e.g., by contacting the reported arresting agency or court).

661—11.15(692) Fees. All individuals, their attorneys, and other non-criminal justice agencies applying for receipt of criminal history information may be assessed a fee. The department may accept cash, money orders, or checks. Other arrangements may be made, such as a prepaid retainer or credit card. The fee for receipt of criminal history information from the department shall be not more than $13 for each surname for which information is requested and not more than $15 per surname for fax service. The fee shall be prominently posted at the headquarters of the division of criminal investigation. Each alias or maiden name submitted shall be considered a separate name for purposes of computing this fee. Employers must pay the cost of the criminal history fee of a potential employee.

661—11.16(692) Subpoenas and civil process. Rescinded IAB 7/3/96, effective 7/1/96.

661—11.17(17A,22,692) Requests for criminal history data.

11.17(1) *Requests for criminal history data.* Persons or agencies requesting criminal history data should direct requests in writing using forms or methods approved by the commissioner of public safety. Requests for forms to use in requesting criminal history information may be addressed by mail to the Identification Section, Division of Criminal Investigation, Iowa Department of Public Safety, Wallace State Office Building, Des Moines, Iowa 50319, or by electronic mail via the Internet to cchinfo@dps.state.ia.us.

The commissioner may authorize other methods of requesting criminal history information besides mail. These other methods may include fax transmission, electronic mail, or computer access. This authorization by the commissioner of public safety shall be based on the ability to efficiently and accurately receive and disseminate criminal history information.

11.17(2) *Public complaints.* Public complaints concerning the operation of criminal history or intelligence data systems should be directed in writing to the commissioner of public safety. Complaints should be specific in spelling out the time, date and place of the alleged violation and any action requested of the commissioner.

11.17(3) *Approval of agreements.* All agreements, arrangements and systems for the transmission and exchange of criminal history data required to be approved by the commissioner shall be submitted in writing at least 30 days before their proposed effective date.

This rule is intended to implement Iowa Code section 692.19.

661—11.18(690) Administrative sanctions. The commissioner of public safety shall deny or restrict access to criminal history records maintained by the identification section of the division of criminal investigation to any agency which fails to comply with the requirements of Iowa Code chapters 690 and 692 for submission of fingerprints and disposition reports to the department of public safety. The commissioner shall notify the affected agency in writing prior to denying or restricting access, giving details of the requirements and the nature of the failure to comply.

Any agency which has received notification from the commissioner that their access to criminal history records is to be denied or restricted may protest this action. Protests must be filed with the administrative services division within 30 days of the date of the notification from the commissioner in accordance with rule 661—10.101(17A).

This rule is intended to implement Iowa Code section 690.5.

661—11.19(232) Juvenile fingerprints and criminal histories.

11.19(1) *Authority to fingerprint.* A law enforcement agency may fingerprint and photograph any juvenile who has been taken into custody and charged with the commission of an offense which would be a serious misdemeanor or above if committed by an adult. Fingerprints of juveniles taken pursuant to this subrule shall be submitted to the division of criminal investigation.

11.19(2) *Fingerprints of juveniles waived to adult court.* If jurisdiction over a juvenile suspect has been transferred from juvenile court to adult court, then fingerprints of that suspect taken pursuant to Iowa Code section 232.148 and transmitted to the division of criminal investigation shall be handled by the division in the same manner as fingerprints of adult suspects are handled and are subject to the same provisions of law and these rules which govern fingerprints of adult criminal suspects.

11.19(3) *Fingerprints entered into Automated Fingerprint Identification System (AFIS).* Fingerprints of juveniles shall be entered into the AFIS maintained by the department of public safety.

11.19(4) *Juvenile criminal histories.*

a. A fingerprint card received for a juvenile suspect shall be used to establish a criminal history record for the suspect.

b. Criminal histories of juveniles over whom jurisdiction has been transferred from juvenile court to adult court shall be handled in the same manner as criminal histories of adults.

c. Criminal histories of juveniles who remain under the jurisdiction of the juvenile court shall be maintained only if the juvenile is adjudicated delinquent based upon an offense which would be a serious or aggravated misdemeanor or felony if committed by an adult. The criminal history record established in response to receiving a fingerprint card shall be expunged if the delinquency petition is dismissed. Juvenile court judges shall order that juveniles be fingerprinted and the prints submitted to the division of criminal investigation if the juvenile has been adjudicated delinquent for an offense of serious misdemeanor or above if committed by an adult.

d. Criminal history records of juveniles over whom jurisdiction has not been transferred from juvenile to adult court shall be expunged when the subject reaches the age of 21 unless the subject has been convicted of a serious or aggravated misdemeanor or a felony between the ages of 18 and 21. If the subject has been convicted of a serious or aggravated misdemeanor or a felony between the ages of 18 and 21, the criminal history record shall be maintained in the same manner as adult criminal history records.

11.19(5) *Tracking criminal history records.* The division of criminal investigation shall establish an internal procedure for tracking criminal history records expunged from the files of the division for audit purposes only.

This rule is intended to implement Iowa Code section 232.148 as amended by 1999 Iowa Acts, House File 403.

661—11.20(135C) Release of dependent adult abuse records. Effective July 1, 1997, the department of public safety, division of criminal investigation, may release to health care facilities licensed under Iowa Code chapter 135C dependent adult abuse registry information received from the department of human services. The department of public safety and the department of human services shall enter into a 28E agreement to carry out this rule.

661—11.21(692) Criminal history checks for qualified entities.

11.21(1) The department of public safety may process requests for national criminal history record checks for a qualified entity.

11.21(2) All qualified entities requesting criminal history record checks shall be required to pay any applicable state and federal fees associated with non-criminal justice record checks. The qualified entity is responsible for such fees whether the qualified entity requests or receives the information directly or through an agency authorized to make fitness determinations as provided in subrule 11.21(3).

11.21(3) Any public entity which has been duly authorized by statute or administrative rule to conduct fitness determinations of volunteers or employees of a qualified entity may receive state and national criminal history checks in order to do so.

11.21(4) A school district considering an applicant for a teaching position is a qualified entity pursuant to 2007 Iowa Acts, Senate File 601, section 102. A school district may submit a request for a national criminal history check of an applicant for employment as a teacher. The request shall be submitted on a form designated by the division of criminal investigation and shall be accompanied by completed fingerprint cards for the applicant and the applicable fee. The district may contact the division of criminal investigation by telephone at (515)725-6066 or by electronic mail at cchinfo@dps.state.ia.us, prior to submitting the request, to obtain instructions on the submission or may consult the Web site of the division for this information.

These rules are intended to implement Iowa Code chapter 692.

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CHAPTER 121
BAIL ENFORCEMENT, PRIVATE INVESTIGATION, AND PRIVATE SECURITY BUSINESSES

[Prior to 4/20/88, see Public Safety Department [680] Ch 2]
[Prior to 11/23/05, see 661—Ch 2]

661—121.1(80A) Licensing. The administrative services division shall administer the bail enforcement, private investigation and private security statute. Any questions, comments, information, requests for information, or application for a license or an identification card should be directed to the Department of Public Safety, Program Services Bureau, Wallace State Office Building, Third Floor, Des Moines, Iowa 50319-0045, or, with the exception of applications, by electronic mail via the Internet to piinfo@dps.state.ia.us.

661—121.2(80A) Definitions. As used in this chapter unless the context otherwise requires:

"Aggravated misdemeanor" means an offense so defined in the Iowa Code or an offense committed in another jurisdiction with a penalty of imprisonment for two years or more.

"Applicant" means any person applying to the commissioner for a license or a permanent identification card.

"Background investigation" means the actions taken by the department to verify that the applicant for a license or employee identification card meets the requirements. Such actions include, but are not limited to, inquiries to the Iowa on-line warrants and articles (IOWA) criminal justice information system for outstanding arrest warrants, active protection orders, sex offender registry records and Iowa criminal history records. A background investigation shall also include the submission of fingerprints of the applicant to the FBI for a nationwide criminal history record check.

"Bail enforcement agent" means a person engaged in the bail enforcement business, including licensees and persons engaged in the bail enforcement business whose principal place of business is in a state other than Iowa.

"Bail enforcement business" means the business of taking or attempting to take into custody the principal on a bail bond issued or a deposit filed in relation to a criminal proceeding to ensure the presence of the defendant at trial, but does not include such actions that are undertaken by a peace officer or law enforcement officer in the course of the officer's official duties.

"Chief law enforcement officer" means the county sheriff, or the sheriff's designee, in the county where the defendant is located, or the chief of police, or the chief's designee, when the defendant is located within the city limits of a city or town which has a police force.

"Commissioner" means the commissioner of the department of public safety or the commissioner's authorized designee.

"Conviction resulting from domestic abuse" means a conviction at any level in any jurisdiction if the conviction has, as an element, the use or attempted use of physical force, or the threatened use of a deadly weapon, committed by a current or former spouse, parent or guardian of the victim, by a person with whom the victim shares a child in common, by a person who is cohabiting with or has cohabited with the victim as a spouse, parent or guardian, or by a person similarly situated to a spouse, parent, or guardian of the victim. Applicable convictions may include, but are not limited to, crimes of assault, domestic assault, domestic abuse assault, battery, disorderly conduct and other crimes meeting this definition.

"Defendant" means the principal on a bail bond issued or deposit filed in relation to a criminal proceeding in order to ensure the presence of the defendant at trial.

"Department" means the department of public safety.

"Duplicate license" means a license that is issued to substitute for a license that has been lost or destroyed, except that a "duplicate license" shall not mean a "replacement license" as defined herein.

"Felony" means an offense defined as a felony by the jurisdiction in which the offense was committed.

"Licensee" means a person licensed under this chapter.

"Moral turpitude" is an act of baseness, vileness, or depravity or conduct which is contrary to justice, honesty, or good morals. Examples of moral turpitude may include, but are not limited to, the following:

1. Any act or pattern of conduct involving dishonesty, fraud, or deception;
2. Any act of conducting a bail enforcement, private investigative or private security business in violation of Iowa Code chapter 80A, whether in Iowa or another jurisdiction, or a determination from another jurisdiction that the individual or entity has violated the bail enforcement, private investigative, or private security laws, rules, or regulations of that jurisdiction;
3. Any act or pattern of conduct of harassment or stalking;
4. Any criminal act of sexual misconduct;
5. Any illegal act of selling, delivery, possession with intent to deliver, or manufacturing drugs;
6. Conviction resulting from domestic abuse.

"Peace officer" means any such individual as designated by Iowa Code section 801.4, subsection 11.

"Person" means an individual, partnership, corporation, or other business entity.

"Private investigation business" means the business of making, for hire or reward, an investigation for the purpose of obtaining information on any of the following matters:

1. Crimes or wrongs which are committed or threatened.
2. The habits, conduct, movements, whereabouts, associations, transactions, reputation, or character of a person.
3. The credibility of witnesses or other persons.
4. The location or recovery of lost or stolen property.
5. The cause or origin of or responsibility for fires, accidents, or injuries to property.
6. The truth or falsity of a statement or representation.
7. The detection of deception.
8. The securing of evidence to be used before authorized investigating committees, boards of award or arbitration, or in the trial of civil or criminal cases.
9. The locating of owners or heirs of unclaimed funds.

"Private investigative agency" means a person engaged in a private investigation business.

"Private security agency" means a person engaged in a private security business.

"Private security business" means a business of furnishing, for hire or reward, guards, watch personnel, armored car personnel, patrol personnel, or other persons to protect persons or property, to prevent the unlawful taking of goods and merchandise, or to prevent the misappropriation or concealment of goods, merchandise, money, securities, or other valuable documents or papers, and includes an individual who for hire patrols, watches, or guards a residential, industrial, or business property or district.

"Proof of financial responsibility" means proof of the ability of a licensee to respond in damages for liability on account of accidents or wrongdoings occurring subsequent to the effective date of the proof, arising out of ownership and operation of a bail enforcement business, private security business or a private investigation business.

"Replacement license" means a license that is issued to substitute for a license that has been lost or destroyed as a result of damage from flooding, storms or other conditions which form a basis for issuance of a disaster emergency proclamation by the governor pursuant to Iowa Code section 29C.6.

"Reserve peace officer" means a volunteer, nonregular, sworn member of a law enforcement agency who serves under the direction of regular peace officers with or without compensation, has regular police powers while functioning as a law enforcement agency's representative, and participates on a regular basis in the law enforcement agency's activities including crime prevention and control, preservation of the peace, and enforcement of law.

"Uniform" means a manner of dress which is of a particular style and distinctive appearance as distinguished from ordinary clothing customarily used and worn by the general public and which clearly identifies the person as an employee of a licensed agency.

661—121.3(80A) Persons exempt. This chapter does not apply to the following:

121.3(1) An officer or employee of the United States, or a state, or a political subdivision of the United States or of a state while the officer or employee is engaged in the performance of official duties or an employee of a contractor or subcontractor with a federal agency while performing duties pursuant to a contract with the federal agency.

121.3(2) A peace officer engaged in the private security business or the private investigation business with the knowledge and consent of the chief executive officer of the peace officer's law enforcement agency.

121.3(3) A person employed full- or part-time exclusively by one employer in connection with the affairs of the employer.

121.3(4) An attorney licensed to practice in Iowa, while performing duties as an attorney.

121.3(5) A person engaged exclusively in the business of obtaining and furnishing information regarding the financial rating or standing and credit of persons.

121.3(6) A person exclusively employed in making investigations and adjustments for insurance companies. This exemption does not apply to persons who contract with a third party, such as an attorney or a broker, to conduct investigations on behalf of insurance companies. However, this exemption does apply to independent contractors who contract directly with insurance companies and exclusively conduct insurance investigative work.

121.3(7) A person who is the legal owner of personal property which has been sold under a security agreement, or a conditional sales agreement, or a secured party under the terms of a security interest while the person is performing acts relating to the repossession of the property.

121.3(8) A person engaged in the process of verifying the credentials of physicians and allied health professionals applying for hospital staff privileges.

121.3(9) A person engaged in the business of retrieval and dissemination of public record information.

121.3(10) A person engaged in the business of process service in either a criminal or civil action, where the determination of the whereabouts of the person is only incidental to the service of process.

121.3(11) The business of repossession or recovery of property, including debt collection, where the determination of the whereabouts of the person is only incidental to the repossession or collection.

121.3(12) A person engaged in the business of genealogical research.

121.3(13) A person who sells, installs, maintains, repairs or monitors burglar alarm systems at protected premises or premises to be protected.

121.3(14) Iowa Code sections 80A.2, 80A.4(1)*"b,"* and 80A.4(3) address the ability of peace officers to operate as private investigators and private security guards. The department interprets these three references, when read in concert, to mean the following:

a. An individual peace officer may conduct private investigation business or private security business with permission of the officer's chief executive, without securing either a state license or identification card.

b. Two or more peace officers may form a partnership to conduct private investigation business or private security business without securing either a state license or identification card. The partnership, association, or business may employ other peace officers to conduct investigation or security functions; however, the chief executive of each partner, association member, owner, or employee must give permission to engage in the business.

c. A partnership owned and operated by peace officers may not employ nonpeace officers to perform investigation or security functions.

d. An agency licensed by the department may not have any peace officers involved in the ownership or management of the agency.

e. An agency licensed by the department may not employ a peace officer to do investigative or security functions.

f. No corporation in the private security or private investigation business is exempt from the license or identification card requirement or limitations on the employment of peace officers.

121.3(15) A person engaged in the business of transporting prisoners under a contract with the Iowa department of corrections or a county sheriff, a similar agency from another state, or the federal government.

121.3(16) A person engaged exclusively in the business of providing courier service and who does not wear the uniform or use a marked motor vehicle of a licensed private security agency.

661—121.4(80A) Licenses. Each person who engages in the operation of a bail enforcement, private investigation, or private security business in this state shall be licensed prior to such activity. Each business requires a separate license. For a license to be valid, the business shall have at least one current valid licensee who is a director, officer, partner or person who is involved in the business in Iowa.

121.4(1) *Application for licenses—generally.* Anyone who wishes to be considered for a bail enforcement, private investigative or private security license should contact the program services bureau as indicated in rule 661—121.1(80A) and request application information.

121.4(2) *Jurisdiction.* Any private investigative, private security, or bail enforcement business shall be licensed in Iowa if it is conducting business in Iowa. The department will consider the following factors when determining jurisdiction:

a. Whether the private investigative, private security, or bail enforcement business has an office or place of business in Iowa, is organized in Iowa, or conducts business in Iowa.

b. Whether services are provided to a client who resides in Iowa, is organized in Iowa, has an office or place of business in Iowa, provided that some of the services are conducted in Iowa.

c. Types of activities that are viewed as demonstrating jurisdiction in Iowa include, but are not limited to, the following:

(1) A private investigation business conducts an investigation that occurs entirely or partially in Iowa.

(2) A private investigation business investigates a criminal, civil, or administrative case that originates or is filed in Iowa.

(3) A private security business conducts security at any location in Iowa.

(4) A bail enforcement business takes into custody, or attempts to take into custody, a defendant in an Iowa criminal case.

(5) A business provides bodyguard service to a person who resides in or regularly does business in Iowa.

(6) A business provides armored car service to a client who resides in or does business in Iowa, if part of the services are conducted in Iowa.

d. Types of activities that are not, by themselves, viewed as demonstrating jurisdiction in Iowa include, but are not limited to, the following:

(1) A non-Iowa-based private investigation business works on a criminal, civil, or administrative case that originates and is filed in another state, but that contains some investigative elements in Iowa.

(2) A non-Iowa-based business provides bodyguard service to a client who does not reside in Iowa and only occasionally does business in Iowa.

(3) A bail enforcement business takes into custody, or attempts to take into custody, a defendant in a criminal case filed in another state.

e. The fact that a business uses the Internet to retrieve public record information from Iowa databases does not, absent other factors, establish jurisdiction in Iowa.

121.4(3) *Forms.* An applicant for a license or identification card shall execute forms provided by the department. These forms must be submitted to the commissioner and will not be processed unless complete. The forms used in the administration of this chapter are as follows:

a. Application for Bail Enforcement Agency License, Private Investigative Agency License and/or Private Security Agency License, Form #PD1.

b. Identification Card Application for: Private Investigator/Private Security Guard/Bail Enforcement Agent, Form #PD2.

c. Application for License Renewal, Form #PD3.

d. FBI Fingerprint Card, Form #FD–258.

e. Limited Liability Company, Form #PD5.

f. License Surety Bond, Form #PD6.

g. Corporate Information, Form #PD7.

h. Identification Card, Form #PD8.

121.4(4) *Application requirements.* An applicant for a license as a bail enforcement agency, private investigative agency or private security agency must submit the following to complete the application process:

a. A completed Application for Bail Enforcement Agency License, Private Investigative Agency License and/or Private Security Agency License (Form #PD1) for each individual.

With respect to an applicant who is a corporation, Form #PD1 must be completed by each officer or director who is actively involved in the licensed business in Iowa.

With respect to an applicant who is a partnership or association, Form #PD1 must be completed by each partner or association member.

b. Two completed Fingerprint Cards (Form #FD–258) and the associated processing fees for each individual identified in paragraph *"a"* of this subrule.

c. A completed surety bond form (Form #PD6) issued by a surety company authorized to do business in this state.

d. If the applicant is a corporation, a completed Corporate Information form (Form #PD7).

e. Two 1″ × 1″ color photographs of the head and shoulders of each individual identified in paragraph *"a"* of this subrule, taken not more than one year prior to application.

f. A fee of $100 for each agency license requested, plus $10 for each application form for an employee identification card (Form #PD2) requested pursuant to this subrule.

g. Proof of financial responsibility.

h. Pictures, photocopies or physical descriptions of all uniforms, hats, badges, and insignia to be used by the private security agency.

121.4(5) *Abandonment of applications.* If an applicant for an agency license fails to complete the application within six months after it has been filed, the application shall be deemed abandoned. Any application submitted subsequent to the abandonment of a former application shall be treated as a new application, and must be filed in accordance with subrule 121.4(4).

121.4(6) *Proof of financial responsibility.* Proof of financial responsibility shall be given by filing a certificate of insurance from a licensed insurance company demonstrating coverage for general liability, completed operations and personal injury. Personal injury insurance shall include coverage for the following groups of offenses:

a. False arrest, detention, or imprisonment, or malicious prosecution.

b. Libel, slander, defamation or violation of rights of privacy.

c. Wrongful entry or eviction or other invasion of rights of private occupancy.

The certificate shall provide that the insurance shall not be modified or canceled unless 30 days' prior notice is given to the department. Licensees shall have no more than 30 days following any specified expiration dates to comply with insurance requirements. The license shall be automatically revoked if the licensee has not complied with the certificate of insurance requirement within the 30 days.

EXCEPTION: Current licensees who have provided proof of financial responsibility by filing an irrevocable letter of credit as of May 1, 2003, shall be allowed to continue using that means of providing proof of financial responsibility as long as their license remains continuously valid or until such proof is replaced by liability insurance. Licensees who provide proof of financial responsibility pursuant to this exception shall continue to meet the applicable requirements established in subrule 121.4(5) prior to May 1, 2003.

121.4(7) *Mandatory examinee.* Rescinded IAB 5/25/05, effective 5/1/05.

121.4(8) *Application for examination.* Rescinded IAB 5/25/05, effective 5/1/05.

121.4(9) *Time and place of examination.* Rescinded IAB 5/25/05, effective 5/1/05.

121.4(10) *Reexaminations.* Rescinded IAB 5/25/05, effective 5/1/05.

661—121.5(80A) License requirements. In order to be considered for a license, the applicant must undergo a background investigation by the department and must meet the following standards:

121.5(1) Be at least 18 years old;

121.5(2) Not be a peace officer (except a reserve peace officer);

121.5(3) Never have been convicted of a felony or aggravated misdemeanor;

121.5(4) Not be an abuser of alcohol or a controlled substance;

121.5(5) Not have a history of repeated acts of violence;

121.5(6) Be of good moral character. Consideration of whether an applicant is of good moral character includes but is not limited to:

a. Any of the applicant's references indicating the applicant is not of good moral character;

b. The sheriff of the county of residence or business or the police chief of the city of residence or business so indicating in writing;

c. The applicant's failing to discharge just obligations;

d. The applicant's writing a check on an account with knowledge that there are insufficient funds to cover it;

e. The applicant's failing to pay employees wages legally due the employees;

f. The applicant's knowingly obstructing justice or interfering in the lawful duties of a peace officer or with any official investigation;

g. Unless rendered confidential by law, the applicant's failing to report:

(1) A serious crime, or

(2) The location of any stolen property;

h. The applicant's committing an act which involves moral turpitude, whether or not a criminal conviction occurred.

i. The applicant's being subject to any court order that restrains the person from harassing, stalking, or threatening an intimate partner of the person or child of the intimate partner or person, or engaging in other conduct that would place an intimate partner in reasonable fear of bodily injury to the partner or child, and includes a finding that the person represents a credible threat to the physical safety of the intimate partner or child, or explicitly prohibits the use, attempted use, or threatened use of physical force against the intimate partner or child that would reasonably be expected to cause bodily injury;

j. The applicant's being a registered sex offender in any jurisdiction;

k. The applicant's being the subject of any arrest warrant, mittimus or other court order for detention in any jurisdiction.

121.5(7) Not been convicted of any crime defined in Iowa Code section 708.3, 708.4, 708.5, 708.6, 708.8, or 708.9, or a like offense in another jurisdiction;

121.5(8) Not been convicted by any court of illegally using, carrying, or possessing a dangerous weapon;

121.5(9) Not have a history of mental illness or instability.

661—121.6(80A) Identification cards. Each person employed by and engaged in the business of a licensed bail enforcement, private investigative or private security agency must obtain an employee identification card from the department and must meet the standards established in rule 661—121.5(80A). However, applicants for employee identification cards are not required to comply with surety bond or proof of financial responsibility requirements as those requirements have already been met by the licensed agency. For purposes of this rule, an employee who is required to obtain an identification card from the department is an agent or employee of a licensed agency who is engaged in the activities of the business which render it subject to the regulation of Iowa Code chapter 80A. Employees who are engaged exclusively in the unregulated activities of a licensed agency are considered exempt from this standard. Such exempt activities include clerical work, dispatching, building maintenance, vehicle maintenance, payroll and other financial processing, selling and taking tickets, parking cars and other activities that do not provide direct security services and that are generally conducted away from a contracted job site.

121.6(1) To obtain an employee identification card, the licensed agency shall submit:

a. A completed Identification Card Application for: Private Investigator/Private Security Guard/Bail Enforcement Agent, Form #PD2;

b. Two 1″ × 1″ color photographs of the head and shoulders of the applicant; and

c. Two completed fingerprint cards (Form #FD–258), with the associated processing fees.

121.6(2) Reserved.

661—121.7(80A) License and background investigation fees.

121.7(1) A fee of $100 shall accompany each application for a bail enforcement, private investigative or private security license. If the application is approved, the money shall be applied to the license fee, but if the application is disapproved, the deposited application fee shall be refunded to the applicant. Application fees shall not be refunded for abandoned applications described in subrule 121.4(5) or for canceled, suspended or revoked licenses.

121.7(2) A nonrefundable fee to cover the cost of processing fingerprint cards through the FBI must be submitted with each new or renewal application and with each application subsequent to a license cancellation or revocation. If fingerprints are rejected as unreadable the first time they are submitted, they may be resubmitted once for no additional fee. If fingerprints are submitted twice and both submissions are rejected as unreadable, subsequent submissions shall require additional processing fees, which shall be included with the submissions. Information regarding fees may be obtained by contacting the department as provided in rule 661—121.1(80A).

661—121.8(80A) Display of license. Immediately upon receipt of the license issued by the department, the licensee named therein shall cause such license to be posted and at all times displayed in a conspicuous place in the licensee's principal place of business within the state, so that all persons visiting such place may readily see it. If there is more than one place of business, then there shall be a photocopy of the original license posted in every such place of business. The licensee shall notify the commissioner of each location where a copy of the license is posted. If the licensee has no office in the state of Iowa, the licensee shall post the license at the principal place of business and notify the commissioner of the address where such license is posted. Such license shall at all reasonable times be subject to inspection by the commissioner. It shall be unlawful for any person holding such license to post such license or to permit such license to be posted upon premises other than those authorized therein. Every license, and each copy thereof, shall be surrendered to the department within seven days after written notice to the holder that such license has been revoked. Failure to comply with any of the provisions of this rule is sufficient cause for revocation of the license.

661—121.9(80A) Duplicate license. The commissioner shall issue a duplicate license upon the payment of $5 and upon receiving a written statement that the original license has been lost, destroyed, stolen or otherwise rendered useless, and that if the original license is recovered, the original or the duplicate will be returned immediately to the department.

661—121.10(80A) License renewal. Each applicant for a license renewal must execute Form #PD3 provided by the department. This renewal form and two completed FBI Fingerprint Cards (Form #FD–258) shall be submitted to the commissioner not less than 30 days prior to expiration of the applicant's current license and shall not be processed unless complete. In order for the application to be complete, the applicant must satisfy the requirements of rules 661—121.4(80A), 661—121.5(80A), and 661—121.7(80A) and, for renewals of private investigation licenses, 661—121.22(80A).

In the event the department has not processed a complete renewal application prior to the lapse of the license, the renewal shall be deemed temporarily granted until the department issues a new license or denies the renewal.

In no event will a renewal license be granted if the application for renewal is received by the department after the expiration date of the existing license.

If the former licensee wishes to continue the bail enforcement, private investigative or private security business, all of the requirements for an initial application must be met.

661—121.11(80A) Employee identification cards.

121.11(1) The employee identification card issued by the commissioner shall include the employee's name and color photograph, agency name and number, type of business, date of issuance and identification card number.

The identification card shall be evidence that the holder is duly authorized to work for the licensed agency. The holder shall have this card in the holder's possession at all times when acting within the scope of employment. Failure to do so may result in suspension or revocation of the identification card or the agency license. This identification card shall remain the department's property. When any person to whom a card is issued terminates the person's position for any reason, the card must be surrendered to the commissioner within seven days. In the event of loss, destruction, or theft of this card, the licensee shall within five days of such discovery send to the commissioner a written report that describes the circumstances surrounding the loss, destruction, or theft. If the agency license has been terminated or revoked, the agency must return the license and all identification cards to the commissioner within seven days. The penalty for any knowing or willful misconduct in the use of the identification card may be revocation of the identification card or the agency license or both, depending on the nature and degree of the misconduct.

The fee for each application form (Form #PD2) for an original, temporary, or replacement employee identification card is $10. The fee is refundable for blank, unused forms returned to the department.

A nonrefundable fee to cover the cost of processing fingerprint cards through the FBI shall be submitted with each new application for an employee identification card. If fingerprints are rejected as unreadable the first time they are submitted, they may be resubmitted once for no additional fee. If fingerprints are submitted twice and both submissions are rejected as unreadable, subsequent submissions shall require additional processing fees, which shall be included with the submissions.

121.11(2) Temporary identification cards. The Identification Card Application for: Private Investigator/Private Security Guard/Bail Enforcement Agent, Form #PD2, shall contain a temporary identification card that shall be valid for 14 calendar days from the date of issuance. This temporary identification card shall be issued to new employees of a licensee so that the requirement that employees have in their possession a valid identification card may be met while the application for a permanent identification card is being processed. The application for an employee identification card must be received by the department in sufficient time to allow four business days for processing. Any application for an employee identification card received by the department without the specified minimum time for processing or after the temporary identification card has expired will be returned to the licensed agency. A new Form #PD2 must then be resubmitted under the requirements of rule 661—121.6(80A).

121.11(3) Replacement of identification cards. The commissioner shall issue a duplicate employee identification card upon the submission of a complete new application (Form #PD2), with associated fees as required in rule 661—121.6(80A) and upon receipt of a written statement that the original employee identification card has been lost, destroyed, stolen or otherwise rendered useless. If the original employee identification card is recovered, it shall be returned immediately to the department.

121.11(4) Display of identification cards. When an employee of a licensed agency is acting within the scope of employment and is requested to produce identification, the employee shall promptly display the employee identification card and allow the requester to reasonably examine the identification card and write down any information contained thereon. Failure to comply may result in revocation of the identification card or license. The employee may refuse to comply with the request to produce identification if, and only if, displaying the employee identification card would put the employee or another person in danger, or would jeopardize an assignment or investigation.

661—121.12(80A) Badges, uniforms, insignia, patches and hats. No badges, uniforms, insignia, patches, or hats will be approved for private investigative or bail enforcement agents. No holder of a license or identification card while performing the duties of a private security guard shall wear any

uniform, or wear, display, or likewise use any badge, insignia, patch, shield, or the like, without prior written approval of the commissioner. Any person wearing an approved uniform shall carry a valid identification card issued by the department.

The commissioner will not approve any item subject to this rule if in the commissioner's opinion it would cause a person to confuse the operation of the licensed business with that of a law enforcement agency. The commissioner may consider the appearance of the badge, uniform, insignia, patch or hat of the requesting agency, as well as the appearance of badges, uniforms, insignias, patches or hats of law enforcement agencies in or near the area in which the requesting agency performs services. The commissioner may also consider any other information when making a decision regarding the approval of any item subject to this rule.

Badges, insignia and patches will be approved only for private security as a part of an approved uniform. No badge, insignia, patch or hat will be approved which contains the word or words "police," "officer," "policeman," or "enforcement," or the Great Seal of the State of Iowa. The words "security" and "officer" may be used when they appear as the single term "security officer."

661—121.13(80A) Advertisement, cards, letterhead and the like. No holder of a license or identification card shall use, display, cause to be printed or distributed in any fraudulent, false, or misleading manner, cards, letterheads, circulars, brochures, or any other advertising material or advertisement in which any name or indicia of the license status of the licensee is set forth in any manner other than the name under which the licensee is duly licensed.

Such holder of a license or identification card shall not publish or cause to be published any advertisement, letterhead, circular or statement or phrase of any sort which suggests that the holder is a peace officer.

Any violation of this rule may result in suspension or revocation of the identification card or the license, and possible referral for criminal prosecution.

661—121.14(80A) Misleading statements. No holder of a license or identification card may make any statement which indicates or tends to indicate the individual is a peace officer.

661—121.15(80A) Reports. Any private investigative agency licensee who provides services to any client in this state shall make and offer to the client a typed or legibly written ink report containing the findings and complete details of the investigation, a copy of which shall be retained by the licensee for three years and made available to the commissioner for examination at any reasonable time upon a complaint from the client for whom the report was prepared. In the event a client does not desire a written report, the licensee will note the time and date on the file copy of the report that the client stated no desire for a written report or refused the offer. A private security agency need not submit a written report unless the client so requests one.

Descriptive reports, chronological reports, and cover letters to the client shall be personally signed by the licensee or the licensee's designee. The licensee's file copy will reflect the names of all participating employees and a description of the work performed by each one.

661—121.16(80A) Denial, cancellation, suspension, or revocation of a license or identification card.

121.16(1) *Actions by the commissioner.* The commissioner may deny, suspend, cancel or revoke a license or identification card(s) for any of the following reasons:

a. Failure to comply with all of the provisions of Iowa Code chapter 80A and Iowa Administrative Code, 661—Chapter 121.

b. Receipt by the department of a certificate of noncompliance from the child support recovery unit of the Iowa department of human services, as provided for in Iowa Code chapter 252J.

c. Receipt by the department of written notice that the licensed agency is no longer conducting business and is abandoning the remaining term of the license.

121.16(2) *Voluntary suspension.* The commissioner may allow an agency to place its license in voluntary suspension and may reinstate the license when all requirements are met. The license shall expire at the time of renewal unless all requirements are met.

121.16(3) *Surrender of license and identification card(s).* Every license, and each copy thereof, and all employee identification cards shall be surrendered to the department within seven days after written notice to the holder that such license has been canceled, abandoned, suspended or revoked.

121.16(4) *Surrender of identification card(s).* An employee identification card shall be surrendered to the department within seven days after written notice to the licensee that such employee identification card has been canceled or revoked.

121.16(5) *Temporary denial or suspension.* An agency license or employee identification card shall be temporarily denied or suspended until the outcome of any pending action is known if the result of that action would disqualify the applicant, licensee or employee.

661—121.17(80A) Licensee's duty regarding employees. The licensee shall be held responsible for ascertaining that all the licensee's employees meet the requirements of the bail enforcement, private investigation and private security statute and rules.

The licensee shall report to the commissioner any violations of the statute and rules, and inconsistencies thereof, and take immediate steps to be in compliance with such statute and rules.

The licensee is responsible for ensuring that each employee who is required to obtain an identification card from the department has a valid temporary or permanent identification card in the employee's possession prior to the employee's commencing work.

Failure to meet these requirements may result in suspension or revocation of the license or identification card(s).

661—121.18(80A) Campus weapon requirements. In addition to the requirements of the statutes, nothing in rule 661—4.3(17A,724) shall preclude the sheriff from requiring additional firearm training. However, if the sheriff so requires additional training, the sheriff shall make such training reasonably available to the applicant.

661—121.19(80A) Professional permit to carry weapons. Each person seeking a professional permit to carry weapons must meet the requirements of the Iowa Code and Iowa Administrative Code, 661—Chapter 4.

661—121.20(80A) Appeals. Any action of the department that the applicant or employee considers adverse may be appealed through the process delineated in Iowa Administrative Code, 661—Chapter 10.

661—121.21(252J) Child support collection procedures. The following procedures shall apply to actions taken by the department on a certificate of noncompliance received from the Iowa department of human services pursuant to Iowa Code chapter 252J:

121.21(1) The notice required by Iowa Code section 252J.8 shall be served upon the applicant, identification card holder, or licensee by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the licensee, identification card holder, or applicant may accept service personally or through authorized counsel.

121.21(2) The effective date of revocation or suspension of a license or identification card, or denial of the issuance or renewal of a license or identification card, as specified in the notice required by Iowa Code section 252J.8, shall be 60 days following service upon the licensee, identification card holder, or applicant.

121.21(3) Licensees, identification card holders, and applicants for licenses or identification cards shall keep the department informed of all court actions and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J and shall provide the department with copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code

section 252J.9, all court orders entered in such actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

121.21(4) All departmental fees for applications, license or identification card renewal or reinstatement must be paid by the licensee, identification card holder, or applicant before a license will be issued, renewed, or reinstated after the department has denied the issuance or renewal of a license or identification card, or has suspended or revoked a license or identification card pursuant to Iowa Code chapter 252J.

121.21(5) In the event a licensee, identification card holder, or applicant files a timely district court action following service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9, the department shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed. For the purpose of determining the effective date of revocation or suspension or denial of the issuance or renewal of a license or identification card, the department shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

661—121.22(80A) Continuing education requirements. The continuing education rules that follow rest upon the premise that the increasing complexity of the private investigation business makes it essential that private investigators who have been granted licenses to practice continue their education; the public interest requires that private investigators keep themselves continually up to date on developments affecting their practice; and formal programs of continuing education provide private investigators the opportunity to continually update themselves on the expanding body of knowledge required to practice the private investigation profession. Compliance with the continuing education requirements of the department shall be as follows:

Each person who is the holder of a license to operate a private investigative agency is required to comply with the continuing education requirements as a condition precedent to renewal of the person's license.

Each person who is the holder of an identification card to operate as a private investigator is required to comply with the continuing education requirements as a condition precedent to renewal of the employer's agency license.

121.22(1) *Cost of continuing education.* All costs of complying with the continuing education requirements of the department are the responsibility of the licensee who seeks to operate a private investigative agency in this state.

121.22(2) *Basic requirement.* A licensee seeking to renew the licensee's private investigative agency license shall, during the two-year period preceding the agency license expiration date, complete a minimum of 12 hours of acceptable continuing education. Employees of licensees shall, during the two-year period preceding the agency license expiration date, complete a minimum of 12 hours of acceptable continuing education. An employee who has worked for a licensed agency for less than 90 days at the time of the agency license expiration date shall be exempt from the continuing education requirement of this chapter, provided that during the preceding two years the employee has not been employed as a private investigator for a licensed agency or agencies in this state for a combined total of more than 180 days.

a. Applicants who are residents of another state, who are licensed to operate a private investigation agency in their state of residency, and who are actively engaged in the practice in their state of residence, shall not be required to meet the basic continuing education requirement if their state of residence requires similar continuing education to maintain their private investigative agency license.

b. The commissioner shall have the authority to make exceptions for reasons of individual hardship including health (certified by a medical doctor), military service, foreign residency, or other good cause.

c. Applicants for new licenses who have held a private investigative agency license in Iowa within the past two years shall complete a minimum of 12 hours of acceptable continuing education during the two-year period preceding the date of application.

121.22(3) *Measurement standards.* The following standards will be used to measure the hours of credit to be given for acceptable continuing education programs completed by individual licensees:

a. Credit will be given for whole hours only, with a minimum of 50 minutes constituting one hour. For example, 100 minutes of continuous instruction would count for two hours; however, more than 50 minutes but less than 100 minutes of continuous instruction would count for only one hour.

b. Only class hours or the equivalent, and not student hours devoted to preparation, may be counted.

c. Service as lecturer or discussion leader of continuing education programs may be counted to the extent that it contributes to the applicant's professional competence.

121.22(4) *Programs which qualify.* The overriding consideration in determining whether a specific program qualifies as acceptable continuing education is that it be a formal program of learning which contributes directly to the professional competence of an individual licensed to practice in this state. It will be left to the individual license holder to determine the course of study to be pursued. Thus, each licensee may study subjects related to the licensee's particular practice.

a. Continuing education programs will qualify only if:

(1) An outline of the program is prepared in advance and preserved.

(2) The program is at least one hour (50-minute period) in length.

(3) The program is conducted by a qualified instructor, discussion leader, or lecturer. A qualified instructor, discussion leader, or lecturer is anyone whose background, training, education or experience makes it appropriate for that person to lead a discussion on the subject matter of the particular program.

(4) A record of attendance is maintained.

b. The following programs are deemed to qualify provided all other requirements of this rule are met:

(1) Professional development programs of recognized national and state private investigation organizations.

(2) Technical sessions at meetings of recognized national private investigation organizations and their chapters.

(3) University or college courses.

1. Each semester hour credit shall equal 10 hours toward the requirement.
2. Each quarter hour credit shall equal 6 hours toward the requirement.
3. Each classroom hour of noncredit courses will equal 1 qualifying hour.

(4) Formal organized in-firm and interfirm educational programs.

(5) Programs in other recognized organizations (accounting, industrial, legal and others).

(6) Other organized educational programs on technical and other related subjects.

c. The following general subject matters are acceptable as long as they contribute to the professional competence of the individual investigator.

(1) Accounting and auditing.

(2) Management.

(3) Computer science.

(4) Communications arts.

(5) Law.

(6) Functional fields of the business, including but not limited to the following:

1. Accident investigation.
2. Background investigation.
3. Business taxes.
4. Criminal investigation.
5. Court testimony.
6. Employee theft.
7. Process service.
8. Personnel law.
9. Product liability.
10. Public records availability/access.

11. Report writing.
12. Substance abuse in the workplace.
13. Surveillance techniques.
14. Wage and hour law.
15. Workers' compensation law.

Areas other than those listed above may be acceptable if the licensee can demonstrate that they contribute to the licensee's professional competence. The responsibility for substantiating that a particular program is acceptable and meets the requirements rests solely upon the licensee.

d. Formal correspondence and formal individual study programs contributing directly to the professional competence of an individual which require registration and provide evidence of satisfactory completion will be considered for credit. The amount of credit to be allowed for correspondence and formal individual study programs is to be recommended by the program sponsor and shall not exceed 50 percent of the continuing education requirement.

e. Practical training, also known as field training or on-the-job training, qualifies if it meets the criteria of paragraphs *"a"* through *"c"* of this subrule, is accompanied by classroom training in the same topic area, and counts for no more time than the classroom training.

f. The right is specifically reserved to the commissioner to approve or disapprove credit for continuing education claimed under these rules.

121.22(5) *Controls and reporting.*

a. Applicants for license renewal must provide a signed statement, on forms provided by the department, setting forth the continuing education in which the licensee and the licensee's employees have participated in such manner and at such times as prescribed by the commissioner. This information may include:

(1) School, firm or organization conducting the course.
(2) Location of course.
(3) Title of course and description of content.
(4) Principal instructor.
(5) Dates attended.
(6) Hours claimed.

b. The commissioner may require sponsors of courses to furnish attendance lists or any other information the commissioner deems essential for administration of these continuing education rules.

c. The commissioner will verify on a test basis information submitted by licensees. If an application for license renewal is not approved, the applicant will be so notified and may be granted a period of time by the commissioner in which to correct the deficiencies noted.

d. Primary responsibility for documenting the requirements rests with the licensee and evidence to support fulfillment of those requirements must be retained for a period of three years subsequent to submission of the report claiming the credit. Satisfaction of the requirements, including retention of attendance records and written course outlines, may be accomplished as follows:

(1) For courses taken for scholastic credit in accredited universities and colleges or high school districts, evidence of satisfactory completion of the course will be sufficient. For noncredit courses taken, a statement of the hours of attendance, signed by the instructor, must be obtained by the permit holder.

(2) For correspondence and formal independent study courses, written evidence of completion must be obtained by the licensee.

(3) In all other instances, the licensee must maintain a record of the information listed in subrule 121.22(4) and a copy of the course outline prepared by the course sponsor.

121.22(6) *Compliance.*

a. *Renewals.* If a licensee fails to comply with continuing education requirements prior to the expiration of the license, the department may grant a temporary 30-day license. If the licensee does not complete the continuing education requirements within the 30-day period, the license renewal shall be denied. If the former licensee then wishes to continue the private investigation business, all of the requirements for an initial application must be met. This includes continuing education requirements if the new application is submitted within two years of the date on which the last license became invalid.

b. *New applications for previously licensed persons.* If an applicant for a private investigative agency license has been licensed in Iowa within the past two years, continuing education requirements must be met. Failure to comply shall result in the denial of the license until such time as the requirements are met.

c. *Employees.* If any employee of a licensee fails to comply with continuing education requirements, the employee's identification card shall be revoked and the licensee shall surrender the identification card to the department. An employee may reapply for an identification card as if it were an initial application when continuing education requirements have been met.

661—121.23(80A) Reciprocity.

121.23(1) *Eligibility.* A temporary permit to conduct business in Iowa may be issued to a private investigative or private security agency licensed in another state provided that the requirements and qualifications in the licensing state are similar to those in Iowa and that the licensing state allows similar privileges by reciprocity. A temporary permit may be issued for a period not to exceed 90 days and is not renewable. Employees of an agency granted a temporary permit must comply with Iowa employee requirements in rules 661—121.6(80A) and 661—121.11(80A).

121.23(2) *Requirements.* In order to be considered for a temporary permit, the applicant must undergo a background investigation by the department and shall submit the following:

a. Proof of a current valid bail enforcement, private investigative or private security license in another state. Such license shall be of the same license type as the temporary permit requested from Iowa.

b. A completed Application for Bail Enforcement Agency License, Private Investigative Agency License and/or Private Security Agency License (Form #PD1).

c. Two completed FBI Fingerprint Cards (Form #FD–258), with the associated processing fees.

d. Proof of surety bond issued by a surety company authorized to do business in this state.

e. Proof of insurance.

f. If the applicant is a corporation, articles of incorporation and an Iowa certificate of authority issued by the Iowa secretary of state.

g. Two 1″ × 1″ color photographs of the head and shoulders of the applicant, taken not more than one year prior to application.

h. A fee of $100 for each temporary permit requested.

i. An application, with associated fees, for an employee identification card (Form #PD2) for the temporary permit holder.

121.23(3) *Employee identification cards.* The temporary permit holder shall submit an application for an employee identification card for each employee as required in rule 661—121.6(80A).

661—121.24(80A) Replacement license. The commissioner shall issue a replacement license upon receiving a written statement that the original license has been lost, destroyed, stolen or otherwise rendered useless by damage from flooding, storms or other conditions which form a basis for issuance of a disaster emergency proclamation by the governor pursuant to Iowa Code section 29C.6. If the original license is recovered, the original or the replacement will be returned immediately to the department. No fee shall be charged for the issuance of a replacement license.

These rules are intended to implement Iowa Code chapter 80A.

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CHAPTER 275
CERTIFICATION OF AUTOMATIC FIRE EXTINGUISHING SYSTEM CONTRACTORS

661—275.1(100C) Establishment of program. There is established within the fire marshal division a fire extinguishing system contractors certification program. The program is established pursuant to Iowa Code chapter 100C.

275.1(1) *Certification required.* No person shall act as a fire extinguishing system contractor without being currently certified as a fire extinguishing system contractor by the fire marshal, except as provided in subrule 275.1(3).

275.1(2) *Endorsement.* The certification of each contractor shall carry an endorsement for one or more of the following:

a. Automatic sprinkler system layout;

b. Special hazards suppression systems;

c. Installation of preengineered dry chemical or wet agent fire suppression systems;

d. Installation of preengineered water-based fire suppression systems in one- and two-family dwellings;

e. Testing and inspection of water-based systems; or

f. Any combination thereof.

Any person acting as a fire extinguishing system contractor shall do so only in relation to systems covered by the endorsements on the contractor's certification.

275.1(3) *Length of certification.* Certification shall normally be for one year and shall expire on March 31 each year. A certification which is effective on a date other than April 1 shall be effective on the date on which the certification is issued and shall expire on the following March 31.

a. Certification between July 1, 2006, and October 1, 2006. A contractor may operate without certification between July 1, 2006, and September 30, 2006, as follows:

(1) Prior to August 15, 2006, the contractor may operate as a contractor only if the contractor intends to apply for certification by August 15, 2006; a contractor operating under this subparagraph may perform contracting work only within the scope of certification for which the contractor intends to apply.

(2) On or after August 15, 2006, and before October 1, 2006, the contractor may operate as a contractor subject to this chapter only if the contractor has applied for certification under this chapter. A contractor operating under this subparagraph may perform contracting work only within the scope of certification for which the contractor has applied.

b. Any certification for which application is made by August 15, 2006, and accepted, shall be effective retroactive to July 1, 2006, and appropriate fees shall be collected pursuant to rule 661—275.5(100C).

275.1(4) *Inquiries.* Inquires regarding the fire extinguishing system contractors certification program may be addressed to:

Fire Extinguishing System Contractors Certification Program
Fire Marshal Division
Iowa Department of Public Safety
401 S.W. 7th Street, Suite N
Des Moines, Iowa 50309

Inquiries may be addressed by electronic mail to fesccp@dps.state.ia.us, by telephone to (515)281-5821, or by facsimile to (515)242-6299.

661—275.2(100C) Definitions. The following definitions apply to rules 661—275.1(100C) through 661—275.7(100C):

"Automatic fire extinguishing system" means a system of devices and equipment that automatically detects a fire and discharges an approved fire extinguishing agent onto or in the area of a fire and includes automatic sprinkler systems, carbon dioxide extinguishing systems, deluge systems, automatic dry-chemical extinguishing systems, foam extinguishing systems, and halogenated extinguishing

systems, or other equivalent fire extinguishing technologies recognized by the fire extinguishing system contractors advisory board.

"Automatic sprinkler system" means an integrated fire protection sprinkler system usually activated by heat from a fire designed in accordance with fire protection engineering standards and includes a suitable water supply. The portion of the system above the ground is a network of specially sized or hydraulically designed piping installed in a structure or area, generally overhead, and to which automatic sprinklers are connected in a systematic pattern.

"Carbon dioxide extinguishing system" means a system supplying carbon dioxide from a pressurized vessel through fixed pipes and nozzles and includes a manual or automatic actuating mechanism.

"Clean agent" means an electrically nonconducting, volatile, or gaseous fire extinguishant that does not leave a residue upon evaporation.

"Deluge system" means a sprinkler system employing open sprinklers attached to a piping system connected to a water supply through a valve that is opened by the operation of a detection system installed in the same area as the sprinklers.

"Dry chemical" means a powder composed of very small particles, usually sodium bicarbonate-, potassium bicarbonate-, or ammonium phosphate-based, with added particulate material supplemented by special treatment to provide resistance to packing, resistance to moisture absorption (caking), and the proper flow capabilities.

"Dry pipe sprinkler system" means an extinguishing system employing automatic sprinklers that are attached to a piping system containing air or nitrogen under pressure, the release of which (as from the opening of a sprinkler) permits the water pressure to open a valve known as a dry pipe valve, which allows the water to flow into the piping system and out the opened sprinklers.

"Fire extinguishing system contractor" or *"contractor"* means a person engaging in or representing oneself to the public as engaging in the activity or business of layout, installation, repair, alteration, addition, maintenance, or maintenance inspection of automatic fire extinguishing systems in this state.

"Foam extinguishing system" means a special system discharging foam made from concentrates, either mechanically or chemically, over the area to be protected.

"Halogenated extinguishing system" means a fire extinguishing system using one or more atoms of an element from the halogen chemical series of fluorine, chlorine, bromine, and iodine.

"Layout" means drawings, calculations and component specifications to achieve the specified system design installation. "Layout" does not include design.

"Listed" means equipment, materials, or services included in a list published by a nationally recognized independent testing organization concerned with evaluation of products or services that maintains periodic inspection of production of listed equipment or materials or periodic evaluation of services and whose listing states that either the equipment, material, or service meets appropriate designated standards or has been tested and found suitable for a specified purpose.

"Maintenance inspection" means periodic inspection and certification completed by a fire extinguishing system contractor. For purposes of this chapter, "maintenance inspection" does not include an inspection completed by a local building official, fire inspector, or insurance inspector, when acting in an official capacity.

"Preengineered dry chemical or wet agent fire suppression system" means any system having predetermined flow rates, nozzle pressures and limited quantities of either agent. These systems have specific pipe sizes, maximum and minimum pipe lengths, flexible hose specifications, number of fittings and number and types of nozzles prescribed by a nationally recognized testing laboratory. The hazards against which these systems protect are specifically limited by the testing laboratory as to the type and size based upon actual fire tests. Limitations on hazards that can be protected against by these systems are contained in the manufacturer's installation manual, which is referenced as part of the listing.

"Preengineered water-based system" means a packaged, water-based sprinkler system including all components connected to a water supply and designed to be installed according to pretested limitations.

"Responsible managing employee" means an owner, partner, officer, or manager employed full-time by a fire extinguishing system contractor who is designated as a responsible managing employee for a fire

extinguishing system contractor and who meets the requirements for a responsible managing employee established in rule 661—275.3(100C).

"Special hazards suppression system" means a fire extinguishing system utilizing fire detection and control methods to release an extinguishing agent, other than water connected to a dedicated fire protection water supply.

"Wet agent" or *"wet chemical"* means an aqueous solution of organic or inorganic salts or a combination thereof that forms an extinguishing agent.

661—275.3(100C) Responsible managing employee. Each fire extinguishing system contractor shall designate a responsible managing employee and may designate one or more alternate responsible managing employees. A contractor may designate more than one responsible managing employee in order to satisfy the requirements for more than one endorsement as provided in subrule 275.1(2). If more than one responsible managing employee is designated, the contractor shall indicate for which responsible managing employee each designated alternate managing employee serves as an alternate.

275.3(1) The responsible managing employee or employees shall be designated in the application for certification; and, if a responsible managing employee is no longer acting in that role, the contractor shall so notify the fire marshal, in writing, within 30 calendar days, on a form designated by the fire marshal.

275.3(2) If a responsible managing employee is no longer acting in that role and the contractor has designated an alternate responsible managing employee, the alternate responsible managing employee shall become the responsible managing employee and the contractor shall so notify the fire marshal, in writing, within 30 calendar days of the date on which the preceding responsible managing employee ceased to act in that role. If the contractor has designated more than one alternate responsible managing employee, the notice to the fire marshal shall indicate which alternate responsible managing employee has assumed the position of responsible managing employee.

275.3(3) If a responsible managing employee designated by a fire extinguishing system contractor is no longer acting in the role of responsible managing employee and the contractor has not designated an alternate responsible managing employee, the contractor shall designate a new responsible managing employee and shall notify the fire marshal, in writing, of the designation within six months of the date on which the former responsible managing employee ceased to act in that capacity, on a form designated by the fire marshal. If the fire marshal has not been notified of the appointment of a new responsible managing employee within six months of the date on which a responsible managing employee ceased serving in that capacity, the fire marshal shall suspend the certification of the fire extinguishing system contractor.

275.3(4) A responsible managing employee or an alternate responsible managing employee shall meet one of the following requirements:

a. Current licensure as a professional engineer by the Iowa engineering and land surveying examining board, with competence in fire extinguishing system design.

b. Current certification by the National Institute for Certification in Engineering Technologies at level III or above in fire protection technology, for automatic sprinkler system layout, special hazards suppression systems, or both.

(1) Prior to April 1, 2008, a fire extinguishing system contractor may receive provisional certification if the person designated as the contractor's responsible managing employee has initiated procedures for obtaining certification by the National Institute for Certification in Engineering Technologies at level III in fire protection technology for automatic sprinkler system layout, special hazards suppression systems, or both, and has satisfactorily completed testing which is offered by a third party and has been approved by the fire marshal, for competency in fire protection technology for automatic sprinkler system layout, special hazards suppression systems, or both. The contractor shall provide the fire marshal with notification and documentation of the satisfactory completion of required third-party testing within 30 days after the date on which the contractor's provisional certification was initially issued.

After one year of provisional certification of the contractor, the responsible managing employee shall have current certification by the National Institute for Certification in Engineering Technologies at level II or above in fire protection technology for automatic sprinkler system layout, special hazards suppression systems, or both. Documentation that this requirement has been met shall be provided by the contractor to the fire marshal within 30 days after the one-year anniversary of the effective date of the initial provisional certification.

Provisional certification shall not be recognized on or after April 1, 2009.

(2) Reserved.

c. A contractor may install preengineered dry chemical or wet agent fire suppression systems, if the responsible managing employee meets the requirements specified in subparagraph (1). Until April 1, 2009, a contractor may install preengineered dry chemical or wet agent fire suppression systems, if the responsible managing employee meets the requirements specified in subparagraph (2), and the contractor has received provisional certification prior to April 1, 2008.

(1) Certification by the National Institute for Certification in Engineering Technologies at level II or above in fire protection technology, for special hazards suppression systems; certification by the National Association of Fire Equipment Distributors in preengineered kitchen fire suppression systems or preengineered industrial fire suppression systems; or satisfactory completion of an applicable training or testing program which has been approved by the fire marshal.

(2) On or prior to April 1, 2008, a contractor may receive provisional certification with endorsement for installation of preengineered dry chemical or wet agent systems if the responsible managing employee has completed training required by a manufacturer of at least one system which the contractor installs or maintains. A contractor who is applying for provisional certification on or after April 1, 2007, shall provide documentation to the fire marshal of such training. A contractor who has received provisional certification prior to April 1, 2007, shall, by April 1, 2007, provide documentation of either training required by a manufacturer of at least one system which the contractor installs or maintains or of the training described in subparagraph (1). If satisfactory documentation is provided of the training required in subparagraph (1), the provisional status of the certification shall be removed at no cost to the contractor.

Provisional certification shall not be recognized on or after April 1, 2009.

d. A contractor may install preengineered water-based systems in one- or two-family dwellings if the responsible managing employee meets the following requirements:

(1) Satisfactory completion of any training required by the manufacturer for the installation of any system the contractor installs; and

(2) Satisfactory completion of an applicable training or testing program which has been approved by the fire marshal.

Until April 1, 2008, a contractor may receive provisional certification if the responsible managing employee has satisfactorily completed training required by the manufacturer for the installation of each system which the contractor installs. The provisional certification shall not be recognized on or after April 1, 2009.

e. A contractor may inspect and test water-based fire extinguishing systems if the responsible managing employee has current certification from the National Institute for Certification in Engineering Technologies at level III in fire protection technology, inspection and testing of water-based systems.

(1) Prior to April 1, 2008, a contractor may receive provisional certification with an endorsement for inspection and testing of water-based fire extinguishing systems if the responsible managing employee has initiated procedures for obtaining certification from the National Institute for Certification in Engineering Technologies at level III in fire protection technology, inspection and testing of water-based systems. After one year of provisional certification with an endorsement for inspection and testing of water-based fire extinguishing systems, the responsible managing employee shall have certification from the National Institute for Certification in Engineering Technologies at level II in fire protection technology, inspection and testing of water-based systems.

Provisional certification shall not be recognized on or after April 1, 2009.

(2) Reserved.

275.3(5) In any case in which training or testing that is offered to satisfy the requirements of this rule is required to be approved by the fire marshal, such approval is required prior to acceptance of the training or testing to meet certification requirements. Approval by the fire marshal of any training or testing to meet these requirements may be sought by the individual, firm, or organization providing the testing or training or initiated by the fire marshal. Any individual, firm or organization seeking to obtain such approval may apply to the fire marshal. An application form for approval of a testing or training program may be obtained by contacting the fire extinguishing system contractors certification program as specified in subrule 275.1(4).

275.3(6) Work performed by a contractor subject to these rules shall be limited to areas of competence indicated by the specific certification or certifications or other training requirements met by the responsible managing employee.

275.3(7) Nothing in this rule shall be interpreted to conflict with or diminish any requirement for training or certification for anyone installing or servicing a fire extinguishing system or portable fire extinguisher set forth in any rule of the fire marshal or local fire ordinance or standard adopted by reference therein.

661—275.4(100C) Certification requirements. A fire extinguishing system contractor shall meet all of the following requirements in order to receive certification from the fire marshal and shall continue to meet all requirements throughout the period of certification. The contractor shall notify the fire marshal, in writing, on a form designated by the fire marshal, within 30 calendar days if the contractor fails to meet any requirement for certification.

275.4(1) The contractor shall designate one or more responsible managing employees as provided in rule 661—275.3(100C).

275.4(2) The contractor shall maintain general and complete operations liability insurance for the layout, installation, repair, alteration, addition, maintenance, and inspection of automatic fire extinguishing systems in the following amounts: $500,000 per person, $1,000,000 per occurrence, and $1,000,000 property damage.

a. The carrier of any insurance coverage maintained to meet this requirement shall notify the fire marshal 30 days prior to the effective date of cancellation or reduction of the coverage.

b. The contractor shall cease operation immediately if the insurance coverage required by this subrule is no longer in force and other insurance coverage meeting the requirements of this subrule is not in force. A contractor shall not initiate any installation of a fire extinguishing system which cannot reasonably be expected to be completed prior to the effective date of the cancellation of the insurance coverage required by this subrule and of which the contractor has received notice, unless new insurance coverage meeting the requirements of this subrule has been obtained and will be in force upon cancellation of the prior coverage.

275.4(3) The contractor shall maintain current registration as a contractor with the labor services division of the Iowa workforce development department in compliance with Iowa Code chapter 91C and 875—Chapter 150, Iowa Administrative Code.

EXCEPTION: A contractor shall not be required to maintain registration with the labor services division of the Iowa workforce development department if the contractor does not meet the definition of "contractor" for purposes of Iowa Code chapter 91C and 875—Chapter 150, Iowa Administrative Code.

275.4(4) The contractor shall maintain compliance with all other applicable provisions of law related to operation in the state of Iowa and of any political subdivision in which the contractor is performing work.

661—275.5(100C) Application and fees.

275.5(1) *Application.* Any contractor seeking certification as a fire extinguishing system contractor shall submit a completed application form to the fire marshal. The application shall be filed no later than 30 days prior to the date on which certification is required or on which an existing certification expires. An application form may be obtained from the fire marshal or from the Web site of the fire extinguishing system contractors certification program. The application form shall be submitted with all required

attachments and the required application fee established in subrule 275.5(2). An application shall not be considered complete unless all required information is submitted, including required attachments and fees, and shall not be processed until it is complete.

NOTE: The Web site for the fire extinguishing system contractors certification program is: http://www.dps.state.ia.us/fm/fesccp/index.shtml.

275.5(2) *Certification fee.* The certification fee shall be $500 per year. If an application is denied, all except $100 of the fee may be refunded if the applicant applies to the fire marshal for a refund. No refund of the certification fee shall be made if the certification is revoked or if the denial of the certification is based on the applicant's knowingly including false or misleading information on the application.

If an application for certification provides for more than one responsible managing employee pursuant to rule 661—275.3(100C), there shall be an additional fee of $50 for each responsible managing employee beyond the first. If an application for certification provides for more than one endorsement as provided in subrule 275.1(2), there shall be an additional fee of $50 for each endorsement beyond the first.

EXCEPTION: If a certification is effective after April 1 and no later than June 30, the certification fee shall be $500. The certification fee for a certification which becomes effective between July 1 and September 30 shall be $400. The certification fee for a certification which becomes effective between October 1 and December 31 shall be $300. The certification fee for a certification which becomes effective between January 1 and March 31 shall be $200. If an application for certification provides for more than one responsible managing employee pursuant to rule 661—275.3(100C), there shall be an additional fee of $50 for each responsible managing employee beyond the first. If an application for certification provides for more than one endorsement as provided in subrule 275.1(2), there shall be an additional fee of $50 for each endorsement beyond the first.

275.5(3) *Payment.* The certification fee shall be submitted by draft, check, or money order in the applicable amount payable to the Fire Extinguishing System Contractors Certification Program. If the application is denied, the certification fee less $100 shall be returned to the applicant, except as provided in subrule 275.5(2).

275.5(4) *Amended certification fee.* The fee for issuance of an amended certification is $100. The fee shall be submitted with the request for an amended certification. A contractor shall request and the fire marshal shall issue an amended certificate for any of the items listed in paragraphs *"a," "b,"* and *"c"*:

a. A change in the designation of a responsible managing employee;

b. A change in insurance coverage; or

c. A change in any other material information included in or with the initial or renewal application. A change in the address of the business is a material change. However, if the request for an amended certificate is solely a change of business address, the address of the business to which the certificate being amended was sent is in an area subject to a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6, and the relocation occurs as a result of flooding or storm damage or other conditions which form a basis for the issuance of the disaster emergency proclamation, the fee shall not apply, although an amended certificate shall be issued.

d. Other changes in the information required in the application form, including renewal of insurance coverage with a new expiration date, shall be reported to the fire marshal but shall not require issuance of an amended certification or payment of the amended certification fee.

275.5(5) *Attachments.* Required attachments to the application for certification include, but are not limited to, the following:

a. Documentation verifying that the contractor has in force the insurance coverage required by subrule 275.4(2). The documentation shall include an acknowledgment that the contractor's insurance coverage extends to any work performed by the contractor within the scope of certification pursuant to this chapter. The documentation may consist of a letter from the insurance carrier or a copy of the insurance certificate with an endorsement showing the required information.

b. Documentation verifying that the person designated as the responsible managing employee and any persons designated as alternate responsible managing employees have met the applicable certification requirements.

661—275.6(100C) Complaints. Complaints regarding the performance of any certified contractor, failure of a certified contractor to meet any of the requirements established in Iowa Code chapter 100C or this chapter or any other provision of law, or operation as a fire extinguishing system contractor without certification may be filed with the fire marshal. Complaints should be addressed as follows:

Fire Extinguishing System Contractors Certification Program
Fire Marshal Division
Iowa Department of Public Safety
401 S.W. 7th Street, Suite N
Des Moines, Iowa 50309

Complaints may be submitted by electronic mail to fesccp@dps.state.ia.us or by facsimile to (515)242-6299.

Complaints should be as specific as possible and shall clearly identify the contractor against whom the complaint is filed. A form which may be used to file complaints is available on the Web site of the fire extinguishing system contractors certification program. Complaints may be filed without using the complaint form provided, but shall be submitted in writing. A complaint may be submitted anonymously, but if the name and contact information of the complainant are provided, the complainant will be notified of the disposition of the complaint.

NOTE: The Web site for the fire extinguishing system contractors certification program is: http://www.dps.state.ia.us/fm/fesccp/index.shtml.

661—275.7(100C) Denial, suspension, or revocation of certification; civil penalties; and appeals. The fire marshal may deny, suspend or revoke the certification of a contractor, or assess a civil penalty to the contractor, if any provision of these rules or any other provision of law related to operation as a fire extinguishing system contractor is violated.

275.7(1) *Denial.* The fire marshal may deny an application for certification:

a. If the applicant makes a false statement on the application form or in any other submission of information required for certification. "False statement" means providing false information or failing to include material information, such as a previous criminal conviction or action taken by another jurisdiction, when requested on the application form or otherwise in the application process.

b. If the applicant fails to meet all of the requirements for certification established in this chapter.

c. If the applicant is currently barred for cause from acting as a fire extinguishing system contractor in another jurisdiction.

d. If an applicant has previously been barred for cause from operating in another jurisdiction as a fire extinguishing system contractor and if the basis of that action reflects upon the integrity of the applicant in operating as a fire extinguishing system contractor. If an applicant is found to have been previously barred for cause from operating as a fire extinguishing system contractor in another jurisdiction and is no longer barred from doing so, the fire marshal shall evaluate the record of that action with regard to the likelihood that the applicant would operate with integrity as a certified contractor. If an applicant is denied under this provision, the applicant shall be notified of the specific reasons for the denial.

e. If the applicant has been convicted of a crime which reflects upon the integrity of the applicant in operating as a fire extinguishing system contractor. If an applicant is found to have a criminal record, the fire marshal shall evaluate that record with regard to the likelihood that the applicant would operate with integrity as a certified contractor. If an applicant is denied under this provision, the applicant shall be notified of the specific reasons for the denial.

275.7(2) *Suspension.* A suspension of a certification may be imposed by the fire marshal for any violation of these rules or Iowa Code chapter 100C or for a failure to meet any legal requirement to operate as a fire extinguishing system contractor in this state. Failure to provide any notice to the fire

marshal as provided in these rules shall be grounds for suspension. An order of suspension shall specify the length of the suspension and shall specify that correction of all conditions which were a basis for the suspension is a condition of reinstatement of the certification even after the period of the suspension.

275.7(3) *Revocation.* A revocation is a termination of a certification. A certification may be revoked by the fire marshal for repeated violations or for a violation which creates an imminent danger to the safety or health of individuals protected by a fire extinguishing system incorrectly installed by a certified contractor or when information comes to the attention of the fire marshal which, if known to the fire marshal when the application was being considered, would have resulted in denial of the certification.

A new application for certification from a contractor whose certification had previously been revoked shall not be considered for a period of one year after the effective date of the revocation and, in any event, until every condition which was a basis for the revocation has been corrected. The fire marshal may specify in the revocation order a longer period than one year before a new application for certification may be considered. When a new application for certification from a contractor whose certification was previously revoked is being considered, the applicant may be denied certification based upon the same information which was the basis for revocation even after any such period established by the fire marshal has expired.

275.7(4) *Civil penalties.* The fire marshal may impose a civil penalty of up to $500 per day during which a violation has occurred and for every day until the violation is corrected. A civil penalty may be imposed in lieu of or in addition to a suspension or may be imposed in addition to a revocation. A civil penalty shall not be imposed in lieu of a revocation.

275.7(5) *Suspension or revocation for nonpayment of child support.* The following procedures shall apply to actions taken by the department on a certificate of noncompliance received from the Iowa department of human services pursuant to Iowa Code chapter 252J:

a. The notice required by Iowa Code section 252J.8 shall be served upon the certified contractor by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the contractor may accept service personally or through authorized counsel.

b. The effective date of revocation or suspension of certification of a contractor, as specified in the notice required by Iowa Code section 252J.8, shall be 60 days following service upon the contractor.

c. Contractors shall keep the fire marshal informed of all court actions and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J and shall provide the fire marshal with copies, within 7 days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in such actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

d. All applicable fees for an application or reinstatement must be paid by the contractor before a certificate will be issued, renewed, or reinstated after the fire marshal has denied the issuance or renewal of a certification or has suspended or revoked a certification pursuant to Iowa Code chapter 252J.

e. In the event a contractor files a timely district court action following service of a notice pursuant to Iowa Code sections 252J.8 and 252J.9, the fire marshal shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed. For the purpose of determining the effective date of revocation or suspension of the certification, the department shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

f. Suspensions or revocations imposed pursuant to this subrule may not be appealed administratively within the department of public safety.

NOTE: The procedures established in subrule 275.7(5) implement the requirements of Iowa Code chapter 252J. The provisions of Iowa Code chapter 252J establish mandatory requirements for an agency which administers a certification program, such as the one established in this chapter, and provide that actions brought under these provisions are not subject to contested case procedures established in Iowa Code chapter 17A, but must be appealed directly to district court.

275.7(6) *Appeals.* Any denial, suspension, or revocation of a certification, or any civil penalty imposed upon a certified contractor under this rule, other than one imposed pursuant to subrule

275.7(5), may be appealed by the contractor within 14 days of receipt of the notice. Appeals of actions taken by the fire marshal under this rule shall be to the commissioner of public safety and shall be treated as contested cases, following the procedures established in rules 661—10.301(17A) through 661—10.332(17A).

These rules are intended to implement Iowa Code chapter 100C.

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CHAPTER 322
STATE BUILDING CODE —
MANUFACTURED HOUSING SUPPORT AND ANCHORAGE SYSTEMS

[Prior to 7/2/08, see rules 661—16.625(103A) and 661—16.626(103A)]

661—322.1 Reserved.

661—322.2(103A) Definitions. The definitions in 661—subrule 16.620(4) apply to the rules in this chapter.

661—322.3 to **322.10** Reserved.

661—322.11(103A) Support and anchorage of manufactured homes.

322.11(1) Manufactured homes shall be installed in accordance with one of the following paragraphs, as applicable:

a. Homes manufactured prior to October 20, 2008, shall be installed with support and anchorage as recommended by the manufacturer and as required by 24 CFR Part 3280, Manufactured Home Construction and Safety Standards, as published April 1, 2004; or

b. Homes manufactured on or after October 20, 2008, shall be installed in accordance with 24 CFR Part 3285, Model Manufactured Home Installation Standards, as published October 19, 2007; or

c. With a support and anchorage system designed by a licensed professional engineer; or

d. With a support and anchorage system that complies with subrules 322.11(2) and 322.11(3). This option shall apply only if the manufacturer's instructions are not available or the unit was manufactured before June 15, 1976. "The manufacturer's instructions are not available" means that the installer has requested and been unable to obtain the instructions from the manufacturer or its successor company and has requested and been unable to obtain the instructions from the building code bureau.

EXCEPTION: Minor adjustments in pier locations may be necessary to avoid utility and service lines. Additional supports may be needed to ensure that the maximum allowed distance between supports and anchors is not exceeded.

e. Only in areas subject to a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6, in compliance with subrule 322.11(4).

322.11(2) Requirements for support system installations.

a. Piers placed on foundations shall be installed and centered directly under the main frame longitudinal beams. The piers should not be farther apart than 10 feet on centers for manufactured homes 12 feet wide or less and not more than 8 feet on centers for manufactured homes over 12 feet wide to less than 16 feet wide and no more than 6 feet on centers for manufactured homes 16 feet wide or more. The main frame, front or back, should not extend farther than 2 feet beyond the centerline of the end piers.

NOTE: When making excavations for footings and piers on private property, installers shall take precautions to ensure that no telephone, electrical, plumbing or water lines are contacted. Utility line locations shall be verified with the property owner or property owner's representative.

b. Pier foundations shall be placed below the frostline on level, undisturbed soil, or on controlled fill that is free of grass and organic materials. (A small amount of sand may be of use to provide a level surface.) All pier foundations shall be set level, and piers must be installed plumb. The pier foundation shall be at least a 16″ × 16″ × 4″ solid concrete pad, precast or poured in place, or other approved material. Two nominal 4″ × 8″ × 16″ solid concrete blocks may be used provided that the joint between the blocks is parallel to the main frame longitudinal beam. Concrete used in foundations shall have a 28-day compressive strength of not less than 3,000 pounds per square inch (3,000 psi).

c. Unless otherwise directed by the owner of the site, the soil-bearing capacity of the site may be assumed to be 2,000 pounds per square foot. The acceptable construction under this subrule is based upon a soil-bearing capacity of 2,000 pounds per square foot. Sites with less soil-bearing capacity will require increased-size footings.

EXPLANATION: The permissible footing sizes and pier spacing are based upon a combined live and dead load of 65 pounds per square foot of unit. This assumes that the full snow and internal live load will not be present at the same time.

d. Piers may be constructed of concrete or undamaged nominal 8″ × 8″ × 16″ concrete blocks, open-celled or solid, placed on the pier foundation. All open-celled concrete block shall be installed with the cells of the block in a vertical position. Nominal 2″ × 8″ × 16″ or nominal 4″ × 8″ × 16″ solid concrete blocks may be utilized as needed to achieve the necessary heights of the piers for a particular installation. A nominal 2″ × 8″ × 16″ wood plate, or equivalent, shall be placed on top of each pier, unless there is at least 4 inches of solid block, with shims fitted and driven between the wood plate or solid block and the main frame longitudinal beam. The wood blocking shall not occupy more than a nominal 2 inches of vertical space, and shims shall not occupy more than 1 inch of vertical space. Shims which have a thickness of more than 3/8″ shall be hardwood.

(1) Piers up to 40 inches in height, except corner piers over three blocks high (a nominal 24″), may be of single-block construction and shall be installed transverse (right angle) to the main frame longitudinal beam.

(2) Piers over 40 inches in height but not exceeding 80 inches in height and corner piers over three blocks high shall be of double-block construction with every other course either parallel or transverse (right angle) to the main frame longitudinal beam. These piers shall be capped with a nominal 16″ × 16″ × 4″ solid concrete block or equivalent. Wood blocking and hardwood shims shall be installed accordingly.

(3) Piers over 80 inches in height shall be of reinforced concrete or of double-block construction and installed exactly according to the procedure given in subparagraph (2) above. Only celled concrete blocks shall be used (with open cells vertical) with 3/8″ diameter or larger steel reinforcing rods placed in the pier corners and all cells filled with 3,000 psi concrete. Wood blocking and shims shall be installed accordingly.

322.11(3) Requirements for anchorage systems. When instructions are not provided by the manufacturer, ties shall be attached vertically and diagonally to a system of ground anchors in a manner as illustrated in Figures 4 and 5. The minimum number of ties required are listed in Table 6–A. There shall be a diagonal tie between the ground anchors and the unit at each vertical tie. Additional diagonal ties may be required between vertical ties. The ties shall be as evenly spaced as practicable along the length of the unit with not over 8 feet open on each end.

a. Ties may be either steel cable, steel strapping, or other materials that meet the requirements of 322.11(3)*"f."* Ties are to be fastened to ground anchors and drawn tight with galvanized turnbuckles or yoke-type fasteners and tensioning devices. Turnbuckles shall be ended with jaws of forged or welded eyes (hook ends are not approved).

b. When continuous straps (over-the-top tie-downs) are provided as vertical ties, they should be positioned at rafters and studs to prevent structural damage. Where a vertical tie and diagonal tie are located at the same place, both ties may be connected to a single doublehead ground anchor provided that the anchor used is capable of carrying the combined loads and the anchor is included on a list of approved products maintained by the commissioner.

c. Cable used for ties shall be either galvanized steel or stainless steel and shall have a breaking strength of at least 4,725 pounds. Cable should be either 7/32″ diameter or greater (7 × 7) steel cable or ¼″ diameter or greater (7 × 19) aircraft cable. All cable ends should be secured with at least two I-bolt-type cable clamps or other nationally approved fastening devices.

d. When flat steel straps are used as ties, they shall be type 1, class B, grade 1, 1¼″ wide and 0.035″ thick, conforming with federal standard QQ-S-781-F, with a breaking strength of at least 4,725 pounds. Zinc coating (weather protection) shall be a minimum of 0.30 ounces per square foot of surface. Steel strap ties shall terminate with D-rings, bolts, or other nationally approved fastening devices that will not cause distortion or reduce the breaking strength of the ties.

e. The direction of pull of the diagonal ties should be at a right angle to the main frame longitudinal beam. Connection of the diagonal tie to the main frame longitudinal beam should be in accordance with anchor system instructions for those fastening devices. When steel strap ties are used,

care should be exercised that the minimum bending radius is adhered to so the breaking strength is not reduced.

f. The anchorage materials shall be capable of resisting an allowable minimum working load of 3,150 pounds (pullout in a vertical direction) with no more than 2 percent elongation and shall withstand a 50 percent overload. All anchorage materials shall be resistant to weathering deterioration at least equivalent to that provided by a coating of zinc on steel strapping of not less than 0.30 ounces per square foot surface coated. Anchors to reinforced concrete slab or to rock shall be of comparable strength as provided within this paragraph.

Each ground anchor, when installed, shall be capable of resisting an allowable working load at least equal to 3,150 pounds in the direction of the ties plus a 50 percent overload (4,750 pounds total) without failure. Failure shall be considered to have occurred when the point of connection between the tie and anchor moves more than 2 inches at 4,750 pounds in the direction of the vertical tie when anchoring equipment is installed in accordance with the anchorage manufacturer's instructions. Those ground anchors which are designed to be installed so that the loads on the anchor are other than direct withdrawal shall be designed and installed to resist an applied design load of 3,150 pounds at 45° from horizontal without displacing the anchor more than 4 inches horizontally at the point where the tie attaches to the anchor.

Anchors designed for connection of multiple ties shall be capable of resisting the combined working load and overload consistent with the intent expressed in this paragraph.

g. Ground anchors shall be installed so that the load-carrying portion of the anchor in its final working position is below the frost depth (42 inches), and the anchor head shall be at ground level. Total anchor length shall be more than 42 inches as necessary.

NOTE: When installing ground anchors on private property, installers shall take precautions to ensure that no telephone, electrical, plumbing or water lines are contacted. Utility line locations shall be verified with the property owner or property owner's representative.

TABLE 6–A
MINIMUM NUMBER OF TIEDOWNS
REQUIRED FOR SINGLEWIDE MOBILE HOMES

MOBILE HOME BOX LENGTH NOT EXCEEDING	MINIMUM NUMBER OF TIEDOWNS PER SIDE	
	DIAGONAL TIES	VERTICAL TIES*
40′–0″	3	2
54′–0″	3	2
73′–0″	4	2
84′–0″	5	2

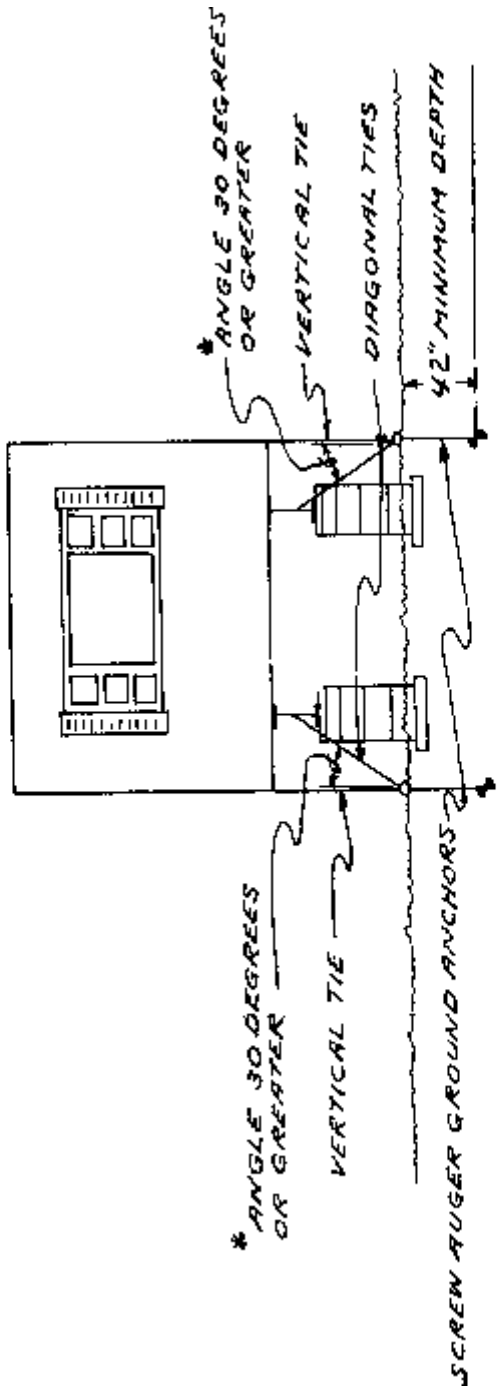
*If more than the minimum number of vertical or diagonal ties have been supplied, they shall all be used.

NOTES:

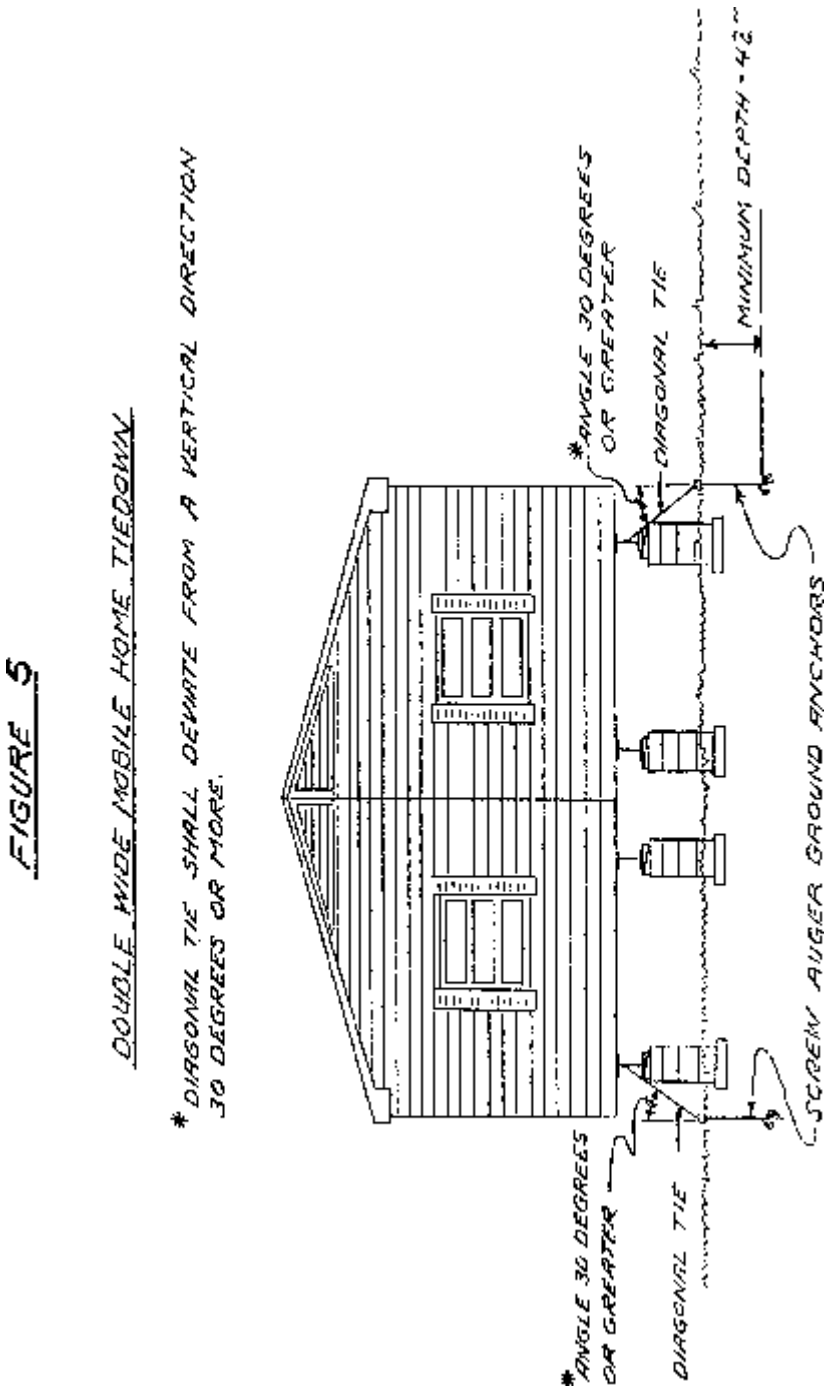
1. Doublewide mobile homes shall comply with Table 6–A except that no vertical ties are required.
2. Wherever a vertical tie and a diagonal tie lie in a plane that is vertical and transverse to the main longitudinal beam, both ties may be connected to the same ground anchor, providing that particular anchor withstands both loadings.
3. This table shall be used only if there are no manufacturer's approved installation requirements.

FIGURE 4

MOBILE HOME TIEDOWN



*DIAGONAL TIE SHALL DEVIATE FROM A VERTICAL DIRECTION 30 DEGREES OR MORE.



322.11(4) In an area subject to a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6, a manufactured home may be installed without a permanent support system provided that all of the following apply:

a. The installation complies with anchorage requirements and aboveground support requirements specified by the manufacturer or specified in subrule 322.11(3) as applicable;

b. A government agency or a third-party contractor is contractually obligated to regularly inspect the home while it is occupied and to loosen the ties or straps used in the anchoring system as needed between November 15 of each year and April 15 of the following year, in order to prevent frost heave from affecting the home, and to retighten the ties or straps on or after April 15 and prior to May 15 of the following year; and

c. The home shall be vacated within 18 months after installation without a support system which is fully compliant with subrules 322.11(1), 322.11(2), and 322.11(3). A home installed in compliance with this subrule may continue to be occupied if it has been reinstalled in compliance with the provisions of this rule that would apply in the absence of a proclaimed disaster emergency.

661—322.12(103A) Suspension of installation requirements in proclaimed disaster emergencies. The commissioner may suspend any requirement established in this chapter or 661—Chapter 16 for the installation of manufactured homes, provided that all of the following apply:

1. The installation is within an area that is currently subject to a disaster emergency proclamation issued by the governor.

2. The commissioner finds that suspension of the requirement or requirements presents no imminent threat to the health or safety of any individual and specifically of any person who may occupy a manufactured home installed while the suspension is in effect.

3. Any manufactured home whose installation is subject to a suspension of any requirement shall be occupied only for the duration of the disaster emergency proclamation and for no more than 180 days after the expiration of the proclamation, or for a shorter time specified by the commissioner, unless the home has been installed or reinstalled in compliance with all requirements of this chapter and 661—Chapter 16 prior to the expiration of the period specified for suspension of the requirements.

661—322.13 to **322.19** Reserved.

661—322.20(103A) Fees.

322.20(1) All remittances of fees shall be made by check or money order payable to Iowa Department of Public Safety — Building Code Bureau. Fees shall be remitted to the Building Code Bureau, Fire Marshal Division, Iowa Department of Public Safety, 215 East 7th Street, Des Moines, Iowa 50319.

322.20(2) The following table sets out the fee schedule for the manufactured home program.

Installation Seal	$25
Installation Seal Replacement	$10
Verification Inspections Requested by Installer or Owner	No Charge
Ground Support and Anchoring System Approval	$100

These rules are intended to implement Iowa Code section 103A.9.

[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
[Filed emergency 6/25/08—published 7/16/08, effective 7/1/08]
[Filed emergency 7/8/08—published 7/30/08, effective 7/10/08]

CHAPTER 323
TEMPORARY EMERGENCY USE OF FACTORY-BUILT STRUCTURES—COMMERCIAL USE

661—323.1(103A) Temporary factory-built structures for commercial use. A factory-built structure, as defined in Iowa Code section 103A.3, may be installed and used as a temporary location for a business or commercial operation, provided that all of the following apply:

323.1(1) The installation is in an area currently subject to a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6.

EXCEPTION: If outside any area covered by a current disaster emergency proclamation, the installation is approved in writing by the building code commissioner provided that all of the other requirements of this rule are met.

323.1(2) The structure was manufactured to be installed without a permanent foundation.

323.1(3) The installation fully complies with all applicable installation requirements established by the manufacturer.

EXCEPTION: If specifications provided by the manufacturer provide for the use of both a support system and an anchoring system, a structure may be installed without a permanent support system, provided that an anchoring system is installed in compliance with specifications provided by the manufacturer and the owner or occupant ensures that straps or ties are loosened to prevent the structure from suffering damage from frost heave as needed between November 15 of any year during which it is in use and April 15 of the following year. The straps or ties must be retightened on or after April 15 and no later than May 15 of the following year.

323.1(4) The owner ensures full compliance with all maintenance requirements established by the manufacturer.

323.1(5) The structure meets all requirements of other applicable codes for the use of the structure, except that a structure installed in compliance with this rule is not required to display an Iowa seal as otherwise required by 661—subrules 16.610(21), 16.610(22), and 16.610(24).

323.1(6) The structure is not used as a private residence.

323.1(7) The structure is vacated within 18 months of installation.

323.1(8) No portion of the structure is used as an educational occupancy, unless written permission for such use has been issued by the state fire marshal and the state building code commissioner.

323.1(9) No portion of the structure is used as a health care facility or portion of a health care facility unless written permission for such use has been issued by the state fire marshal and the state building code commissioner.

This rule is intended to implement Iowa Code section 103A.9.

[Filed emergency 7/8/08—published 7/30/08, effective 7/10/08]

CHAPTERS 324 to 349
Reserved

CHAPTER 372
MANUFACTURED OR MOBILE HOME RETAILERS, MANUFACTURERS, AND DISTRIBUTORS

661—372.1(103A) Definitions. The definitions in 2006 Iowa Acts, Senate File 2394, section 1, are made part of this chapter. In addition, the following words and phrases when used in this chapter shall have these meanings respectively ascribed to them, except when the context otherwise requires.

"Bureau" means the Building Code Bureau, Fire Marshal Division, Iowa Department of Public Safety, 401 S.W. 7th Street, Suite N, Des Moines, Iowa 50309.

"Certificate of title" means a document issued by the appropriate official which contains a statement of the owner's title, the name and address of the owner, a description of the vehicle, a statement of all security interests and additional information required under the laws or rules of the jurisdiction in which the document was issued, and which is recognized as a matter of law as a document evidencing ownership of the vehicle described. The terms "title certificate," "title only," and "title" are synonymous with the term "certificate of title."

"Commissioner" means the building code commissioner.

"Department" means the Iowa department of public safety.

"Manufacturer's certificate of origin" means a certification signed by the manufacturer or importer that the manufactured or mobile home described has been transferred to the person or retailer named and that the transfer is the first transfer of the manufactured or mobile home in ordinary trade and commerce. The description shall include the make, model year, vehicle identification number, and other information which may be required by statute or rule. The terms "manufacturer's statement," "importer's statement or certificate," "MSO" and "MCO" are synonymous with the term "manufacturer's certificate of origin."

"Model year" means the year of original manufacture or the year certified by the manufacturer.

661—372.2(103A) Criteria for obtaining a manufactured or mobile home retailer's license.

372.2(1) *Licensing information.* Information concerning license requirements may be obtained from the Building Code Bureau, Fire Marshal Division, Iowa Department of Public Safety, 401 S.W. 7th Street, Suite N, Des Moines, Iowa 50309.

372.2(2) *Application.* A manufactured or mobile home retailer shall file a completed application form at least 30 days prior to the expiration of a current license or, if the application is for an initial license, 30 days prior to the date on which the retailer anticipates doing business. A retailer may not operate without a current license.

372.2(3) *Expiration.* Each license expires on January 1 of the calendar year following the year in which the license is issued, except that a license issued in December of any year shall cover the following calendar year.

372.2(4) *Fees.* The license fee established by statute is $100 annually or for any portion of a year, except that a license issued in December of any year is valid for the following calendar year and any retailer with a license valid for a particular calendar year may continue to operate under that license until the end of January of the following calendar year.

372.2(5) *Surety bond.* The applicant shall obtain a surety bond in the amount of $50,000. The original bond shall be filed with the department. The bond shall provide for a 30-day notice to the bureau, prior to cancellation. The bureau shall notify the bonding company of any violations of Iowa Code chapter 103A or these rules by the license holder. The bureau shall notify the retailer by mail or personal service that the retailer's license shall be revoked the same date the bond is canceled unless the bond is reinstated or a new bond is filed.

372.2(6) *Place of business.* The applicant shall maintain a place of business at a designated location. A manufactured or mobile home may be used as an office if the home's taxes are current. The place of business shall include telephone service and an office area in which are kept the business records, manufacturer's certificates of origin, certificates of title or other evidence of ownership of each manufactured or mobile home offered for sale.

372.2(7) *Separate place of business.* A separate retailer's license shall be obtained for each county in which the applicant maintains a place of business.

661—372.3(103A) Operation under distinct name. A manufactured or mobile home retailer shall not represent or advertise the business under any name other than the name that appears on the retailer's license.

661—372.4(103A) Supplemental statements. A manufactured or mobile home retailer shall file with the commissioner a written statement upon change of name or change of location of the retailer's place of business. The written statement shall be filed within ten days of the change with a fee of $100 in payment for a new license reflecting the change.

661—372.5(103A) Denial, suspension, or revocation—civil penalties.

372.5(1) The commissioner may deny the issuance or renewal of a license if the applicant has committed any violation of any provision of law applicable to the operation of a business required to be licensed pursuant to this chapter.

372.5(2) The commissioner may suspend or revoke a license for any violation of this chapter or of any other provision of law applicable to the operation of a business required to be licensed pursuant to this chapter.

372.5(3) The commissioner may impose a civil penalty for any violation of this chapter or of Iowa Code chapter 103A relating to the manufacture of a manufactured or mobile home. A civil penalty may be imposed in addition to a denial of the issuance or renewal of a license, a suspension of a license, or a revocation of a license. A civil penalty shall not be imposed in lieu of a denial of the issuance or renewal of a license or of a revocation of a license. A civil penalty shall not exceed $1,000 for each offense. Each violation involving a separate manufactured or mobile home, or a separate failure or refusal to allow an act to be performed or to perform an act as required by this chapter or Iowa Code chapter 103A, constitutes a separate offense. However, the maximum amount of civil penalties which may be assessed for any series of violations occurring within one year from the date of the first violation shall not exceed $1 million.

372.5(4) Suspension or revocation for nonpayment of child support. The following procedures shall apply to actions taken by the building code commissioner on a certificate of noncompliance received from the Iowa department of human services pursuant to Iowa Code chapter 252J:

a. The notice required by Iowa Code section 252J.8 shall be served upon the licensee by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the licensee may accept service personally or through authorized counsel.

b. The effective date of revocation or suspension of certification of a licensee, as specified in the notice required by Iowa Code section 252J.8, shall be 60 days following service upon the licensee.

c. Licensees shall keep the building code commissioner informed of all court actions and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J and shall provide the building code commissioner with copies, within 7 days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in such actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

d. All applicable fees for an application or reinstatement must be paid by the licensee before a license will be issued, renewed, or reinstated after the building code commissioner has denied the issuance or renewal of a license or has suspended or revoked a license pursuant to Iowa Code chapter 252J.

e. In the event a licensee files a timely district court action following service of a notice pursuant to Iowa Code sections 252J.8 and 252J.9, the building code commissioner shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed. For the purpose of determining the effective date of

revocation or suspension of the certification, the building code commissioner shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

f. Suspensions or revocations imposed pursuant to this subrule may not be appealed administratively within the department of public safety.

NOTE: The procedures established in subrule 372.5(4) implement the requirements of Iowa Code chapter 252J. The provisions of Iowa Code chapter 252J establish mandatory requirements for an agency which administers a licensure program, such as the one established in this chapter, and provide that actions brought under these provisions are not subject to contested case procedures established in Iowa Code chapter 17A, but must be appealed directly to district court.

372.5(5) Appeals. Any denial, suspension, or revocation of a certification, or any civil penalty imposed upon a licensee under this rule, other than one imposed pursuant to subrule 372.5(4), may be appealed by the licensee within 14 days of receipt of the notice. Appeals of actions taken by the building code commissioner under this rule shall be to the commissioner of public safety and shall be treated as contested cases, following the procedures established in rules 661—10.301(17A) through 661—10.332(17A).

661—372.6(103A,321) Sale or transfer of manufactured or mobile homes. The following criteria apply to the sale or transfer of manufactured or mobile homes.

372.6(1) *Retailer sales.*

a. A manufactured home, which was manufactured on or after June 15, 1976, and which is owned by a retailer, shall not be offered for sale unless the retailer has a properly assigned manufacturer's certificate of origin or a certificate of title, a seal from the United States Department of Housing and Urban Development properly attached, a data plate attached by the manufacturer, and a manufacturer's installation manual for the home, if the manual is available to the retailer. A retailer shall not sell a manufactured or mobile home owned by the retailer without delivering to the transferee a manufacturer's certificate of origin or a certificate of title duly assigned to the transferee.

b. A used manufactured or mobile home with an Iowa title assigned to the retailer shall not be reassigned by the retailer. After acquiring the used home, the retailer shall obtain a new certificate of title as required by law.

372.6(2) *Transfers.* A manufactured or mobile home not owned by a retailer may be offered for sale and sold by a retailer under the following conditions:

a. The manufactured or mobile home owner and retailer shall enter into a written listing agreement, signed by the owner or by one owner of a manufactured or mobile home owned jointly by more than one person, and signed by the retailer, which shall be dated and include the following provisions:

(1) The make, model year, and vehicle identification number.

(2) The period of time that the agreement shall remain in force.

(3) The commission or other remuneration that the retailer is entitled to receive.

(4) The price for which the manufactured or mobile home shall be sold.

(5) The name and address of the secured party, if the manufactured or mobile home is subject to a security interest.

(6) Any additional terms to which the owner(s) and retailer agree.

b. If current taxes have not been paid, the taxes and penalties shall be paid from the proceeds of the sale.

c. The retailer shall inform a prospective purchaser of a manufactured or mobile home that the home is not owned by the retailer and, if requested by a prospective purchaser, provide the name and address of the owner(s).

d. An offer to purchase a manufactured or mobile home shall be in writing.

e. The retailer shall make a written disclosure to the purchaser of the description of the manufactured or mobile home; the name and address of the owner; if the home is subject to a security interest, the name and address of the secured party; and, if the current taxes have not been paid, the amount of taxes and penalties due. The disclosure statement shall be signed and dated by the transferee.

The disclosure statement shall be in duplicate. The original shall be given to the transferee and the duplicate retained by the retailer, at the retailer's principal place of business, for a period of three years.

f. The documents required pursuant to this subrule shall be made available to the commissioner or any designee of the commissioner for inspection upon request.

661—372.7(103A) Right of inspection. The commissioner or any designee of the commissioner shall have the authority to inspect manufactured or mobile homes, business records, manufacturer's certificates of origin, certificates of title or other evidence of ownership of each manufactured or mobile home offered for sale.

661—372.8(103A) Criteria for obtaining a manufactured or mobile home manufacturer's or distributor's license. Information concerning license requirements may be obtained from the Building Code Bureau, Fire Marshal Division, Iowa Department of Public Safety, 401 S.W. 7th Street, Suite N, Des Moines, Iowa 50309.

372.8(1) *Application.* A manufactured or mobile home manufacturer or distributor shall file a completed application form at least 30 days prior to the expiration of a current license, or if the application is for an initial license, 30 days prior to the date on which the manufacturer or distributor anticipates doing business. A manufacturer or distributor may not operate without a current license.

372.8(2) *Expiration.* Each license expires on January 1 of the calendar year following the year in which it is issued, except that a license issued in December of any year shall cover the following calendar year.

372.8(3) *Fees.* The license fee established by statute is $100 annually or for any portion of a year, except that a license issued in December of any year is valid for the following calendar year and any manufacturer or distributor with a license valid for a particular calendar year may continue to operate under that license until the end of January of the following calendar year.

372.8(4) *Notification.* Manufactured or mobile home manufacturers and distributors shall, within ten days of the fact, notify the bureau in writing of:

a. Any change in the name, method of doing business or location of the place of business as shown on the license and shall include a fee of $100 in payment of a new license reflecting the change. However, a change in the location of the place of business when the original location is in an area subject to a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6 and when the relocation results from flooding, storm damage, or other conditions which form a basis for issuance of the disaster emergency proclamation shall not require the issuance of a new license. In these circumstances, an amended license shall be furnished to the licensee at no charge to the licensee.

b. Issuance of a contract with a person in this state to sell new manufactured or mobile homes at retail.

c. Any change in the trade names of manufactured or mobile homes being manufactured for delivery in this state.

372.8(5) *Required acts.* Manufactured or mobile home manufacturers and distributors shall furnish sample manufacturer's certificates of origin to the commissioner for each make of manufactured or mobile home assembled by the manufacturer for delivery in this state.

661—372.9(17A,103A) Waivers. Applications for waivers of the provisions of the rules in this chapter may be submitted and shall be considered under the procedures and criteria established in rule 661—10.222(17A), except for the following:

1. Petitions for waivers shall be addressed to:

Building Code Commissioner
Fire Marshal Division
Iowa Department of Public Safety
401 S.W. 7th Street, Suite N
Des Moines, Iowa 50309

2. Consideration of and determinations regarding requests for waivers of any provision of this chapter shall be the responsibility of the building code commissioner. Any reference to "department" in rule 661—10.222(17A) shall be replaced, for purposes of this rule, with "building code commissioner."

These rules are intended to implement Iowa Code chapter 103A as amended by 2006 Iowa Acts, Senate File 2394.

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SECRETARY OF STATE[721]

DIVISION I
ADMINISTRATION

CHAPTER 1
DESCRIPTION OF ORGANIZATION

1.1(17A)	Central organization
1.2(17A)	Corporations
1.3(17A)	Uniform Commercial Code
1.4(17A)	Elections
1.5(17A)	Land office
1.6(17A)	Notaries public
1.7(17A)	Legislative division—enrolled bills
1.8(17A)	Process agent
1.9(17A)	Oaths and bonds
1.10(17A)	Joint governmental agreements
1.11	Reserved
1.12(17A)	Judiciary

CHAPTER 2
RULES OF PRACTICE

2.1(17A)	Forms used
2.2(17A)	Filing complaints
2.3(17A)	Payment for services
2.4(17A)	Examination and preservation of records
2.5(17A)	Telecopier service

CHAPTER 3
ADMINISTRATIVE HEARINGS

3.1(17A)	Scope
3.2(17A)	Definitions
3.3(17A)	General information
3.4(17A)	Commencing the contested case
3.5(17A)	Notice of hearing
3.6(17A)	Contested case hearing procedures
3.7(17A)	Presiding officer
3.8(17A)	Decisions
3.9(17A)	Request for rehearing
3.10(17A)	Judicial review

CHAPTER 4
FORMS

4.1(17A)	Forms and instructions
4.2(17A)	Corporation forms
4.3(17A)	Election forms
4.4(17A)	Uniform Commercial Code forms
4.5(17A)	Verified lien statement forms
4.6(9A,17A)	Athlete agent

CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

5.1(17A,22)	Definitions
5.3(17A,22)	Requests for access to records
5.6(17A,22)	Procedure by which additions, dissents, or objections may be entered into certain records
5.9(17A,22)	Disclosures without the consent of the subject
5.10(17A,22)	Routine use
5.11(17A,22)	Consensual disclosure of confidential records
5.12(17A,22)	Release to subject
5.13(17A,22)	Availability of records
5.14(17A,22)	Personally identifiable information
5.15(17A,22)	Personnel files
5.16(17A,22)	Other groups of records

CHAPTER 6
Reserved

CHAPTER 7
AGENCY PROCEDURE FOR RULE MAKING

7.1(17A)	Applicability
7.2(17A)	Advice on possible rules before notice of proposed rule adoption
7.3(17A)	Public rule-making docket
7.4(17A)	Notice of proposed rule making
7.5(17A)	Public participation
7.6(17A)	Regulatory analysis
7.7(17A,25B)	Fiscal impact statement
7.8(17A)	Time and manner of rule adoption
7.9(17A)	Variance between adopted rule and published notice of proposed rule adoption
7.10(17A)	Exemptions from public rule-making procedures
7.11(17A)	Concise statement of reasons
7.12(17A)	Contents, style, and form of rule
7.13(17A)	Agency rule-making record
7.14(17A)	Filing of rules
7.15(17A)	Effectiveness of rules prior to publication
7.16(17A)	General statements of policy
7.17(17A)	Review by agency of rules

CHAPTER 8
PETITIONS FOR RULE MAKING

8.1(17A)	Petition for rule making
8.2(17A)	Briefs
8.3(17A)	Inquiries
8.4(17A)	Agency consideration

CHAPTER 9
DECLARATORY ORDERS

9.1(17A)	Petition for declaratory order
9.2(17A)	Notice of petition
9.3(17A)	Intervention
9.4(17A)	Briefs

9.5(17A) Inquiries
9.6(17A) Service and filing of petitions and other papers
9.7(17A) Consideration
9.8(17A) Action on petition
9.9(17A) Refusal to issue order
9.10(17A) Contents of declaratory order—effective date
9.11(17A) Copies of orders
9.12(17A) Effect of a declaratory order

CHAPTER 10
WAIVER AND VARIANCE RULES

10.1(17A) Definition
10.2(17A) Scope of chapter
10.3(17A) Applicability
10.4(17A) Criteria for waiver or variance
10.5(17A) Filing of petition
10.6(17A) Content of petition
10.7(17A) Additional information
10.8(17A) Notice
10.9(17A) Hearing procedures
10.10(17A) Ruling
10.11(17A) Public availability
10.12(17A) Summary reports
10.13(17A) Cancellation of a waiver
10.14(17A) Violations
10.15(17A) Defense
10.16(17A) Judicial review

CHAPTERS 11 to 19
Reserved

DIVISION II
ELECTIONS

CHAPTER 20
DEPUTY COMMISSIONERS OF ELECTIONS

20.1(47) Deputy secretary of state and deputy county auditor to act
20.2(47) County commissioner of elections may appoint special deputies

CHAPTER 21
ELECTION FORMS AND INSTRUCTIONS

DIVISION I
GENERAL ADMINISTRATIVE PROCEDURES

21.1(47) Emergency election procedures
21.2(47) Facsimile documents
21.3(49,48A) Voter identification documents
21.4(49) Changes of address at the polls
21.5(49) Eligibility declarations in the election register
21.6(43,50) Turnout reports
21.7(48A) Election day registration
21.8(48A) Notice to election day registrant
21.9(49) “Vote here” signs
21.10(43) Application for status as a political party
21.11 to 21.19 Reserved

21.20(62) Election contest costs
21.21(62) Limitations
21.22 to 21.24 Reserved
21.25(50) Administrative recounts
21.26 to 21.29 Reserved
21.30(49) Inclusion of annexed territory in city reprecincting and redistricting plans
21.31 to 21.49 Reserved
21.50(49) Polling place accessibility standards
21.51 to 21.74 Reserved
21.75(49) Voting centers for certain elections
21.76 to 21.199 Reserved

DIVISION II
BALLOT PREPARATION

21.200(49) Constitutional amendments and public measures
21.201(44) Competing nominations by nonparty political organizations
21.202 to 21.299 Reserved

DIVISION III
ABSENTEE VOTING

21.300(53) Satellite absentee voting stations
21.301(53) Absentee ballot requests from voters whose registration records are inactive
21.302(48A) In-person absentee registration
21.303(53) Mailing absentee ballots
21.304 to 21.350 Reserved
21.351(53) Receiving absentee ballots
21.352(53) Review of returned affidavit envelopes
21.353(53) Opening the return carrier envelopes
21.354(53) Review process
21.355(53) Notice to voter
21.356 to 21.358 Reserved
21.359(53) Processing absentee ballots before election day
21.360(53) Failure to affix postmark date
21.361(53) Rejection of absentee ballot
21.362 to 21.399 Reserved

DIVISION IV
INSTRUCTIONS FOR SPECIFIC ELECTIONS

21.400(376) Signature requirements for certain cities
21.401(376) Signature requirements in cities with primary or runoff election provisions
21.402(372) Filing deadline for charter commission appointment petition
21.403(81GA,HF2282) Special elections to fill vacancies in elective city offices for cities that may be required to conduct primary elections
21.404(81GA,HF2282) Special elections to fill vacancies in elective city offices for cities without primary election requirements
21.405 to 21.499 Reserved
21.500(277) Signature requirements for school director candidates
21.501 to 21.599 Reserved
21.600(43) Primary election signatures—plan three supervisor candidates
21.601(43) Plan III supervisor district candidate signatures after a change in the number of supervisors
21.602(43) Primary election—nominations by write-in votes for certain offices
21.603 to 21.799 Reserved
21.800(422B) Local sales and services tax elections

21.801(422B) Form of ballot for local option tax elections
21.802(422B) Local vehicle tax elections
21.803(82GA,HF2663) Revenue purpose statement ballots
21.804 to 21.809 Reserved
21.810(34A) Referendum on enhanced 911 emergency telephone communication system funding
21.811 to 21.819 Reserved
21.820(99F) Gambling elections
21.821 to 21.829 Reserved
21.830(357E) Benefited recreational lake district elections

CHAPTER 22
VOTING SYSTEMS

TESTING AND EXAMINATION OF VOTING EQUIPMENT

22.1(52) Definitions for certification of voting equipment
22.2(52) Voting system standards
22.3(52) Examiners
22.4(52) Fees and expenses paid to the examiners
22.5(52) Examination of voting equipment—application
22.6(52) Review of application by examiners
22.7(52) Consultant
22.8(52) Contact other users
22.9(52) Testing the equipment
22.10(52) Test primary election for three political parties
22.11(52) Test general election
22.12(52) Report of findings
22.13(52) Notification
22.14(52) Denial of certification
22.15(52) Application for reconsideration
22.16(52) Appeal
22.17(52) Reexamination following changes in equipment
22.18(52) Rescinding certification
22.19(52) Examination of voting booths—application
22.20(52) Review of application by examiners
22.21(52) Contact other users
22.22(52) Criteria for approval
22.23(52) Report
22.24(52) Notification
22.25(52) Denial of certification
22.26(52) Application for reconsideration
22.27(52) Appeal
22.28(52) Reexamination following changes in voting booth
22.29(52) Rescinding certification
22.30(50,52) Electronic transmission of election results
22.31(52) Acceptance testing
22.32(52) Optical scan voting system purchase program
22.33 to 22.38 Reserved
22.39(52) Public testing for direct recording electronic voting machines
22.40 Reserved
22.41(52) Testing of optical scan systems
22.42(52) Preparing test decks
22.43(52) Public testing of optical scan systems

22.44 to 22.49 Reserved
22.50(52) Voting system security
22.51(52) Memory cards
22.52(52) Voting equipment malfunction at the polls
22.53 to 22.99 Reserved

OPTICAL SCAN VOTING SYSTEMS

22.100(52) Optical scan ballots, automatic tabulating equipment, and absentee voting
22.101(52) Definitions
22.102(52) Optical scan ballots
22.103 to 22.199 Reserved

PRECINCT COUNT SYSTEMS

22.200(52) Security
22.201(52) Programming and testing the tabulating devices for precinct count systems
22.202 to 22.220 Reserved
22.221(52) Sample ballots and instructions to voters
22.222 to 22.230 Reserved
22.231(52) Emergency ballot box or bin
22.232(52) Manner of voting
22.233 to 22.239 Reserved
22.240(52) Results
22.241(52) Electronic transmission of election results
22.242 to 22.249 Reserved
22.250(52) Absentee voting instructions
22.251 to 22.259 Reserved
22.260(52) Specific precinct count systems
22.261(52) Election Systems & Software Model 100—preparation and use in elections
22.262(52) Diebold Election Systems' AccuVote-OS precinct count device
22.263 to 22.339 Reserved

OPTICAL SCAN VOTING SYSTEM USED FOR ABSENTEE AND SPECIAL VOTERS PRECINCT

22.340(52) Processing
22.341(52) Reporting results from absentee ballots and provisional ballots
22.342(52) Tally list for absentee and special voters precinct
22.343 to 22.349 Reserved
22.350(52) Election Systems & Software models
22.351(52) Diebold Election Systems' AccuVote-OS central count process
22.352 to 22.430 Reserved

VOTING MACHINES

22.431(52) Temporary use of printed ballots in voting machine precincts
22.432(52) Abandoned ballots
22.433(52) Prohibited uses for direct recording electronic voting machines
22.434(52) Audio ballot preparation
22.435 to 22.462 Reserved
22.463(52) Election Systems & Software iVotronic
22.464(52) Diebold Election Systems AccuVote TSX DRE
22.465 to 22.499 Reserved
22.500(52) Blended systems

CHAPTER 23
VOTER REGISTRATION IN STATE AGENCIES

23.1(48A) Definitions
23.2(48A) Registration forms

23.3(48A) Declination forms
23.4(48A) Electronic declination records
23.5(48A) Retention and storage of declination forms
23.6(48A) Distribution of voter registration forms
23.7(48A) Applications, recertifications, renewals and changes of address received from applicant representatives
23.8(48A) Recertification and renewal applications
23.9(48A) Change of address notices
23.10(48A) Ineligible applicants
23.11(48A) Other voter registration agencies

CHAPTER 24
UNOFFICIAL CANVASS OF VOTES

24.1(47) Unofficial canvass
24.2(47) Duties of the county commissioner of elections
24.3(47) Duties of the state commissioner of elections

CHAPTER 25
ELECTION ADMINISTRATION—ADMINISTRATIVE COMPLAINT PROCEDURE

25.1(17A,39A,47) General provisions
25.2(17A,39A,47) Form of complaint
25.3(17A,39A,47) Filing, service, and initial review of complaint
25.4(17A,39A,47) Notice of proceedings
25.5(17A,39A,47) Informal settlement
25.6(17A,39A,47) Answer
25.7(17A,39A,47) Presiding officer
25.8(17A,39A,47) Proceedings based upon written submissions
25.9(17A,39A,47) Written decisions, available remedies
25.10(17A,39A,47) Hearings
25.11(17A,39A,47) Time requirements
25.12(17A,39A,47) Waiver of procedures
25.13(17A,39A,47) Telephone and electronic proceedings
25.14(17A,39A,47) Disqualification
25.15(17A,39A,47) Consolidation—severance
25.16(17A,39A,47) Service and filing of pleadings and other papers
25.17(17A) Discovery
25.18(17A) Issuance of subpoenas in a complaint proceeding
25.19(17A) Motions
25.20(17A) Continuances
25.21(17A) Withdrawals
25.22(17A) Intervention
25.23(17A) Hearing procedures
25.24(17A) Evidence
25.25(17A) Default
25.26(17A) Ex parte communication
25.27(17A) Recording costs
25.28(17A) Final decisions, publication and party notification
25.29(17A) Interlocutory appeals
25.30(17A) Appeals and review
25.31(17A) Applications for rehearing
25.32(17A) Stays of orders
25.33(17A) No factual dispute complaint proceedings

25.34(17A) Alternate dispute resolution
25.35(17A) Judicial review

CHAPTER 26
COUNTING VOTES

PART I—GENERAL PROVISIONS

26.1(49) Definitions
26.2(49) Counting votes on election day
26.3(50) Reporting overvotes and undervotes
26.4(50) Absentee and special voters precinct
26.5 to 26.9 Reserved

PART II—OPTICAL SCAN VOTING SYSTEMS

26.10(50) Systems affected
26.11(50) Examples used
26.12(50) Wrong ballots
26.13(50) Ballot properly marked by the voter
26.14(50) Ballots with identifying marks
26.15(49) Voter's choice
26.16(49) Determination of voter's choice
26.17(49) Marks not counted
26.18(49) Acceptable marks
26.19(49) Counting straight party or organization votes
26.20(49) Write-in votes
26.21(49) Corrections by voter
26.22 to 26.49 Reserved

PART III—PAPER BALLOTS

26.50(49) Standards
26.51(49) Write-in votes
26.52 to 26.59 Reserved

PART IV—VOTING MACHINES

26.60(49) Abandoned ballots
26.61(49) Counting emergency paper ballots
26.62 to 26.99 Reserved

PART V—RECOUNTS

26.100(50) Requester
26.101(50) Recounts for candidates who run as a team
26.102(50) Bond
26.103(50) Recount board
26.104(50) Responsibilities of the recount board
26.105(50) Duties of commissioner and commissioner's staff
26.106(50) Access to meeting
26.107(50) Report of the recount board

CHAPTER 27
HELP AMERICA VOTE ACT GRANTS

27.1(47,80GA,SF2298) Purpose
27.2(47,80GA,SF2298) Definitions
27.3(47,80GA,SF2298) Eligibility and requirements
27.4(47,80GA,SF2298) Application process
27.5(47,80GA,SF2298) Application contents
27.6(47,80GA,SF2298) Application review

27.7(47,80GA,SF2298) Award process
27.8(47,80GA,SF2298) Reports
27.9(47,80GA,SF2298) Access to records

CHAPTER 28
VOTER REGISTRATION FILE (I-VOTERS) MANAGEMENT
28.1(47,48A) State registrar's responsibility
28.2(48A) Access and fees
28.3(48A) Duplicate and multiple voter registration record deletion process
28.4(48A) Cancellations and restorations of voter registration due to felony conviction

CHAPTER 29
Reserved

DIVISION III
UNIFORM COMMERCIAL CODE

CHAPTER 30
UNIFORM COMMERCIAL CODE
30.1(554) General provisions
30.2(554) Acceptance and refusal of documents
30.3(554) UCC information management system
30.4(554) Filing and data entry procedures
30.5(554) Search requests and reports
30.6(554) Other notices of liens

CHAPTER 31
REGISTRATION OF POSTSECONDARY SCHOOLS
31.1(80GA,HF2559) Postsecondary registration fees

CHAPTERS 32 to 39
Reserved

DIVISION IV
CORPORATIONS

CHAPTER 40
CORPORATIONS
40.1(490,499,504A) Filing of documents
40.2(490,499,504A) Reinstatement of corporations
40.3(487,490,504A) Names distinguishable upon corporate records
40.4(490,491,496C,497,498,499,504A) Payment and refund of fees
40.5(491,496A,499,504A,548) Document to county recorder
40.6(548) Registration and protection of marks
40.7(80GA,SF2274) Revised nonprofit corporation Act fees

CHAPTER 41
Reserved

CHAPTER 42
ATHLETE AGENT REGISTRATION
42.1(9A,17A) Fees
42.2(9A,17A) Surety bond
42.3(9A,17A) Agent contract
42.4(9A,17A) General information

CHAPTER 43
NOTARIAL ACTS

43.1(9E) Certificate of notarial acts
43.2(9E) Short forms
43.3(9E) Notarial acts in other jurisdictions of the United States
43.4(9E) Notarial acts under federal authority
43.5(9E) Foreign notarial acts

CHAPTER 21
ELECTION FORMS AND INSTRUCTIONS

[Prior to 7/13/88, see Secretary of State(750), Ch 11]

DIVISION I
GENERAL ADMINISTRATIVE PROCEDURES

721—21.1(47) Emergency election procedures. The state commissioner of elections may exercise emergency powers over any election being held in a district in which either a natural or other disaster or extremely inclement weather has occurred. The state commissioner may also exercise emergency powers during an armed conflict involving United States armed forces, or mobilization of those forces, or if an election contest court finds that there were errors in the conduct of an election making it impossible to determine the result.

21.1(1) *Definitions.*

"Commissioner" means the county commissioner of elections.

"Election contest court" means any of the courts specified in Iowa Code sections 57.1, 58.4, 61.1, 62.1 and 376.10.

"Extremely inclement weather" means a natural occurrence, such as a rainstorm, windstorm, ice storm, blizzard, tornado or other weather conditions, which makes travel extremely dangerous or which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"Natural disaster" means a natural occurrence, such as a fire, flood, blizzard, earthquake, tornado, windstorm, ice storm, or other events, which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"Other disaster" means an occurrence caused by machines or people, such as fire, hazardous substance or nuclear power plant accident or incident, which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"State commissioner" means the state commissioner of elections.

21.1(2) *Notice of natural or other disaster or extremely inclement weather.* The county commissioner of elections, or the commissioner's designee, may notify the state commissioner of elections that due to a natural or other disaster or extremely inclement weather an election cannot safely be conducted in the time or place for which the election is scheduled to be held. If the commissioner or the commissioner's designee is unable to transmit notice of the hazardous conditions, the notice may be given by any elected county official. Verification of the commissioner's agreement with the severity of the conditions and the danger to the election process shall be transmitted to the state commissioner as soon as possible. Notice may be given by telephone or by facsimile machine, but a signed notice shall also be delivered to the state commissioner.

21.1(3) *Declaration of emergency due to natural or other disaster or extremely inclement weather.* After receiving notice of hazardous conditions, the state commissioner of elections, or the state commissioner's designee, may declare that an emergency exists in the affected precinct or precincts. A copy of the declaration of the emergency shall be provided to the commissioner.

21.1(4) *Emergency modifications to conduct of elections.* When the state commissioner of elections has declared that an emergency exists due to a natural or other disaster or to extremely inclement weather, the county commissioner of elections, or the commissioner's designee, shall consult with the state commissioner to develop a plan to conduct the election under the emergency conditions. All modifications to the usual method for conducting elections shall be approved in advance by the state commissioner unless prior approval is impossible to obtain.

Modifications may be made to the method for conducting the election including relocation of the polling place, postponement of the hour of opening the polls, postponement of the date of the election if no candidates for federal offices are on the ballot, reduction in the number of precinct election officials in nonpartisan elections, or other reasonable and prudent modifications that will permit the election to be conducted.

21.1(5) *Relocation of polling place.* The substitute polling place shall be as close as possible to the usual polling place and shall be within the same precinct if possible. Preference shall be given to buildings which are accessible to the elderly and disabled. Buildings supported by taxation shall be made available without charge by the authorities responsible for their administration. If it is necessary, more than one precinct may be located in the same room.

A notice of the location of the substitute polling place shall be posted on the door of the former polling place not later than one hour before the scheduled time for opening the polls or as soon as possible. If it is unsafe or impossible to post the sign on the door of the former polling place, the notice shall be posted in some other visible place at or near the site of the former polling place. If time permits, notice of the relocation of the polling place shall be published in the same newspaper in which notice of election was published, otherwise notice of relocation may be published in any newspaper of general circulation in the political subdivision which will appear on or before election day. The commissioner shall inform all broadcast media and print news organizations serving the jurisdiction of the modifications.

21.1(6) *Postponement of election.* An election may be postponed until the following Tuesday. If the election involves more than one precinct, the postponement must include all precincts within the political subdivision. If the election is postponed, ballots shall not be reprinted to reflect the modification in the election date. The date of the close of voter registration for the election shall not be extended. Precinct election registers prepared for the original election date may be used or reprinted at the commissioner's discretion.

On the day that the postponed election is actually held all election day procedures must be repeated.

21.1(7) *Absentee voting in postponed elections.* Absentee ballots shall be delivered to voters until the date the election is actually held. Absentee ballots shall be accepted at the commissioner's office until the hour the polls close on the date the election is held. Absentee ballots which are postmarked no later than the day before the election is actually held shall be accepted if received no later than the time prescribed by the Iowa Code for the usual conduct of the election. The time shall be calculated from the date on which the election is held, not the date for which the election was originally scheduled.

21.1(8) *Special precinct board in postponed elections.* The special precinct board shall meet to consider special ballots at the times specified in Iowa Code sections 50.22 and 52.23, calculated from the date the election is held. No absentee ballots shall be counted until the date the election is held.

21.1(9) *Canvass of votes in postponed elections.* The canvass of votes shall also be rescheduled for one week following the original date.

21.1(10) *Postponements made on election day.* If the emergency is declared while the polls are open and the decision is made to postpone the election, each precinct polling place in the political subdivision shall be notified to close its doors and to halt all voting immediately. People present in the polling place who are waiting to vote shall not be given ballots or admitted to the voting machines, as appropriate. People who have received ballots shall deposit them in the ballot box; unmarked ballots may be returned to the precinct election officials.

The precinct election officials shall seal all ballots which were cast before the declaration of the emergency in secure containers. The containers shall be clearly marked as ballots from the postponed election. If it is safe to do so, the ballot containers, election register, and other election supplies shall be transported to the commissioner's office. The ballots shall be stored in a secure place. If it is unsafe to travel to the commissioner's office, the chairperson of the precinct election board shall see that the ballots and the election register are securely stored until it is safe to return them to the commissioner. If no contest is pending six months after the canvass for the election is completed, the unopened ballot containers shall be destroyed.

If voting machines or automatic tabulating equipment is used, the machines or automatic tabulating equipment shall be closed and sealed without printing the results. Before the date the election is held, the machines or automatic tabulating equipment shall be reset to zero. Any documents showing the progress of the count, including paper records required by 2007 Iowa Acts, Senate File 369, section 7, subsection 2, shall be sealed and stored. No one shall reveal the progress of the count. After six months, the envelope containing the vote totals shall be destroyed if no contest is pending.

21.1(11) *Records kept.* The state commissioner of elections shall maintain records of each emergency declaration. The records shall include the following information:

a. The county in which the emergency occurred.

b. The date and time the emergency declaration was requested.

c. The name and title of the person making the request.

d. Name and date of the election affected.

e. The jurisdiction for which the election is to be conducted (school, city, county, or other).

f. The number of precincts in the jurisdiction.

g. The number of precincts affected by the emergency.

h. The nature of the emergency, i.e., natural or other disaster, or extremely inclement weather.

i. The date or dates of the occurrence of the natural or other disaster or extremely inclement weather.

j. Conditions affecting the conduct of the election.

k. Whether the polling places may safely be opened on time.

l. Action taken: such as moving the polling place, change voting system, postpone election until the following Tuesday.

m. Method to be used to inform the public of changes made in the election procedure.

n. The signature of the state commissioner or the state commissioner's designee who was responsible for declaring the emergency.

21.1(12) *Federal elections.*

a. If an emergency occurs that will adversely affect the conduct of an election at which candidates for federal office will appear on the ballot, the election shall not be postponed or delayed. Emergency measures shall be limited to relocation of polling places, modification of the method of voting, reduction of the number of precinct election officials at a precinct and other modifications of prescribed election procedures which will enable the election to be conducted on the date and during the hours required by law.

The primary election held in June of even-numbered years and the general election held in November of even-numbered years shall not be postponed. Special elections called by the governor pursuant to Iowa Code section 69.14 shall not be postponed unless no federal office appears on the ballot.

b. If a federal or state court order or any other order extends the time established for closing the polls pursuant to Iowa Code section 49.73, any person who votes after the statutory hour for closing the polls shall vote only by casting a provisional ballot pursuant to Iowa Code section 49.81. Provisional ballots cast after the statutory hour for closing the polls shall be sealed in a separate envelope from provisional ballots cast during the statutory polling hours. The absentee and special voters precinct board shall tabulate and report the results of the two sets of provisional ballots separately.

21.1(13) *Report to state commissioner.* A report of the actions taken and recommendations for future situations shall be prepared by the commissioner and sent to the state commissioner of elections not later than one week following the canvass of the election.

21.1(14) *Military emergencies.* During an armed conflict involving the United States armed forces, or mobilization of those forces, the state commissioner of elections may order the use of facsimile transmission of absentee ballots to electors if the Federal Voting Assistance Office in the Department of Defense requests that this service be made available to personnel in military operations.

If requested by the Department of Defense, absentee ballots may be returned via facsimile transmission if the elector waives the right to a secret ballot. In addition to the affidavit required by Iowa Code section 53.13, the elector shall sign a statement in substantially the following form: "I understand that by returning this ballot by facsimile transmission my voted ballot will not be secret. I hereby waive my right to a secret ballot."

When absentee ballots are received via facsimile transmission, the person receiving the transmission shall examine the transmission to determine that all pages have been received and are legible. The person receiving a facsimile transmission shall not reveal how the elector voted.

The absentee ballot shall be sealed in an envelope marked with the elector's name. The affidavit of the elector and the application for the ballot shall be attached to the envelope. These materials shall be stored with other returned absentee ballots.

21.1(15) *Election contest emergency.* If an election contest court finds that there were errors in the conduct of an election which make it impossible to determine the result of the election, the contest court shall notify the state commissioner of elections of its finding. The state commissioner shall order a new election to be held. The election date shall be set by the state commissioner. The repeat election shall be conducted under the state commissioner's supervision.

The repeat election shall be held at the earliest possible time, but it shall not be held earlier than 14 days after the date the election was set aside. Voter registration, publication, equipment testing and other applicable deadlines shall be calculated from the date of the repeat election.

The repeat election shall be conducted under the same procedures required for the election that was set aside, except that all known errors in preparation and procedure shall be corrected. The nominations from the initial election shall be used in the repeat election unless the contest court specifically rejects the initial nomination process in its findings. Precinct election officials for the repeat election may be replaced at the discretion of the auditor.

The following materials prepared for the original election shall be used or reconstructed for the repeat election:

Ballots (showing the date of repeat election). This may be stamped on ballots printed for the original election.

Notice of election (showing the date of repeat election).

This rule is intended to implement Iowa Code section 47.1.

721—21.2(47) Facsimile documents. Certain documents may be submitted via facsimile machine.

21.2(1) *Facsimile documents accepted for filing.* Assuming that all other legal requirements are met, the following documents may be submitted by facsimile machine if presented to the appropriate filing officer as facsimiles of the original and if subrule 21.2(2) is complied with:

a. Affidavits of candidacy required by Iowa Code chapters 43, 44, 45, 161A, 260C, 277, 376, and 420.

b. Applications for absentee ballots pursuant to Iowa Code chapter 53.

c. Certificates of nomination by convention under Iowa Code chapters 43, 44 and 54.

d. Judicial declarations of candidacy required under Iowa Code chapter 46.

e. Lists of presidential electors required by Iowa Code chapters 43 and 54.

f. Notices of intent to contest elections filed under Iowa Code chapters 61, 62 and 376.

g. Objections to nomination papers filed under Iowa Code chapters 43, 44, and 277.

h. Resignation notice by elected or appointed officials filed under Iowa Code section 69.4.

i. Requests for recounts filed under Iowa Code chapters 43 and 50.

j. Withdrawal notices by candidates filed under Iowa Code chapters 43, 44, 50.46 and 277.

k. Abstracts of votes filed with the state commissioner of elections.

21.2(2) *Original documents.* The original copy of documents submitted by facsimile machine shall also be filed. The original shall be mailed to the appropriate commissioner. The envelope bearing the original document shall be postmarked not later than the last day to file the document.

a. The filing shall be void if the original of a document filed by facsimile machine is not received within seven days after the filing deadline for the original document.

b. The filing shall be void if the postmark on the envelope containing the original document is later than the filing deadline date.

c. If a filing is voided because the original of a document submitted by facsimile machine was postmarked too late or arrives too late, the person who filed the document shall be notified immediately in writing.

21.2(3) *Documents not acceptable by facsimile.* Only the original of the following documents will be accepted for filing:

a. Absentee ballots and any affidavit required to accompany an absentee ballot under Iowa Code chapter 53.

b. Nomination petitions filed under Iowa Code chapters 43, 45, 161A, 277, 280A, and 376.

This rule implements Iowa Code sections 43.6, 43.11, 43.16, 43.19, 43.21, 43.23, 43.24, 43.54, 43.56, 43.60, 43.67, 43.76, 43.78, 43.80, 43.88, 43.115, 43.116, 44.3, 44.4, 44.9, 44.16, 45.3, 45.4, 46.20, 47.1, 47.2, 50.30, 50.31, 50.32, 50.33, 50.46, 50.48, 53.2, 53.8, 53.11, 53.17, 53.21, 53.22, 53.40, 53.45, 54.5, 61.3, 62.5, 69.4, 161A.5, 260C.15, 277.4, 277.5, 376.4, 376.10, 376.11, and 420.130.

721—21.3(49,48A) Voter identification documents.

21.3(1) *Optional identification.* A precinct election official may require identification from any person whom the official does not know.

21.3(2) *Required identification.* Precinct election officials shall require identification under the following circumstances:

a. From any person offering to vote whose name does not appear on the election register as an active voter.

b. From any person whose name appears on the election register as an inactive voter.

c. From any person offering to vote whose name is not on the election register and who wants to report a change of address from one precinct to another within the same county.

d. From any person who applies to register to vote on election day pursuant to 2007 Iowa Acts, House File 653, section 2.

21.3(3) *Identification documents for persons other than election day registrants.* Unless the person is registering to vote at the polls on election day, precinct election officials shall accept the following identification documents from any person who is asked to present ID:

a. Current and valid photo identification card; or

b. A copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows the name and address of the voter.

21.3(4) *Identification for election day registrants.*

a. A person who applies to register to vote on election day shall provide proof of identity and residence in the precinct where the person is applying to register and vote.

(1) Proof of identity must be a photo ID card that is current and valid and includes an expiration date. The following forms of identification are acceptable: an Iowa driver's license or nonoperator's ID, an out-of-state driver's license or nonoperator's ID, a United States passport, a United States military identification card, an identification card issued by an employer, or a student identification card issued by an Iowa high school or an Iowa postsecondary educational institution. If the photo ID does not show the person's address in the appropriate precinct, the person must show proof of residence.

(2) Proof of residence may be any of the following documents provided that the document shows the person's name and address in the precinct: residential lease, property tax statement, utility bill, bank statement, paycheck, government check, or other government document.

b. Any registered voter who attests for another person registering to vote at the polls on election day shall be a registered voter of the same precinct. The registered voter may be a precinct election official or a pollwatcher, but may not attest for more than one person applying to register at the same election.

21.3(5) *Current and valid identification.*

a. "Current and valid" or "ID," for the purposes of this rule, means identification that meets the following criteria:

(1) The expiration date on the ID has not passed. An ID is still valid on the expiration date. An Iowa nonoperator's ID that shows "none" as the expiration date shall be considered current and valid.

(2) The ID has not been revoked or suspended.

b. A current and valid ID may include a former address.

21.3(6) *ID not provided.* A person who has been requested to provide identification and does not provide it shall vote only by provisional ballot pursuant to Iowa Code section 49.81. However, a person who is registering to vote on election day pursuant to 2007 Iowa Acts, House File 653, section 2, may

establish identity and residency in the precinct by written oath of a person who is registered to vote in the precinct.

This rule is intended to implement Iowa Code section 49.77, 2007 Iowa Acts, House File 653, section 2, and P.L. 107-252, Section 303.

721—21.4(49) Changes of address at the polls. An Iowa voter who has moved from one precinct to another in the county where the person is registered to vote may report a change of address at the polls on election day.

21.4(1) To qualify to vote in the election being held that day the voter shall:

a. Go to the polling place for the precinct where the voter lives on election day.

b. Complete a registration by mail form showing the person's current address in the precinct.

c. Present proof of identity as required by subrule 21.3(3).

21.4(2) The officials shall require a person who is reporting a change of address at the polls to cast a special ballot if the person's registration in the county cannot be verified. Registration may be verified by:

a. Telephoning the office of the county commissioner of elections, or

b. Consulting a printed list of all registered voters who are qualified to vote in the county for the election being held that day, or

c. Consulting the county's voter registration records by use of a computer.

21.4(3) In precincts where the voter's declaration of eligibility is included in the election register pursuant to rule 721—21.5(49) and Iowa Code section 49.77 as amended by 2006 Iowa Acts, House File 2050, section 3, the commissioner shall provide to each precinct one of the two following methods for recording changes of address:

a. The voter shall be provided with a form that includes both the eligibility declaration and the voter registration form. The instructions for the voter registration form shall be printed in large type on a separate sheet of paper and shall be provided to each person who completes a voter registration form at the polls. In lieu of signing in the election register, the voter who is reporting a change of address shall complete the required fields on both the eligibility declaration form and the registration form.

b. The commissioner shall provide blank lines on the election register for the precinct election officials to record the voter's name, address, and, if provided, telephone number, and, in primary elections, political party affiliation. The voter shall also complete a voter registration form showing the voter's current address.

This rule is intended to implement Iowa Code section 49.77(3).

721—21.5(49) Eligibility declarations in the election register. To compensate for the absence of a separate declaration of eligibility form, the commissioner shall provide to each precinct a voter roster with space for each person who appears at the precinct to vote to print the following information: first and last name, address, and, at the voter's option, telephone number, and, in primary elections, political party affiliation.

The roster forms shall include the name and date of the election and the name of the precinct, and may be provided on paper that makes carbonless copies. If the multicopy form is used, the commissioner shall retain the original copy of the voter roster with other records of the election.

This rule is intended to implement Iowa Code section 49.77 as amended by 2006 Iowa Acts, House File 2050, section 3.

721—21.6(43,50) Turnout reports. For all elections, the commissioner shall prepare a report of the number of people who voted. The board of supervisors shall certify the turnout at the canvass of votes.

21.6(1) This report shall provide a single number that includes the number of persons:

a. Who voted at the polls on election day,

b. Whose absentee ballots were accepted for counting, and

c. Whose provisional ballots were accepted for counting.

21.6(2) The report shall not include the number of persons whose absentee ballots or provisional ballots were not accepted for counting.

21.6(3) In primary elections, the report shall include the number of persons who voted in each political party and the total number of persons who voted in the county.

This rule is intended to implement Iowa Code sections 43.59 and 50.24.

721—21.7(48A) Election day registration. In addition to complying with the identification provisions in rule 721—21.3(49,48A), precinct election officials shall comply with the following requirements:

21.7(1) Precinct election officials shall inspect the identification documents presented by election day registrants to verify the following:

a. The photograph shows the person who is registering to vote.

b. The name on the identification document is the same as the name of the applicant.

c. The address on the identification document is in the precinct where the person is registering to vote.

21.7(2) Precinct election officials shall verify that each person who attempts to attest to the identity and residence of a person who is registering to vote on election day is a registered voter in the precinct and has not attested for any other voter in the election. The officials shall note in the "remarks" column of the election register that the person has attested for an election day registrant.

21.7(3) Precinct election officials shall permit any person who is in line to vote at the time the polls close to register and vote on election day if the person otherwise meets all of the election day registration requirements.

This rule is intended to implement 2007 Iowa Acts, House File 653.

721—21.8(48A) Notice to election day registrant. The commissioner shall send to each person who registers to vote on election day, pursuant to 2007 Iowa Acts, House File 653, section 2, an acknowledgment of the registration by nonforwardable mail. If the postal service returns the acknowledgment as undeliverable, the commissioner shall send a notice to the voter by forwardable mail. The notice shall be in substantially the following form:

Dear [name of voter],

You have registered and voted under Iowa's Election Day registration law. On [date], this office mailed an acknowledgment to you at the address you used on the voter registration form. The United States Postal Service has returned that acknowledgment to us as undeliverable.

Please return the enclosed response form no later than [date]. If we do not receive your response by [date], your voter registration record will be made inactive and we will notify the county attorney and the State Registrar of Voters.

Please note that voter registration fraud is a felony under Iowa law. Registration fraud includes submitting a voter registration application that is known by the person to be materially false, fictitious, forged, or fraudulent.

_____

County Auditor and Commissioner of Elections

Date: _____

Response Form

Please confirm your residence at:

[address on registration]

OR

Explain why the Postal Service does not deliver your mail to that address.

□ There appears to be an error in recording my address. My correct address is: _____

_____

□ I receive mail at a different address. My mailing address is: _____

_____

□ My address has changed since election day. My current address is: _____

_____

□ The Postal Service made a mistake. I do reside at [list registration address]: _____

_____

□ Other, please explain: _____

_____

_____

Signature of registrant

Date: _____

This rule is intended to implement 2007 Iowa Acts, House File 653.

721—21.9(49) "Vote here" signs.

1. Size. The signs shall be no smaller than 16 inches by 24 inches.

2. Exceptions. If a driveway leads away from the entrance to the voting area, or if the driveway is located in such a way that posting a "vote here" sign at the driveway entrance would not help potential voters find the voting area, no "vote here" sign shall be posted at the entrance to that driveway.

This rule is intended to implement Iowa Code section 49.21.

721—21.10(43) Application for status as a political party. A political organization which is not currently qualified as a political party may file an application for determination of political party status with the state commissioner of elections. The application may be filed after the completion of the executive council's canvass of votes for the general election, but not later than one year after the date of the election at which the organization's candidate for President of the United States or governor received at least 2 percent of the vote.

21.10(1) *Application form.* The application shall be in substantially the following form:

STATE OF IOWA

APPLICATION FOR POLITICAL PARTY STATUS

To the State Commissioner of Elections:

At the General Election held on November ____, _____, a candidate of the political organization named below received at least 2 percent of the total number of votes cast for the office of

□ President of the United States

□ Governor of Iowa

Pursuant to the requirements of Iowa Code section 43.2, we hereby request that the State Commissioner of Elections notify the state registrar of voters, the voter registration commission and

the 99 counties of Iowa that the political organization named below qualifies as a political party under Iowa law.

Political organization name: _____

(Please print the party name in the form it should appear on ballots, voter registration forms, and other records.)

Name of candidate for President or Governor: _____

Signed: _____
Candidate

Address: _____

_____

Telephone: _____

Signed: _____
Chairperson of Political Organization

Address: _____

_____

Telephone: _____

Date submitted: _____

Office use only:

Office of □ President of the United States
□ Governor of Iowa

Total number of votes received for office: _____

Number of votes received by applicant: _____

Percentage of total: _____

The application is □ rejected.
□ approved, effective 21 days from date of approval.

_____
Secretary of State and State Commissioner of Elections

Date: _____

21.10(2) *Response.* If the political organization meets the requirements established in Iowa Code section 43.2, the commissioner shall declare that the organization has qualified as a political party, effective 21 days after the application is approved. If the organization does not meet the requirements, the state commissioner shall immediately notify the applicant in writing of the reason for the rejection of the application.

21.10(3) *Disqualification of political party.* If at the close of nominations for the general election a political party has not nominated a candidate for the office of President of the United States, or for governor, as the case may be, the political party shall be disqualified immediately.

If the candidate of a political party for President of the United States or for governor, as the case may be, does not receive 2 percent of the votes cast for that office at a general election, the political party shall be disqualified. The effective date of the disqualification shall be the date of the completion of the state canvass of votes.

When a political party is disqualified, the state commissioner shall immediately notify the chairperson or central committee of the disqualified political party.

21.10(4) *Notice of qualification and disqualification of political parties.* The state commissioner of elections shall immediately notify the state registrar of voters, the voter registration commission, and the county commissioners of elections when a political party is qualified or disqualified. The notice shall include the name of the political party and the date upon which change in political party status becomes effective.

The state commissioner of elections shall also publish notice of the qualification or disqualification of a political party in a newspaper of general circulation in each congressional district. The publication shall be made within 30 days of the approval of an application for qualification or within 30 days of the effective date of a disqualification.

This rule is intended to implement Iowa Code sections 43.2 and 47.1.

721—21.11(44) Nonparty political organizations—nominations by petition. Rescinded IAB 9/10/97, effective 10/15/97.

721—21.12 to **21.19** Reserved.

721—21.20(62) Election contest costs. In determining the amount of the bond for election contests, the commissioner shall consider the following aspects of the cost of the election contest proceedings:

1. Fees as provided in Iowa Code section 62.22.
2. Fees for judges as provided in Iowa Code section 62.23.
3. The cost of making an official record of the proceedings.

721—21.21(62) Limitations. The amount of the bond shall not include costs not directly related to the contest court proceedings. Specifically, the amount of the bond shall not be intended to replace any potential lost income to the county caused by the delay in implementing the decision of the voters at the election being contested.

Rules 721—21.20(62) and 721—21.21(62) are intended to implement Iowa Code sections 62.6, 62.22, 62.23, and 62.24.

721—21.22 to **21.24** Reserved.

721—21.25(50) Administrative recounts. When the commissioner suspects that voting equipment used in the election malfunctioned or that programming errors may have affected the outcome of the election, the commissioner may request an administrative recount after the day of the election but not later than three days after the canvass of votes. The request shall be made in writing to the board of supervisors explaining the nature of the problem and listing the precincts to be recounted and which offices and questions shall be included in the administrative recount.

The recount shall be conducted by members of the special precinct board following the provisions of Iowa Code section 50.48 as amended by 2007 Iowa Acts, Senate File 369, section 3, Iowa Code section 50.49 and 721—Chapter 26. The recount board may use a computer program board which was not used in the election to compare with the suspected defective one.

If direct recording electronic voting machines were used in the election, the paper record required by 2007 Iowa Acts, Senate File 369, section 7, subsection 2, shall be used in the recount. However, if the commissioner believes or knows that the paper records produced from a machine have been compromised

due to damage, mischief, malfunction, or other cause, the printed ballot images produced from the internal audit log for that machine shall be the official record used in the recount. In addition to the external paper record, the internal audit log required by 2007 Iowa Acts, Senate File 369, section 7, subsection 1, paragraph *"k,"* shall be available for use in the recount and shall be used if the paper record has been compromised.

This rule is intended to implement Iowa Code section 50.48 as amended by 2007 Iowa Acts, Senate File 369, section 3, and Iowa Code section 50.49.

721—21.26 to **21.29** Reserved.

721—21.30(49) Inclusion of annexed territory in city reprecincting and redistricting plans. If a city has annexed territory after January 1 of a year ending in zero and before the completion of the redrawing of precinct and ward boundaries during a year ending in one, the city shall include the annexed land in precincts drawn pursuant to Iowa Code sections 49.3 and 49.5.

21.30(1) When the city council draws precinct and ward boundaries, if any, the city shall use the population of the annexed territory as certified by the city to the state treasurer pursuant to Iowa Code section 312.3(4).

21.30(2) When the board of supervisors, or the temporary county redistricting commission, draws precinct and county supervisor district boundaries, if any, it shall subtract from the population of the adjacent unincorporated area the population of the annexed territory as certified by the city to the state treasurer pursuant to Iowa Code section 312.3(4).

21.30(3) The use of population figures for reprecincting or redistricting shall not affect the official population of the city or the county. Only the U.S. Bureau of the Census may adjust the official population figures, by corrections or by conducting special censuses. See Iowa Code section 9F.6.

This rule is intended to implement Iowa Code sections 49.3 and 49.5.

721—21.31 to **21.49** Reserved.

721—21.50(49) Polling place accessibility standards.

21.50(1) *Inspection required.* Before any building may be designated for use as a polling place, the county commissioner of elections or the commissioner's designee shall inspect the building to determine whether it is accessible to persons with disabilities.

21.50(2) *Frequency of inspection.* Polling places that have been inspected using the Polling Place Accessibility Survey Form prescribed in subrule 21.50(4) shall be reinspected if structural changes are made to the building or if the location of the polling place inside the building is changed.

21.50(3) *Review of accessibility.* Not less than 90 days before each primary election, the commissioner shall determine whether each polling place needs to be reinspected.

21.50(4) *Standards for determining polling place accessibility.* The following survey form shall be used to evaluate polling places for accessibility to persons with disabilities.

The term "off-street parking" used in the polling place accessibility survey means parking places in lots separated from the street and includes angle parking along the street if the accessible route from the parking place to the polling place is entirely out of the path of traffic. Parking arrangements that require either the driver or passengers of the vehicle to go into the traveled part of the street are not accessible.

An access aisle at street level that is at least 60 inches wide and the same length as each accessible parking space shall be provided. An accessible public sidewalk curb ramp shall connect the access aisle to the continuous passage to the polling place. At least one parking place shall be van-accessible with a 96-inch access aisle connected to the continuous passage to the polling place by an accessible public sidewalk curb ramp. Two accessible parking spaces may share a common access aisle.

Polling Place Accessibility Survey Form

County: _____

Polling place name or number: _____

Polling place address/location:

_____

_____

_____

INSTRUCTIONS

Purpose. This form shall be used to evaluate the accessibility of polling places to persons with disabilities.

How to use this form. Inspect each potential polling place by going from the parking area to the voting area. You will need a yardstick, a tape measure and about 30 minutes.

Answer every question on the form by marking either "YES," "NO," or "N/A" (NOT APPLICABLE), as appropriate. Items on the survey with clear (unshaded) boxes are **required**. If a required item is marked "NO," the polling place is **inaccessible**. The survey questions in shaded boxes are recommended. If a recommended item is marked "NO," the polling place is **accessible, but inconvenient**, if all other responses are "YES" or "N/A."

Polling places may be inaccessible for more than one reason. Please respond to every item and summarize the responses by category on the back page.

1. Name, address, and telephone number of person(s) completing this form:

2. Date of inspection: _____

Category I: Parking	**YES**	**NO**	**N/A**
1. Are there off-street parking spaces either permanently or temporarily designated for the handicapped?			
2. Accessible off-street parking: a. Are designated parking spaces at least 13 feet wide,with at least one space van-accessible? (Parking space = 8 ft., aisle = 5 ft.; van-accessible parking space = 8 ft., aisle = 8 ft.)			
b. Are parking spaces on level ground (with a slope no greater than a rise of 1 foot in 50 feet)?			
c. Is the parking area surface stable, firm, and slip-resistant (concrete, asphalt, etc.)?			
d. Are the parking places within a reasonable travel distance (200 feet maximum) from the building?			

Category I: Parking	**YES**	**NO**	**N/A**
e. Is there a curb cut to connect these parking spaces to an accessible walk or to the building entrance?			
f. Are these parking spaces designated by post-mounted signs bearing the symbol of accessibility? (Signs should be high enough to be seen even when a vehicle is parked in the space.)			
3. Is there a relatively level passenger drop-off zone at least 4 feet wide with a curb cut connecting it to an accessible walk or to the building entrance?			

End of Category I

Please go to next category ⇨

Category II: Walkways or pathways to the building	**YES**	**NO**	**N/A**
1. Is the surface of the walkway or pathway to the building stable, firm, and slip-resistant (concrete, asphalt, etc.)?			
2. Is the walkway or pathway to the building at least 48 inches wide?			
3. Are all curbs along the pathway to the building cut or ramped with at least 36 inches clear width and with slopes of no more than a 1-inch rise in 12 inches?			
4. Are all stairs or steps along the walkway or pathway to the building either ramped (with a slope of no more than a 1-foot rise in 20 feet) or else provided with a suitable alternative means of access?			
5. Do stairsteps along the walkway or pathway to the building have non-slip surfaces and handrails?			
6. Is the walkway or pathway to the building entrance: a. Free of protrusions (such as fire hydrants, tree trunks, or other obstacles) which narrow the passage to less than 48 inches?			
b. Free of any abrupt edges or breaks in the surface where the difference is over ¼ inch in height (such as where it crosses a driveway, parking lot, or another walkway, etc.)?			
c. Free of any overhanging objects (such as tree branches, signs, etc.) which hang lower than 80 inches?			
d. Free of any grating with openings of over ½ inch wide?			
7. Are walkways always well-lighted?			
8. Are provisions made to ensure that walkways are free of such hazards as ice, snow, leaves, or other debris on the day of election?			
9. Are there signs which identify the accessible route of travel if that route is different from the primary route of travel to the building?			

End of Category II

Please go to next category ⇨

Category III: Ramps and elevators entering or inside the building	**YES**	**NO**	**N/A**
1. Are building stairs or steps which are over ¾ inch high (either at the entrance or between the entrance and the voting area) provided either with a ramp, with an elevator, or with an alternative means of unassisted passage (such as a chairlift or an alternative route of travel)?			
2. Ramps: a. Do all ramps have a slope no greater than a rise of 1 foot in 12 feet?			
b. Are ramps provided with non-slip surfaces?			

Category III: Ramps and elevators entering or inside the building	**YES**	**NO**	**N/A**
c. Is a handrail provided for any ramp rising more than 6 inches or longer than 72 inches?			
d. Are handrails at least 32 inches above ramp surface?			
e. Can handrails be gripped?			
f. Are ramps and landing areas with drop-offs provided with at least a 2-inch curb at the side to prevent slipping off the ramps?			
g. If there is a door at the top of a ramp, is there a level space of at least 5 feet by 5 feet where a wheelchair can rest while the door is opened (if the door opens toward the ramp)?			
3. Elevators (if elevators are the only accessible route): a. Is the elevator cab at least 68 inches by 51 inches wide?			
b. Do elevator doors provide at least 36 inches clear width?			
c. Are elevator controls less than 54 inches high (i.e., can a person in a chair operate the controls)?			
d. Are control panels marked with raised lettering?			
e. Is the elevator in close proximity to the entrance of the building?			

End of Category III

Please go to next category ⇨

Category IV: Other architectural features	**YES**	**NO**	**N/A**
1. Doors along the route of travel: a. Do all doors have an opening which clears at least 32 inches wide?			
b. Are all door thresholds less than ½ inch high (¾ inch if the building was erected before 1979)?			
c. Are all doors equipped with either arch or lever-type handles, pushplates, or automatic openers (so that twisting a doorknob is not required)?			
d. Where an automatic door is used, does the door remain open at least 3 seconds?			
e. Are glass doors marked with safety seals?			
2. Stairs along the route: a. Do stairs have non-slip surfaces?			
b. Do stairs have handrails at least 34 to 38 inches above the step level?			
c. Can handrails be gripped?			
d. Do all steps have risers (the vertical wall at the back of each step)?			
e. Do all steps have tread areas at least 11 inches deep?			
f. Are all steps less than 7 inches in height?			
g. Are stairs well-lighted?			
h. Are stairs free of obstacles?			
3. Corridors: a. Is the corridor at least 44 inches wide?			
b. Is the corridor free of obstacles or protrusions (such as boxes, water fountains, etc.) which extend more than 12 inches from the wall?			
c. Is there sufficient lighting at all points along the route?			
d. In any corridor longer than 30 feet is there a seating or rest area?			
e. Does the corridor have a non-slip surface?			
f. Are all rugs and mats securely fastened?			

End of Category IV
Please go to next category ⇨

Category V: Features within the voting area	YES	NO	N/A
1. Are instructions for voting printed in 14-point or larger type, in simple language, and plainly displayed?			
2. Is there sufficient space for reasonable movement of voters in wheelchairs?			
3. Can all necessary parts of the voting equipment be reached by a person seated in a chair or, at least, is an alternative means of casting a ballot provided?			
4. Are magnifying devices available for those who request them?			
5. Is there adequate lighting in the voting area?			
6. Is seating available for elderly or handicapped voters awaiting their turn to vote?			

End of Category V
Please go to next category ⇨

Category VI: If there are other reasons for inaccessibility, please describe:

You may attach additional sheets, if necessary.
Please complete the summary of accessibility on the next page.

Summary of Accessibility by Categories

Please review the responses within each category on the previous pages and indicate below whether each category is:

- INACCESSIBLE (if there is a "NO" response in **any** unshaded box in the category)
- ACCESSIBLE, BUT INCONVENIENT (if all "NO" responses in the category are only in shaded boxes and all the responses in the **unshaded** boxes are either "YES" or "N/A")
- FULLY ACCESSIBLE (if **all** responses in the category are either "YES" or "N/A")

Category	Inaccessible	Accessible, but inconvenient	Fully accessible
I. Parking			
II. Walkways or pathways to the building			
III. Ramps and elevators entering or inside the building			
IV. Other architectural features			
V. Features within the voting area			
VI. Other			

Overall determination of polling place accessibility

If one or more of the categories are marked "INACCESSIBLE,"
then the polling place is . . . . . **INACCESSIBLE** □
If no category is marked "INACCESSIBLE,"
but one or more are marked "ACCESSIBLE, BUT INCONVENIENT"
then the polling place is . . . . . **ACCESSIBLE, BUT INCONVENIENT** □
If all categories above are marked "FULLY ACCESSIBLE,"
then the polling place is . . . . . **FULLY ACCESSIBLE** □

Disposition of inaccessible polling place If the polling place is INACCESSIBLE	**YES**	**NO**
A. Has an alternative accessible facility been sought?		
B. Are permanent or temporary alterations planned to render the polling place accessible in the coming election?		

21.50(5) *Temporary waiver of accessibility requirements.* Notwithstanding the waiver provisions of 721—Chapter 10, if the county commissioner is unable to provide an accessible polling place for any precinct, the commissioner shall apply for a temporary waiver of accessibility requirements pursuant to this subrule. Applications shall be filed with the secretary of state not later than 60 days before the date of any scheduled election. If a waiver is granted, it shall be valid for two years from the date of approval by the secretary of state.

a. Each application shall include the following documents:

(1) Application for Temporary Waiver of Accessibility Requirements.

(2) A copy of the Polling Place Accessibility Survey Form for the polling place to be used.

(3) A copy of the Polling Place Accessibility Survey Form for any other buildings that were surveyed and rejected as possible polling place sites for the precinct.

b. If an accessible place becomes available at least 30 days before an election, the commissioner shall change polling places and shall notify the secretary of state. The notice shall include a copy of the Polling Place Accessibility Survey Form for the new polling place.

21.50(6) *Emergency waivers.* During the 60 days preceding an election, if a polling place becomes unavailable for use due to fire, flood, or changes made to the building, or for other reasons, the commissioner must apply for an emergency waiver of accessibility requirements in order to move the polling place to an inaccessible building. Emergency waiver applications must be filed with the secretary of state as soon as possible before election day. To apply for an emergency waiver, the commissioner shall send the following documents:

a. Application for Temporary Waiver of Accessibility Requirements.

b. A copy of the Polling Place Accessibility Survey Form for the polling place selected.

c. A copy of the Polling Place Accessibility Survey Form for any other buildings that were surveyed and rejected as possible polling place sites for this precinct.

21.50(7) *Application form.* The following form shall be used to apply for a temporary waiver of accessibility requirements.

State of Iowa Application for

Temporary Waiver of Accessibility Requirements

Instructions

Send a separate application for each precinct. Do not list more than one precinct on a waiver form.

Include copies of surveys. With each application you must send copies (you keep the originals) of the **Polling Place Accessibility Survey Form** for the polling place you would like to use, as well as for any buildings you surveyed and rejected.

Complete section A or section B, but not both.

Section A. No Accessible Place. If you cannot provide an accessible polling place for a precinct because no accessible buildings are available and no available building can be modified to be accessible on election day, you must apply for a temporary waiver of accessibility requirements.

1. Describe why you are unable to provide an accessible polling place for the precinct.

a. Include the reasons that the polling place you have selected cannot be made accessible for the next election. Remember, the polling place must be accessible on election days. Buildings used for polling places are not necessarily required to be permanently accessible.

b. Include letters from three elected officials from governing bodies that include this precinct (city officials, county supervisors, or township officials) supporting your finding that there is no accessible place within the precinct that can be used for a polling place.

c. Explain why it is not reasonable to move this polling place to another, accessible location outside the precinct or to combine this precinct with another adjacent precinct that has an accessible polling location.

2. List other potential polling places you examined and rejected. Enclose a copy of the Polling Place Accessibility Survey Form for each place you list. You keep the original copy of the survey form.

3. List the name and address of the polling place you propose to use. Enclose a copy of the Polling Place Accessibility Survey Form for this place. You keep the original survey form.

4. If a waiver is granted, it will apply to all elections held for two years after the date the waiver is approved by the Secretary of State.

Section B. Emergency Use. Use this section to report changes in polling places during the two months before a federal election. For example, you may need to change from an accessible polling place to an inaccessible one because the building has become unusable due to an emergency, such as a fire or flood.

1. Describe the emergency that made it necessary to move the polling place to an inaccessible site.

2. List the name and address of the polling place you propose to use. Enclose a copy of the Polling Place Accessibility Survey Form for this place. You keep the original survey form.

Review the application form carefully, sign and date it.

State of Iowa Application for

Temporary Waiver of Accessibility Requirements

County: _____ **Precinct:** _____

Section A—No Accessible Place.

I have surveyed all potential polling places in the precinct listed above and hereby certify that no accessible place is available in or for the precinct. I further certify that this county is unable to make a polling place temporarily accessible in the precinct for the following reasons:

Other potential polling places that have been surveyed and rejected as inaccessible are:

I request permission to use the following building as a polling place until an accessible place becomes available, or for two years, whichever is sooner:

Section B—Emergency Use.

Due to emergency conditions, no accessible polling place will be available for the precinct listed above for the next election. The emergency conditions are as follows:

I request permission to use the following building as a polling place for the election to be held on ___/___/20___:

_____

Statement by Commissioner:

Copies of the surveys for all polling places examined and rejected and for the polling place that will be used are included. Any voters with disabilities who are assigned to this precinct and who are unable to enter the polling place will be provided with ballots delivered to their vehicles by the two election officials selected to assist voters. I hereby apply for a determination from the State Commissioner of Elections that an inaccessible polling place may be used in this precinct for the period requested above.

Signed: _____, County Auditor and Commissioner of Elections

Date: _____

21.50(8) *Evaluation of waivers.* When the secretary of state receives waiver applications, the applications shall be reviewed carefully. A response shall be sent to the commissioner within one week by E-mail or by fax to notify the commissioner when the waiver request was received and whether additional information is needed.

21.50(9) *Granting waivers.* If the secretary of state determines from the documents filed with the waiver request that conditions justify the use of a polling place that does not meet accessibility standards, the secretary of state shall grant the waiver of accessibility requirements. If the secretary of state determines from the documents filed with the waiver request that all potential polling places have been surveyed and no accessible place is available, and the available building cannot be made temporarily accessible, the waiver shall be granted.

21.50(10) *Notice required.* Each notice of election published pursuant to Iowa Code section 49.53 shall clearly describe which polling places are inaccessible. The notice shall include a description of the services available to persons with disabilities who live in precincts with inaccessible polling places. The notice shall be in substantially the following form:

Any voter who is physically unable to enter a polling place has the right to vote in the voter's vehicle. For further information, please contact the county auditor's office at the telephone or TTY number or E-mail address listed below:

Telephone: _____ TTY: _____ E-mail address: _____

21.50(11) *Denial of waiver requests.* The secretary of state shall review each waiver request. The secretary of state shall consider the totality of the circumstances as shown by the information on the waiver request, information contained in previous applications for waivers for the same precinct and for other precincts in the county, and other relevant available information. The waiver request may be denied if it appears that the commissioner has not made a good-faith effort to find an accessible polling place. If the waiver request is denied, the secretary of state shall notify the commissioner in writing of the reason for denying the request.

This rule is intended to implement Iowa Code section 49.21.

721—21.51 to **21.74** Reserved.

721—21.75(49) Voting centers for certain elections. The commissioner may establish voting centers for the regular city election, city primary election, city runoff election, regular school election, and special elections.

21.75(1) *Definition.*

"Voting center" means a location established by the commissioner for the purpose of providing ballots to all registered voters who are qualified to vote in a particular jurisdiction for a regular city election, city primary election, city runoff election, regular school election, or special election.

21.75(2) *Minimum requirements.*

a. Establishment. One or more voting centers may be established in lieu of precinct polling places for the elections at which the use of voting centers is permitted.

b. Choices. Regular polling place sites that are accessible to people with disabilities may be used as voting centers for any election at which the use of voting centers is permitted. Other suitable locations may also be used.

c. Accessibility. A voting center is subject to the requirements of Iowa Code section 49.21 relating to accessibility to persons who are elderly and persons with disabilities and relating to the posting of signs.

21.75(3) *Hours.* Voting center hours shall be the same as permitted for an election pursuant to Iowa Code Supplement section 49.67. Except for school elections, a voting center that serves a jurisdiction which includes both unincorporated territory and a city with a population in excess of 3500 shall open at 7 a.m.

21.75(4) *Publications.* The location of each voting center shall be published in the notice of election by the commissioner in the same manner as the location of polling places is required to be published. The notice of election shall also include a description of the voting center in substantially the following form:

For the _____ election to be held on [date], voting centers will be available. Any registered voter of [jurisdiction name] may vote at any of the following places in this election:

[List addresses of voting centers.]

21.75(5) *I-Voters use prohibited.* The commissioner shall not provide direct access from voting centers to the I-Voters system on election day.

21.75(6) *Operation of voting centers.*

a. Election registers and voter lists. Each voting center shall have a list of all registered voters who are eligible to vote in that election. The voter list may be a paper list or may be available on computers in an electronic format, rather than as an interactive connection to I-Voters.

b. Election day registration at voting centers. A person who needs to register to vote may register and vote at a voting center provided that the person has appropriate identification and is a resident of the jurisdiction served by the voting center.

c. Ballots. Each voting center shall have all ballot styles necessary to provide a ballot to any voter who is eligible to vote in the election for the jurisdiction served by the voting center.

d. Precinct election officials. Voting centers shall be administered by a minimum of five precinct election officials selected pursuant to Iowa Code sections 49.12 to 49.16. These officials shall be trained before each election and shall have specific instructions regarding the differences between voting centers and polling places.

21.75(7) *Postelection review of voter participation.*

a. Within 30 days after the election, the commissioner shall review the signed declarations of eligibility or the signed election registers from each voting center, and if any person is found to have voted in more than one voting center in the election, the commissioner shall immediately notify the county attorney.

b. The notice to the county attorney shall include a copy of the person's voter registration record and copies of the declarations of eligibility signed by the voter. The notice shall also include a reference to 2008 Iowa Acts, House File 2620, section 23(1A)*"d,"* which reads as follows: "*d.* Pursuant to section 39A.2, subsection 1, paragraph "b", subparagraph (3), a person commits the crime of election misconduct in the first degree if the person knowingly votes or attempts to vote at more than one voting center for the same election." The notice shall also include a reference to Iowa Code section 39A.2(2), which reads as follows: "2. Election misconduct in the first degree is a class 'D' felony."

This rule is intended to implement 2008 Iowa Acts, House File 2620, division II.

721—21.76 to **21.199** Reserved.

DIVISION II
BALLOT PREPARATION

721—21.200(49) Constitutional amendments and public measures.

21.200(1) The order of placement on the ballot for constitutional amendments and statewide public measures to be voted upon at a single election shall be determined by the state commissioner, and a number shall be assigned to each constitutional amendment or statewide public measure by the state commissioner.

a. The number assigned by the state commissioner to each constitutional amendment or statewide public measure to appear on the ballot for a single election shall be printed on the ballot immediately preceding and above the words "Shall the following amendment to the Constitution (or public measure) be adopted?" or the words "Shall there be a Convention to revise the Constitution, and propose amendment or amendments to same?".

b. The number assigned by the state commissioner shall be printed on the ballot at least 1/8 of an inch high in the designated place.

c. Even if only one constitutional amendment or statewide public measure is to appear on a ballot to be voted upon at a single election, an identifying number shall be assigned by the state commissioner and shall be printed on the ballot in the prescribed manner.

21.200(2) The order of placement on the ballot for each local public measure to be voted upon at a single election shall be determined by the commissioner, and a letter shall be assigned to each local public measure by the commissioner.

a. The letter assigned by the commissioner to each local public measure to appear on a ballot for a single election shall be printed on the ballot immediately preceding and above the words "Shall the following public measure be adopted?".

b. The letter assigned by the commissioner shall be printed on the ballot at least 1/8 of an inch high in the designated place.

c. Even if only one public measure is to appear on a ballot to be voted upon at a single election, an identifying letter shall be assigned by the commissioner and shall be printed on the ballot in the prescribed manner.

21.200(3) The words describing proposed constitutional amendments and statewide public measures when they appear on the ballot shall be determined by the state commissioner. The state commissioner shall select the words describing the proposed constitutional amendments and statewide public measures in the following manner:

a. Not less than 150 days prior to the election at which a proposed constitutional amendment or statewide public measure is to be voted on by the voters, the state commissioner shall prepare a proposed description to be used on the ballots in administrative rule form and shall file the proposed rules with the administrative rules coordinator for publication in the Iowa Administrative Bulletin.

b. The rules shall provide that written comments regarding the proposed description will be accepted by the state commissioner for a period of time not less than 20 days after the date of publication in the Iowa Administrative Bulletin.

c. The state commissioner shall review any written comments which have been timely received and make any changes deemed to be warranted in the description to be printed on the ballots.

This rule is intended to implement Iowa Code sections 47.1 and 49.44.

721—21.201(44) Competing nominations by nonparty political organizations.

21.201(1) *Nominations by convention and by petitions.* If one or more nomination petitions are received from nonparty political organization candidates for an office for which the same organization has also nominated one candidate by convention, the candidate nominated by convention shall be considered the nominee of the organization. The names of the other candidates shall appear on the

ballot as candidates "nominated by petition," and those candidates shall be notified in writing not later than seven days after the close of the filing period.

21.201(2) *Multiple nomination petitions.* If nomination petitions are received from more than one candidate from the same nonparty political organization for the same office and the organization has not nominated a candidate for the office by convention, the name of each of these candidates shall be written on a separate piece of paper, all of which shall be as nearly uniform in size and material as possible and placed in a receptacle so that the names cannot be seen. On the next working day following the close of the nomination period, all affected candidates shall be notified of the time and place of the drawing. The candidates shall be invited to attend or to send a representative. In the presence of witnesses, the state commissioner of elections or the county commissioner, as appropriate, or a designee of the state or county commissioner, shall publicly draw one of the names; and that person shall be declared to be the nominee of the nonparty political organization. The names of the other candidates shall appear on the ballot as candidates "nominated by petition." A copy of the written record of the result of the drawing shall be kept with the nomination petition of each affected candidate, and each candidate shall be sent a copy for the candidate's records not later than seven days after the close of the filing period.

21.201(3) *Multiple nomination certificates.* If more than one nomination certificate is received for the same office from groups with the same nonparty political organization name, the name of each of these candidates shall be written on a separate piece of paper, all of which shall be as nearly uniform in size and material as possible and placed in a receptacle so that the names cannot be seen. On the next working day following the close of the nomination period, all affected candidates shall be notified of the time and place of the drawing. The candidates shall be invited to attend or to send a representative. In the presence of witnesses, the state commissioner of elections or the county commissioner, as appropriate, or a designee of the state or county commissioner, shall publicly draw one of the names; and that person shall be declared to be the nominee of the nonparty political organization. The names of the other candidates, including any candidate who filed nomination petitions, shall appear on the ballot as candidates "nominated by petition." A copy of the written record of the result of the drawing shall be kept with the nomination certificate of each affected candidate, and each candidate shall be sent a copy for the candidate's records not later than seven days after the close of the filing period.

This rule is intended to implement Iowa Code section 44.17.

721—21.202 to **21.299** Reserved.

DIVISION III
ABSENTEE VOTING

721—21.300(53) Satellite absentee voting stations. The county commissioner of elections may designate locations in the county for absentee voting stations. If the commissioner receives a petition requesting that a satellite absentee voting station be established at a location described on the petition, the commissioner shall provide the requested station if the petition was properly signed and filed. The petition shall be rejected if the site chosen is not accessible to elderly and disabled voters or has other physical limitations that make it impossible to meet the requirements for ballot security and secret voting, or if the owner of the site refuses permission to locate the satellite absentee voting station at the site named on the petition. The commissioner may also refuse to conduct satellite voting for the runoff election if a special election is scheduled to be held between the regular city election and a city runoff election. The petition may be refused if the owner of the site demands payment for its use.

The petition shall be signed by not less than 100 eligible electors of the county. The petition shall be filed with the commissioner no later than the deadline specified in Iowa Code section 53.11 for the election.

Satellite absentee voting stations established by petition shall be open for at least one day for a minimum of six hours. Satellite absentee voting stations shall be accessible to elderly and disabled voters.

Only ballots from the county in which the site is located may be provided at the satellite absentee voting station. However, it is not necessary to provide ballots from all of the precincts in the county.

21.300(1) *Form of petition.* The petition requesting that a satellite absentee voting station be established at a specific location shall be in substantially the following form:

STATE OF IOWA

PETITION FOR ABSENTEE VOTING STATION

Instructions: This petition may be signed by people who

- are U.S. citizens,
- are at least 18 years old,
- have not been convicted of a felony,
- have not been declared mentally incompetent by a court,
- and who live in this county.

They do not need to be registered voters.

The petition must be taken to the county auditor's office before 5 p.m. on _____.

Date of election: _____

We, the people of _____ County, request that there be an absentee voting station at the place described below.

[Instructions: Give the address of the building, and the name of the building, if it has a name. Elderly and disabled voters must be able to get into the building to vote.]

_____

_____

Signature	Address, including street and number, if any	Date signed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		

page _____ of _____

21.300(2) *Notice provided.* Notice shall be published at least seven days before the opening of any satellite absentee voting station. If more than one satellite absentee voting station will be provided, a single publication may be used to notify the public of their availability.

A notice shall also be posted at each satellite absentee voting station at least seven days before the opening of the satellite absentee voting station. The notice shall remain posted as long as the satellite absentee voting station is scheduled for service. If it is not possible to post the notice at least seven days before the station opens due to the receipt of a petition, the notice shall be posted as soon as possible.

Both the published and posted notices shall include the following information:

a. The name and date of the election for which ballots will be available.

b. The location(s) of the satellite absentee voting station(s).

c. The dates and times that the station(s) will be open.

d. The precincts for which ballots will be available.

e. An announcement that voter registration forms will be available for new registrations in the county until the time registration closes before the election and that changes in the registration records of people who are currently registered within the county may be made at any time.

If the satellite absentee voting station is located in a building with more than one public entrance, brief notices of the location of the satellite absentee voting station shall be posted on building directories, bulletin boards, or doors. These notices shall be posted no later than the time the station opens and shall be removed immediately after the satellite absentee voting station has ceased operation for an election.

21.300(3) *Staff.* Satellite absentee voting station workers may be selected from among the staff members of the commissioner's office, from the election board panel drawn up pursuant to Iowa Code sections 49.15 and 49.16, or a combination of these two sources. Compensation of workers selected from the election board panel shall be at the rate provided in Iowa Code section 49.20.

At least three people shall be assigned to work at each satellite absentee voting station; more workers may be added at the commissioner's discretion. All workers must be registered voters of the county, and for primary and general elections the workers must be registered with a political party. No more than a simple majority of the workers shall be members of the same political party.

People who are prohibited from working at the polls pursuant to Iowa Code section 49.16 may not work at satellite absentee voting stations.

21.300(4) *Oath required.* Before the first day of service at a satellite absentee voting station each worker shall take the following oath:

I, _____(name)_____, do solemnly swear or affirm that I will impartially, and to the best of my knowledge and ability, perform the duties of satellite absentee voting station worker, and will endeavor to prevent fraud, deceit and abuse in performing those duties.

_____
Signature of worker

_____
Address

_____ _____
Officer administering oath Date

The oath must be taken before each election.

21.300(5) *Supplies needed for each satellite absentee voting station.* Each satellite absentee voting station shall be provided with the following supplies:

a. Voter registration forms for new registrations and changes of registration information.

b. Absentee ballot application forms.

c. An absentee voters' log in which to record the names of electors casting absentee ballots, the serial numbers on their applications and affidavit envelopes, and the date the ballots are returned. The log may also be used to record the return of absentee ballots which were mailed.

d. Affidavit envelopes for absentee ballots.

e. Secrecy envelopes or folders, if needed for use with electronic voting systems.

f. Absentee ballots in sealed container(s).

g. Marking devices appropriate for the voting system that will be used to tabulate the ballots.

h. Two or more voting booths, at least one of which shall be suitable for use by a person seated in a chair or wheelchair.

i. One or more ballot boxes equipped with locks and keys, or tamperproof seals.

j. Table and chairs for workers.

k. Two or more chairs for voters.

l. Barricade system to control access to voting area.

m. Secure containers for returning unused ballots. Containers used to send ballots to the satellite absentee voting station may be reused.

n. Paper clips, tape or rubber bands to attach request forms to affidavit envelopes.

o. Pens and other supplies for the workers.

p. Instructions in large type explaining the proper method of marking the ballot.

q. A list of other satellite absentee voting stations in the county, if any, and their addresses and scheduled times of operation.

r. Precinct finder.

s. Sample ballots for each precinct served by the satellite absentee voting station.

t. Envelope to return spoiled ballots.

u. Special ballot envelopes and return envelope.

21.300(6) *Ballot transport and storage.* At the commissioner's discretion the ballots may be transported between the commissioner's office and the satellite absentee voting station by the workers who will be on duty that day, or by two people of different political parties who have been designated as couriers by the commissioner. It is not necessary for the same people to transport the ballots in both directions.

If the ballots are transported by the satellite absentee voting station workers, two workers who are members of different political parties and the ballots must travel together in the same vehicle.

Ballots may be stored at the satellite absentee voting station during hours when the station is closed only if they are kept in a locked cabinet or container. The cabinet must be located in a room which is kept locked when not in use. Voted absentee ballots must be delivered to the commissioner's office at least once each week.

21.300(7) *Ballot receipts.* Satellite absentee voting station workers shall sign receipts for the ballots taken to the remote absentee voting site. The receipt shall be in substantially the following form:

SATELLITE ABSENTEE VOTING STATION
BALLOT RECORD AND RECEIPT

Precincts voting at satellite station: _____

Location of satellite station: _____

Satellite station address: _____

BALLOTS DELIVERED TO THE SATELLITE ABSENTEE VOTING STATION

Type of Ballot	Number Delivered	Delivered to: (print name)	(signature of each worker)
TOTAL DELIVERED *	DATE:	TIME:	a.m. p.m.

BALLOTS RETURNED FROM THE SATELLITE ABSENTEE VOTING STATION

Type of Ballot	Voted	Spoiled	Special	Not Voted	Returned

TOTAL NUMBER OF BALLOTS RETURNED:_____ *

***The number of ballots returned must equal the number delivered.**

Number of ballots issued by mail and returned to this station: _____

Print name Signature

Ballots received from:_____

_____

_____

_____

_____

RECEIVED BY: _____ DATE: _____ TIME: _____ a.m. p.m.

A copy of the ballot record and receipt shall be retained in the commissioner's office. The original shall be sent with the ballots to the satellite absentee voting station.

21.300(8) *Arrangement of the satellite absentee voting station.* Protection of the security of the ballots (both voted and unvoted) and the secrecy of each person's vote shall be considered in the arranging of the satellite absentee voting station.

a. Security. The satellite absentee voting station shall be arranged so that ballots are protected against removal from the station by unauthorized people.

b. Voting area. Voting booths without curtains shall be placed so that passersby and other voters may not walk directly behind a person using the booth. At least one voting booth must be accessible to the disabled. The booth must be designed to accommodate a person seated in a chair or wheelchair. A chair must be provided for voters who wish to sit down while voting.

c. Electioneering. No signs supporting or opposing any candidate or question on the ballot shall be posted within 300 feet of the satellite absentee voting station. No electioneering shall be allowed within the sight or hearing of voters while they are at the satellite absentee voting station.

d. Chair provided. One or more chairs must be available for use by elderly or disabled voters waiting in line.

21.300(9) *Operation of the satellite absentee voting station.* At all times the station shall have at least two workers present to preserve the security of the ballots, both voted and unvoted. At satellite absentee voting stations used for primary and general elections, no more than a simple majority of the workers shall be registered with the same political party.

21.300(10) *Voter registration at the satellite absentee voting station.* Each satellite absentee voting station shall provide forms necessary to register voters and to record changes in voter registration records. Workers shall also be provided with a method of verifying whether people applying for absentee ballots are registered voters.

The commissioner may provide a list of registered voters in the precincts served by the station. The list may be on paper, microfiche or other media.

As an alternative, the commissioner may provide a computer connection with the commissioner's office.

21.300(11) *Procedure for issuing absentee ballot.* The following instructions for absentee voting are to be provided to all satellite absentee voting station workers:

HOW TO ISSUE ABSENTEE BALLOTS

1. Application. Each person who wishes to vote shall complete an application for an absentee ballot.

2. Check precinct. Check to be sure that the applicant's address is in a precinct served by this station.

3. Check registration. Check to see whether the applicant is a registered voter at the applicant's current address. People who live in (county name) County but who are not currently registered to vote in the county may register to vote at the satellite absentee voting station until (the date registration closes for the election). Changes of name, address, telephone number or party affiliation may be submitted at any time.

After (date registration closes), anyone who requests an absentee ballot and who is not a registered voter in the county may register to vote if the person provides proof of identity and residence in the precinct in which the voter intends to vote. The voter must also complete an oath of person registering on election day. Otherwise, the person may cast only a provisional ballot. Use the provisional ballot envelopes.

Proof of identity must be a photo ID card that is current and valid and includes an expiration date. An ID is still current on the date it expires. An Iowa nonoperator's ID card that shows "none" as an expiration date is considered current and valid. The following forms of identification are acceptable: an Iowa driver's license or nonoperator's ID, an out-of-state driver's license or nonoperator's ID, a United States passport, a United States military identification card, an identification card issued by an employer, or a student identification card issued by an Iowa high school or an Iowa postsecondary educational institution. If the photo ID does not show the person's address in the appropriate precinct, the person must show proof of residence.

Proof of residence may be any of the following documents provided that the document shows the person's name and address in the precinct: residential lease, property tax statement, utility bill, bank statement, paycheck, government check, or other government document.

A voter who does not have appropriate identification documents may have another registered voter from the same precinct attest to the person's identity and residence. An attester must be a registered voter whose identity and residence have not been established by the attestation of another registered voter and must live in the same precinct as the applicant. The attester shall not attest to the identity of more than one person. The commissioner shall keep a list of all persons who have attested for in-person absentee

registrants and shall send the list to the polling place on election day with the list of absentee voters required by Iowa Code section 49.72.

4. Affidavit envelope. Have the voter complete the affidavit envelope before you issue the ballot.

5. Voters may ask for help. Anyone who is unable to mark a ballot without help may be helped by any person chosen by the voter. EXCEPTIONS: The following people may not help a voter—the voter's employer, an agent of the employer, or an officer or agent of the voter's union.

The voter may also request help from the satellite absentee voting station workers. Two workers from different political parties must assist the voter.

WARNING: Do not tell anyone how the person voted.

6. Issue ballot. When a voting booth is available, give the voter the appropriate ballot. Ballots must be voted at the satellite absentee voting station. Ballots may not be taken away from the station.

7. Instruct voter. Instruct each voter to use only the pen or pencil provided by you, how to mark the ballot so that it can be counted, to enclose the ballot in the secrecy folder (if any), and to place the ballot in the affidavit envelope and seal it before returning it to the workers.

8. Send voter to booth. Each voter must use a voting booth. Do not permit anyone to vote anywhere else.

9. When the ballot is returned: Number the request form and the affidavit envelope with serial number and record the serial number in the log of absentee voters.

10. Storing voted ballots and applications. Attach the application to the sealed affidavit envelope and insert them in the locked ballot box.

21.300(12) *Closing the station.* The following instructions for closing the absentee voting station are to be provided to all satellite absentee voting station workers:

INSTRUCTIONS FOR CLOSING
THE SATELLITE ABSENTEE VOTING STATION

At the end of each day, after everyone has voted who arrived before the time established to close the station, close the satellite absentee voting station. Each task on the list must be completed.

DO NOT OPEN ANY AFFIDAVIT ENVELOPES. These ballots will be opened and counted on election day.

1. Count the number of ballots of each type which have not been voted.

2. Record number of unvoted ballots by precinct on the ballot receipt form.

3. Place the ballots in the container provided and securely seal or lock the container.

4. Record the number of spoiled ballots by precinct on the ballot receipt form.

5. Count the number of spoiled ballots by precinct and place in the envelope provided. Enter this number on the ballot receipt form. Securely seal the envelope. All officials must sign the envelope.

6. From the absentee voters' log determine how many ballots from each precinct have been voted.

7. Compare the total number of ballots in the ballot box with the number of voters listed in the log. If there is a discrepancy, you must resolve it before leaving the station. If you cannot discover the source of the discrepancy, write a detailed explanation of the problem. All workers must sign the report.

8. If couriers will be picking up the ballots, all workers must wait until both couriers arrive. Ask the couriers for identification before surrendering the ballots. If the workers are to return the ballots to the commissioner's office, two workers who are members of different political parties and the ballots must travel together in the same vehicle to return the ballots.

9. Never leave any ballots unattended.

10. If the ballots will be stored at the satellite absentee voting station all workers must be present when the ballots are locked up. A daily log sheet shall be used to record the information requested above. When ballots are returned to the auditor's office the information on the daily log sheets shall be accumulated and entered on the ballot record and receipt form.

This rule is intended to implement Iowa Code section 53.11 as amended by 2007 Iowa Acts, Senate File 416.

721—21.301(53) Absentee ballot requests from voters whose registration records are inactive.

21.301(1) *In person.* Absentee voters whose registration records are inactive and who appear in person to vote, either at the office of the commissioner or at a satellite absentee voting station, shall be required to provide identification before voting. The voter may present any of the identification documents prescribed in subrule 21.3(3). If the voter does not have appropriate identification documents, the official or staff person receiving the application shall challenge the ballot and notify the voter that the voter must provide a copy of the appropriate form of identification not later than the date upon which the absentee and special precinct board will meet to review provisional ballots after election day pursuant to Iowa Code section 50.21.

21.301(2) *By mail.* When a request for an absentee ballot is received by mail from a voter whose registration record has been made inactive pursuant to Iowa Code section 48A.29, the commissioner shall respond to the request.

a. Form. The commissioner shall send a voter registration form and the following notice:

Notice to the Voter:

Your request for an absentee ballot has been received and processed. However, our records show that your voter registration is not currently active. To restore your registration, please complete the enclosed voter registration form and return it to:

County Auditor

(Address)

Return the registration form separately. Do not enclose it with your absentee ballot.

This registration form must be received in my office no later than (the time the polls close) on (election day), or be postmarked no later than (the day before election day).

b. Instructions to commissioner. If the registration form is received by the deadline for receipt of absentee ballots as prescribed in Iowa Code section 53.17, and all other legal requirements are met, the ballot shall be counted. If the return carrier envelope is received before the registration form, the envelope shall not be opened but shall be held until the deadline for receipt of absentee ballots. If the registration form has not been received by the deadline, the officials of the absentee and special voters precinct board shall open the return carrier envelope. If the registration form is enclosed, and all other legal requirements are met, the ballots shall be counted. However, if the registration form is not enclosed in the return carrier envelope, the affidavit envelope containing the ballot shall not be opened.

This rule is intended to implement Iowa Code sections 48A.29 and 53.2.

721—21.302(48A) In-person absentee registration. After the close of voter registration for an election, a person who appears in person to apply for and vote an absentee ballot may register to vote if the person provides proof of identity and residence in the precinct in which the voter intends to vote. The voter must also complete an oath of person registering on election day. Otherwise, the person may cast only a provisional ballot. Provisional ballot envelopes shall be used.

21.302(1) Proof of identity must be a photo ID card that is current and valid and includes an expiration date. An ID is still current on the date it expires. An Iowa nonoperator's ID card that shows "none" as an expiration date is considered current and valid. The following forms of identification are acceptable: an Iowa driver's license or nonoperator's ID, an out-of-state driver's license or nonoperator's ID, a United States passport, a United States military identification card, an identification card issued by an employer, or a student identification card issued by an Iowa high school or an Iowa postsecondary educational institution. If the photo ID does not show the person's address in the appropriate precinct, the person must show proof of residence.

21.302(2) Proof of residence may be any of the following documents provided that the document shows the person's name and address in the precinct: residential lease, property tax statement, utility bill, bank statement, paycheck, government check, or other government document.

21.302(3) A voter who does not have appropriate identification documents may have another registered voter from the same precinct attest to the person's identity and residence. An attester must be a registered voter and must live in the same precinct as the applicant. A person may not attest to the identity and residence of another voter for an election if the person registered to vote under the

provisions of 2007 Iowa Acts, House File 653, section 2, for the same election and the person's identity and residence were established by the attestation of another registered voter. The attester shall not attest to the identity of more than one person. The commissioner shall keep a list of all persons who have attested for in-person absentee registrants and send the list to the polling place on election day with the list of absentee voters required by Iowa Code section 49.72.

This rule is intended to implement 2007 Iowa Acts, House File 653.

721—21.303(53) Mailing absentee ballots. The commissioner shall mail the following materials to each person who has requested an absentee ballot:

1. Ballot. The ballot that corresponds to the voter's residence, as indicated by the address on the absentee ballot application.
2. Public measure text. The full text of any public measures that are summarized on the ballot, but not printed in full.
3. Secrecy envelope. Secrecy envelope, if the ballot cannot be folded to cover all of the voting ovals, as required by Iowa Code section 53.8(1).
4. Affidavit envelope. The affidavit envelope, which shall be marked with the serial number used to identify the absentee request in the commissioner's records.
5. Return carrier envelope. The return carrier envelope, which shall be addressed to the commissioner's office and bear appropriate return postage or a postal permit guaranteeing that the commissioner will pay the return postage and which shall be marked with the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records.
6. Delivery envelope. The delivery envelope, which shall be addressed to the voter and bear the serial number used to identify the absentee request in the commissioner's records. All other materials shall be enclosed in the delivery envelope.
7. Instructions. Absentee voting instructions, which shall be in substantially the form prescribed by the state commissioner of elections.
8. Receipt. The receipt form required by 2007 Iowa Acts, Senate File 601, section 227, which may be printed on the instructions required by numbered paragraph "7" above.

This rule is intended to implement Iowa Code section 53.8 as amended by 2007 Iowa Acts, Senate File 601, section 223, and Iowa Code section 53.17 as amended by 2007 Iowa Acts, Senate File 601, section 227.

721—21.304 to **21.349** Reserved.

721—21.350(53) Absentee ballot processing for elections held following July 1, 2007. Rescinded IAB 9/26/07, effective 9/7/07.

721—21.351(53) Receiving absentee ballots. The commissioner shall carefully account for and protect all absentee ballots returned to the office.

21.351(1) *Note receipt.* The commissioner shall write or file-stamp on the return carrier envelope the date that the ballot arrived in the commissioner's office. The commissioner shall also record receipt of the ballot in I-Voters.

21.351(2) *Temporary storage.* If necessary, the commissioner shall immediately put the ballot into a secure container, such as a locked ballot box, until the ballots can be moved to the secure storage area.

21.351(3) *Secure area.* The commissioner shall deliver the ballots to a secure area where returned absentee ballots will be reviewed for deficiencies.

721—21.352(53) Review of returned affidavit envelopes.

21.352(1) *Personnel.* The commissioner may assign staff members to complete the review of returned affidavit envelopes. Only persons who have been trained for this responsibility shall be authorized to review affidavit envelopes.

21.352(2) *Affidavit envelopes reviewed.* The affidavit envelopes of all absentee ballots returned to the commissioner's office shall be reviewed, including those of ballots returned by the bipartisan team

delivering absentee ballots to health care facilities, such as hospitals and nursing homes. If a reviewer finds deficiencies in absentee affidavits returned from any health care facility, the commissioner shall send the bipartisan delivery team back to make any necessary corrections or to deliver any replacement ballots.

21.352(3) *Instructions.* Each reviewer shall receive instructions in substantially the form prescribed by the state commissioner of elections. The instructions shall provide basic security and procedural guidance and include a method for accounting for all returned absentee ballots. The prohibitions shall include:

a. Not to leave unsecured ballots unattended.

b. Not to alter any information on any affidavit.

c. Not to add any information to any affidavit, except as specifically required to comply with the requirements of the law.

d. Not to seal any affidavit envelope found open.

e. Not to discard any return carrier envelopes, ballots, or affidavit envelopes returned by voters.

721—21.353(53) Opening the return carrier envelopes. The commissioner may direct a staff member to open the return carrier envelopes either manually or with an automatic letter opener, if one is available. Only a trained reviewer may remove the contents of the envelope.

721—21.354(53) Review process. A reviewer shall remove the contents from only one return carrier envelope at a time.

21.354(1) *Return carrier envelopes preserved.* The return carrier envelopes shall be stored in a manner that will facilitate their retrieval, if necessary. They shall be stored for 22 months for federal elections and 6 months for local elections.

21.354(2) *Examination of affidavit envelope.* The reviewer shall make sure that:

a. The affidavit envelope is sealed, apparently with the ballot inside.

b. The affidavit envelope has not been opened and resealed.

c. The affidavit includes all of the following:

(1) An address.

(2) A signature.

(3) For primary elections only, political party affiliation.

21.354(3) *No defects or deficiencies.* If the reviewer finds no defects or deficiencies that would cause the absentee and special voters precinct board to reject the ballot, the reviewer shall put the affidavit envelope into a group of envelopes to be retained in the secure storage area with others that require no further attention until they are delivered to the absentee and special voters precinct board.

21.354(4) *Defective and deficient affidavits.* The commissioner shall contact the voter if the reviewer finds any of the following flaws in the affidavit or affidavit envelope:

a. The commissioner shall contact the voter immediately if the affidavit envelope is defective. An affidavit envelope is defective if:

(1) The absentee ballot is not enclosed in the affidavit envelope.

(2) The affidavit envelope is not sealed.

(3) The affidavit envelope has been opened and resealed.

b. The commissioner shall contact the voter within 24 hours if the affidavit is deficient. A deficient affidavit lacks:

(1) The signature of the voter.

(2) The voter's address.

(3) For primary elections only, political party affiliation.

c. If an affidavit envelope has flaws that are included in both paragraphs *"a"* and *"b,"* the commissioner shall follow the process in paragraph *"a."*

21.354(5) *Defective and deficient affidavits stored separately.* The commissioner shall store the defective and deficient affidavit envelopes separately from other returned absentee ballot affidavit envelopes.

a. Deficient affidavit envelopes requiring voter correction must be available for retrieval when the voter comes to make corrections.

b. Defective (improperly closed) affidavit envelopes must be attached to the original application, replacement application and replacement ballot for review by the special precinct board.

721—21.355(53) Notice to voter. When the commissioner finds a deficiency in an absentee ballot affidavit or finds a defective (improperly closed) affidavit envelope, the commissioner shall notify the voter in writing and, if possible, by telephone or by E-mail. The commissioner shall keep a separate checklist for each voter showing the reasons for which the voter was contacted and the methods used to contact the voter.

21.355(1) *Notice to voter—deficient ballot affidavit.* Within 24 hours after receipt of an absentee ballot with a deficient affidavit, the commissioner shall send a notice to the voter at the address where the voter is registered to vote, as well as to the address where the ballot was sent, if it is a different address. The notice shall include:

a. Reason for deficiency (lack of signature, address or, for primary elections only, political party affiliation).

b. The voter's options for correcting the affidavit as follows:

(1) Completing the affidavit at the commissioner's office by 5 p.m. the day before the election; or

(2) Casting a provisional ballot at the polls on election day.

c. Address of commissioner's office, business hours and contact information.

21.355(2) *Notice to voter—defective ballot affidavit.* Immediately after determining that an absentee ballot affidavit envelope was not properly closed, the commissioner shall send a notice to the voter at the address where the voter is registered to vote, as well as to the address where the ballot was sent, if it is a different address. The notice shall include the following information:

a. Reason for defect, such as envelope not sealed, envelope opened and resealed, or the ballot was outside the affidavit envelope.

b. The voter's options for correcting the defect as follows:

(1) Applying for a replacement ballot; or

(2) Casting a provisional ballot at the polls on election day.

c. Process for applying for a replacement ballot.

d. Address of commissioner's office, business hours and contact information.

21.355(3) *Telephone contact.* If the voter has provided a telephone number, either on the absentee ballot application or on the voter's registration record, the commissioner shall also attempt to contact the voter by telephone. The commissioner shall keep a written record of the telephone conversation. The written record shall include the following information:

a. Name of the person making the call.

b. Date and time of the call.

c. If a person answered the telephone, the name of that person.

21.355(4) *E-mail contact.* If the voter has provided an E-mail address, either on the absentee ballot application or on the voter's registration record, the commissioner shall also attempt to contact the voter by E-mail. The E-mail message shall be the same message that was mailed to the voter. A copy of the E-mail message shall be attached to the checklist.

Rules 21.351(53) through 21.355(53) are intended to implement Iowa Code section 53.18 as amended by 2007 Iowa Acts, Senate File 601, section 229.

721—21.356 to **21.358** Reserved.

721—21.359(53) Processing absentee ballots before election day. Only when the voters have been provided with secrecy envelopes may the commissioner direct the special precinct board to open affidavit envelopes on the day before election day.

21.359(1) The secrecy envelope shall be closed on at least two sides and shall completely cover the ballot. The envelope shall have the following message printed on it using at least 24-point type:

Secrecy Envelope
After you vote, put your ballot in here.

21.359(2) The special precinct board shall review voters' affidavits and applications to determine which ballots will be accepted for counting and prepare the notices to those voters whose ballots have been rejected. The affidavit envelopes containing ballots that will not be counted and the applications submitted for those ballots shall be stored in a secure location.

21.359(3) The affidavit envelopes containing the ballots that will be counted shall be stacked with the affidavits facing down. The envelopes shall be opened and the secrecy envelope containing the ballot shall be removed. The affidavit envelope and application shall be stored together.

21.359(4) If a voter has not enclosed the ballot in a secrecy envelope and the ballot has not been folded in a manner that conceals all votes marked on the ballot, the officials shall put the ballot in a secrecy envelope without examining the ballot. Two of the special precinct election officials, one from each of the political parties referred to in Iowa Code section 49.13(2), shall sign the secrecy envelope.

21.359(5) The following security procedures shall be followed:

a. The process shall be witnessed by observers appointed by the county chairperson of each of the political parties referred to in Iowa Code section 49.13, subsection 2.

b. No ballots shall be counted or examined before election day.

c. The number of secrecy envelopes shall be recorded before the ballots are stored and the number shall be verified before any ballots are removed from the envelopes on election day. The ballots may be bundled and sealed in groups of a specified number to make counting easier.

This rule is intended to implement 1997 Iowa Acts, House File 636, section 73.

721—21.360(53) Failure to affix postmark date. For any absentee ballot referred to in Iowa Code section 53.17, if the officially authorized postal service fails to affix a postmark date on the return carrier envelope, or the postmark date is illegible, but the date of the affidavit envelope is a date no later than the day prior to the election, the ballot shall be counted as provided in Iowa Code section 53.17. If no date can be read on either the return carrier envelope or the affidavit envelope, the affidavit envelope shall not be opened, and the ballot shall be rejected as provided in Iowa Code section 53.25.

This rule is intended to implement Iowa Code section 53.17.

721—21.361(53) Rejection of absentee ballot. The special precinct election board shall reject absentee ballots without opening the affidavit envelope if any of the conditions cited below exist.

21.361(1) An absentee ballot shall be rejected if the absentee voter's affidavit is insufficient. An insufficient affidavit lacks one or more of the following:

a. The signature of the voter,

b. The voter's address,

c. In primary elections only, the political party affiliation of the voter.

21.361(2) An absentee ballot shall be rejected if the applicant is not a duly registered voter in the precinct in which the ballot is cast. "Precinct" means a precinct established pursuant to Iowa Code sections 49.3 through 49.5.

21.361(3) An absentee ballot shall be rejected if the affidavit envelope is open.

21.361(4) An absentee ballot shall be rejected if the affidavit envelope has been opened and resealed.

21.361(5) An absentee ballot shall be rejected if the affidavit envelope contains more than one ballot of any kind. This includes all ballots contained in the affidavit envelope, whether or not they are enclosed in secrecy envelopes.

21.361(6) An absentee ballot shall be rejected if the voter has voted in person.

21.361(7) An absentee ballot shall be rejected if in primary elections the political party declared on the affidavit envelope is different from the political party whose ballot was requested on the application for the ballot.

21.361(8) Rescinded IAB 9/26/07, effective 9/7/07.

This rule is intended to implement Iowa Code sections 43.38, 49.9 and 53.25.

721—21.362 to **21.369** Reserved.

721—21.370(53) Training for absentee ballot couriers. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.371(53) Certificate. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.372(53) Frequency of training. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.373(53) Registration of absentee ballot couriers. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.374(53) County commissioner's duties. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.375(53) Absentee ballot courier training. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.376(53) Receiving absentee ballots. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.377 to **21.399** Reserved.

DIVISION IV
INSTRUCTIONS FOR SPECIFIC ELECTIONS

721—21.400(376) Signature requirements for certain cities. This rule applies to cities which have all of the following characteristics:

1. Nomination procedures under Iowa Code section 376.3 are used. (This includes cities with primary or runoff election provisions. It does not include cities with nominations under Iowa Code chapter 44 or 45.)
2. Some or all council members are voted upon by the electors of wards, rather than by the electors of the entire city.
3. Ward boundaries have been changed since the last regular city election at which the ward seat was on the ballot.
4. The number of wards has not changed.

Calculation of the number of signatures for ward seats shall use the vote totals from the wards as the wards were configured at the time of the last regular city election at which the ward seat was on the ballot.

This rule is intended to implement Iowa Code section 376.4.

721—21.401(376) Signature requirements in cities with primary or runoff election provisions. In cities using the provisions of Iowa Code section 376.4 for nomination of candidates and in which more than one council member was elected at-large at the last preceding regular city election, the number of signatures shall be calculated by the following formula:

V = the total number of votes cast for all candidates for council member at-large at the last regular city election;

E = the number of people to be elected at the last regular city election;

$$\frac{V}{E} \times .02 = \text{the number of signatures needed by each candidate in the next regular city election.}$$

This rule is intended to implement Iowa Code section 376.4.

721—21.402(372) Filing deadline for charter commission appointment petition. If a special election has been called by a city to present to the voters the question of adopting a different form of city

government, receipt by the city council of a petition requesting appointment of a charter commission shall stay the special election if the petition is received no later than 5 p.m. on the Friday preceding the date of the special election.

This rule is intended to implement Iowa Code section 372.3.

721—21.403(81GA,HF2282) Special elections to fill vacancies in elective city offices for cities that may be required to conduct primary elections.

21.403(1) *Notice to the commissioner.* At least 60 days before the proposed date of the special election, the city council shall give written notice to the commissioner who will be responsible for conducting the special election.

a. If the commissioner finds no conflict with other previously scheduled elections, or with other limitations on the dates of special elections, the commissioner shall immediately notify the council that the date has been approved.

b. No special city elections to fill vacancies for cities that may be required to conduct primary elections shall be held with the general election, with the primary election, or with the annual school election. To do so would be contrary to the provisions of Iowa Code section 39.2.

21.403(2) *Election calendar.* The election calendar shall be adjusted as follows:

a. The deadline for candidates to file nomination papers with the city clerk shall be not later than 12 noon on the fifty-third day before the election.

b. The city clerk shall deliver all nomination papers accepted by the clerk to the county commissioner of elections not later than 5 p.m. on the fifty-third day before the election.

c. A candidate who has filed nomination papers for the special election may withdraw not later than 5 p.m. on the fiftieth day before the election.

d. A person who would have the right to vote for the office in question may file a written objection to the legal sufficiency of a candidate's nomination papers or to the qualifications of the candidate for this special election not later than 12 noon on the fiftieth day before the election.

e. The hearing on the objection must be held within 24 hours of receipt of the objection.

This rule is intended to implement Iowa Code section 372.13(2) as amended by 2006 Iowa Acts, House File 2282, section 2.

721—21.404(81GA,HF2282) Special elections to fill vacancies in elective city offices for cities without primary election requirements. This rule applies to cities that have adopted by ordinance one of the following options: nominations under Iowa Code chapter 44 or chapter 45, or a runoff election requirement if no candidate in the special election receives a majority of the votes cast.

21.404(1) *Notice to the commissioner.* At least 32 days before the proposed date of the special election, the city council shall give written notice to the commissioner who will be responsible for conducting the special election. If the commissioner finds no conflict with other previously scheduled elections, or with other limitations on the dates of special elections, the commissioner shall immediately notify the council that the date has been approved.

21.404(2) *Special elections to fill vacancies held in conjunction with the general election.* If the proposed date of the special election coincides with the date of the general election, the council shall give notice of the proposed date of the special city election not later than 76 days before the date of the general election. Candidates shall file nomination papers with the city clerk not later than 5 p.m. on the seventieth day before the general election. The city clerk shall deliver the nomination papers accepted by the clerk not later than 5 p.m. on the sixty-ninth day before the general election. Objection and withdrawal deadlines shall be 64 days before the general election, the same as the deadlines for candidates who file their nomination papers with the commissioner. Hearings on objections shall be held as soon as possible in order to facilitate printing of the general election ballot.

21.404(3) *Election calendar.* If the special election date is not the same as the date of the general election, the election calendar shall be adjusted as follows:

a. The deadline for candidates to file nomination papers with the city clerk shall be not later than 12 noon on the twenty-fifth day before the election.

b. The city clerk shall deliver all nomination papers accepted by the clerk to the county commissioner of elections not later than 5 p.m. on the twenty-fifth day before the election.

c. A candidate who has filed nomination papers for the special election may withdraw not later than 5 p.m. on the twenty-second day before the election.

d. A person who would have the right to vote for the office in question may file a written objection to the legal sufficiency of a candidate's nomination papers or to the qualifications of the candidate for this special election not later than 12 noon on the twenty-second day before the election.

e. The hearing on the objection must be held within 24 hours of receipt of the objection.

This rule is intended to implement Iowa Code section 372.13(2) as amended by 2006 Iowa Acts, House File 2282, section 2.

721—21.405 to **21.499** Reserved.

721—21.500(277) Signature requirements for school director candidates. The number of signatures required to be filed by candidates for the office of director in the regular school election shall be calculated from the number of registered voters in the district on May 1 of the year in which the election will be held. Candidates who are seeking election in districts with election plans as specified in Iowa Code section 275.12(2)*"b"* and *"c,"* where the candidate must reside in a specific director district, but is voted upon by all of the electors of the school district, shall be required to file a number of signatures calculated from the number of registered voters in the whole school district. Candidates who will be voted upon only by the electors of a director district shall be required to file a number of signatures calculated from the number of registered voters in the director district in which the candidate resides and seeks to represent.

If a special election is to be held to fill a vacancy on the school board, the number of registered voters on the first day of the month preceding the date the commissioner receives notice of the special election shall be used to calculate the number of signatures required for the special election.

This rule is intended to implement Iowa Code sections 277.4 and 279.7.

721—21.501 to **21.599** Reserved.

721—21.600(43) Primary election signatures—plan three supervisor candidates. The minimum number of signatures needed by candidates for the office of county supervisor elected under plan three, where candidates are voted upon only by the voters of the supervisor district, shall be determined by one of the two following methods.

21.600(1) If there were 5,000 or more votes cast in the supervisor district for a political party's candidate for governor or for president of the United States, the minimum number of signatures needed is 100.

21.600(2) If there were less than 5,000 votes cast in the supervisor district for a political party's candidate for governor or for president of the United States, the minimum number of signatures is determined by using one of the following formulas:

Democratic candidate's signature requirement: $([AD \div S] + VD) \times .02$

Republican candidate's signature requirement: $([AR \div S] + VR) \times .02$

AD = the number of absentee votes received in the entire county by the Democratic party's candidate for governor or for president of the United States in the previous general election.

AR = the number of absentee votes received in the entire county by the Republican party's candidate for governor or for president of the United States in the previous general election.

S = the number of supervisor districts in the county (3 or 5).

VD = the number of votes cast in the supervisor district for the Democratic party's candidate for governor or for president of the United States in the previous general election. (If this number is 5,000 or more, the minimum number of signatures needed is 100.)

VR = the number of votes cast in the supervisor district for the Republican party's candidate for governor or for president of the United States in the previous general election. (If this number is 5,000 or more, the minimum number of signatures needed is 100.)

This rule is intended to implement Iowa Code section 43.20(1)*"d."*

721—21.601(43) Plan III supervisor district candidate signatures after a change in the number of supervisors. After the number of supervisors has been increased or decreased pursuant to Iowa Code section 331.203 or 331.204, the signatures for candidates at the next primary and general elections shall be calculated as follows:

21.601(1) *Primary election.* Divide the total number of votes cast in the county at the previous general election for the office of president or for governor, as applicable, by the number of supervisor districts and multiply the quotient by .02. If the result of the calculation is less than 100, the result shall be the minimum number of signatures required. If the result of the calculation is greater than or equal to 100, the minimum requirement shall be 100 signatures.

21.601(2) *Nominations by petition.* If the effective date of the change in the number of districts was later than the date specified in Iowa Code section 45.1(6), divide the total number of registered voters in the county on the date specified in Iowa Code section 45.1(6) by the number of supervisor districts and multiply the quotient by .01. If the result of the calculation is less than 150, the result shall be the minimum number of signatures required. If the result of the calculation is greater than or equal to 150, the minimum requirement shall be 150 signatures.

721—21.602(43) Primary election—nominations by write-in votes for certain offices.

21.602(1) The process described in subrule 21.602(2) shall be used to determine whether the primary election is conclusive and a candidate was nominated for partisan offices that are:

a. Not mentioned in Iowa Code section 43.53 (township offices) or 43.66 (state representative and state senator), and

b. For which no candidate's name was printed on the primary election ballot, and

c. For which no candidate's name was printed on the primary election ballot in any previous primary election.

21.602(2) To be nominated by write-in votes, the person must receive at least 35 percent of the number of votes cast in the previous general election for that party's candidate for president of the United States or for governor, as the case may be, as follows:

a. Statewide office: 35 percent of votes cast statewide.

b. Congressional district: 35 percent of votes cast within the current boundaries of the Congressional district.

c. County office, including plan II supervisors: 35 percent of the votes cast within the county.

d. Plan III county supervisor: 35 percent of the votes cast within the supervisor district. If the boundaries of the supervisor district have changed since the previous general election, the number of votes cast within the county for the party candidate for president or for governor, as the case may be, shall be divided by the number of supervisor districts in the county; then the quotient shall be multiplied by 0.35.

21.602(3) If a write-in candidate is declared nominated at the canvass of votes, Iowa Code section 43.67, which requires the appropriate election commissioner to notify the candidate, shall apply.

This rule is intended to implement Iowa Code section 43.66.

721—21.603 to **21.799** Reserved.

721—21.800(422B) Local sales and services tax elections.

21.800(1) Petitions requesting imposition of local sales and services taxes shall be filed with the county board of supervisors.

a. The petition shall be signed by eligible electors equal in number to at least 5 percent of the persons in the whole county who voted at the last preceding state general election. Each petition shall include:

(1) A statement in substantially the following form: We the undersigned eligible electors of _____ County hereby request imposition of a local sales and services tax.

(2) Each person signing the petition shall add the person's address (including street number, if any) and the date that the person signed the petition.

b. Within 30 days after receipt of the petition, the supervisors shall provide written notice to the county commissioner of elections directing that an election be held to present to the voters of the entire county the question of imposition of a local sales and services tax. In the notice the supervisors shall propose a specific date for the election.

c. The proposed election date shall be at least 75 days, but not more than 90 days, after the date upon which notice is given to the commissioner. The local option tax election may be held in conjunction with a state general election, or at a special election held at any time other than the time of a city regular election. However, if the date proposed by the supervisors conflicts with another scheduled election as defined in Iowa Code section 47.6(2), the commissioner shall notify the supervisors of this fact. The supervisors shall propose another date for the special election within 7 days of receiving notice from the commissioner.

21.800(2) As an alternative to the method of initiating a local option tax election described in subrule 21.4(1), governing bodies of cities and the county may initiate a local option tax election by filing motions with the county auditor pursuant to Iowa Code section 422B.1(3)*"b"* requesting submission of a local option tax to the qualified electors. Within 30 days of receiving a sufficient number of motions, the county commissioner shall, in consultation with the governing bodies of the cities and with the board of supervisors, set a date for the local option tax election. The election shall be held no sooner than 105 days nor later than 120 days after the date upon which the commissioner received the motion triggering the election. If this would result in the special election being held at a time of a conflicting election as defined by Iowa Code section 47.6 or on a date upon which special elections are forbidden to be held by Iowa Code section 39.2(1), the election may be held on a date as close as possible to the required time period.

21.800(3) Notice of local sales and services tax election.

a. Not less than 60 days before the date that a local sales and services tax election will be held, the county commissioner of elections shall publish notice of the ballot proposition. The notice does not need to include sample ballots, but shall include all of the information that will appear on the ballot for each city and for the voters in the unincorporated areas of the county.

b. The city councils and the supervisors shall provide to the county commissioner the following information to be included in the notice and on the ballots:

(1) The rate of the tax.

(2) The date the tax will be imposed (which shall be the next implementation date provided in Iowa Code section 423B.6 following the date of the election and at least 90 days after the date of the election, except that an election to impose a local option tax on a date immediately following the scheduled repeal date of an existing similar tax may be held at any time that otherwise complies with the requirements of Iowa Code chapter 423B). The imposition date shall be uniform in all areas of the county voting on the tax at the same election.

(3) The approximate amount of local option tax revenues that will be used for property tax relief in the jurisdiction.

(4) A statement of the specific purposes other than property tax relief for which revenues will be expended in the jurisdiction.

c. The information to be included in the notice shall be provided to the commissioner by the city councils of each city in the county not later than 67 days before the date of the election. If a jurisdiction fails to provide the information in 21.4(3)*"b"*(3) and 21.4(3)*"b"*(4) above, the following information shall be substituted in the notice and on the ballot:

(1) Zero percent (0%) for property tax relief.

(2) The specific purpose for which the revenues will otherwise be expended is: Any lawful purpose of the city (or county).

d. The notice of election provided for in Iowa Code section 49.53 shall also be published at the time and in the manner specified in that section.

21.800(4) Definitions.

"Abstract of ballot" means abstract of votes.

This rule is intended to implement Iowa Code sections 422B.1 and 422B.9.

721—21.801(422B) Form of ballot for local option tax elections. If questions pertaining to more than one of the authorized local option taxes are submitted at a single election, all of the public measures shall be printed on the same ballot. The form of ballots to be used throughout the state of Iowa for the purpose of submitting questions pertaining to local option taxes shall be as follows:

21.801(1) *Local sales and services tax propositions.* Sales and services tax propositions shall be submitted to the voters of an entire county. If the election is being held for the voters to decide whether to impose the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of imposition shall be voted upon in all parts of the county where the tax has not been approved. If the election is being held for the voters to decide whether to repeal the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of repeal shall be voted upon in all parts of the county where the tax was previously imposed. If the election is being held for the voters to decide whether to change the rate or use of the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of rate or use change shall be voted upon in all parts of the county where the tax was previously imposed.

The ballot submitted to the voters of each incorporated area and the unincorporated area of the county shall show the intended uses for that jurisdiction. The ballot submitted to the voters in contiguous cities within a county shall show the intended uses and repeal dates, if not uniform, for each of the contiguous cities. The ballots shall be in substantially the following form:

a. Imposition question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the [city of _____] [unincorporated area of the county of _____], at the rate of _____ percent (_____ %) to be effective on _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25. Counties using

special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25.)

A local sales and services tax shall be imposed in the [city of _____] [unincorporated area of the county of _____] at the rate of _____ percent (_____ %) to be effective on _____ (month and day), _____ (year).

Revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

b. Imposition question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective on _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25.)

A local sales and services tax shall be imposed in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective on _____ (month and day), _____ (year).

Revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

c. Imposition question with an automatic repeal date for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the [city of _____] [unincorporated area of the county of _____], at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25.)

A local sales and services tax shall be imposed in the [city of _____] [unincorporated area of the county of _____] at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

Revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

d. Imposition question with an automatic repeal date for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of ____ percent (____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25.)

A local sales and services tax shall be imposed in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

Revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

e. Repeal question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize repeal of the ____ percent (_____%) local sales and services tax in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25.)

The _____ percent (_____%) local sales and services tax shall be repealed in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).
Revenues from the sales and services tax have been allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

f. Repeal question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize repeal of the ____ percent (_____%) local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25.)

The _____ percent (_____%) local sales and services tax shall be repealed in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

Revenues from the sales and services tax have been allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

g. Rate change question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize an increase (or decrease) in the rate of the local sales and services tax to _____ percent (_____%) in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25.)

The rate of the local sales and services tax shall be increased (or decreased) to ____ percent (_____%) in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year). The current rate is ____ percent (_____%).

Revenues from the sales and services tax are allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

h. Rate change question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize an increase (or decrease) in the rate of the local sales and services tax to _____ percent (_____%) in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25.)

The rate of the local sales and services tax shall be increased (or decreased) to _____ percent (_____%) in the cities of _____, _____, _____,

(list additional cities, if applicable) effective _____ (month and day), _____ (year).

Revenues from the sales and services tax are allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

i. Use change question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize a change in the use of the _____ percent (_____%) local sales and services tax in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25.)

The use of the _____ percent (_____%) local sales and services tax shall be changed in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

PROPOSED USES OF THE TAX:

If the change is approved, revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

CURRENT USES OF THE TAX:

Revenues from the sales and services tax are currently allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

j. Use change question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize a change in the use of the _____ percent (_____%) local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25.)

The use of the _____ percent (_____%) local sales and services tax shall be changed in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

PROPOSED USES OF THE TAX:

If the change is approved, revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

CURRENT USES OF THE TAX:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

k. Imposition question with differing automatic repeal dates for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective from _____ (month/day/year) until automatic repeal date specified.

A local sales and services tax shall be imposed in the following cities at the rate of _____ percent (_____%) to be effective from _____ (month/day/year) until the date specified below and the revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

The tax shall be repealed on _____ (month/day/year).

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

FOR THE CITY OF _____:
The tax shall be repealed on _____ (month/day/year).
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

FOR THE CITY OF _____:
The tax shall be repealed on _____ (month/day/year).
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

21.801(2) *For a local vehicle tax:*

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize the county of (insert name of county) to impose a local vehicle tax at the rate of _____ dollars ($_____) per vehicle and to exempt the following classes from the tax:

_____.

The revenues are to be expended as set forth in the text of the public measure.

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45, or place on the left-hand side inside the curtain of each voting machine as provided in Iowa Code section 52.25.)

The county of _____, Iowa shall be authorized to impose a local vehicle tax at the rate of _____ dollars ($_____) per vehicle and to exempt the following classes of vehicles from the tax:

_____

_____ (insert percentage or dollar amount) of the revenues is/are to be used for property tax relief.
The balance of the revenues is to be expended for:
(List purposes for which remaining revenues will be used)

721—21.802(422B) Local vehicle tax elections.

21.802(1) Petitions requesting imposition of local vehicle taxes shall be filed with the county board of supervisors.

a. The petition shall be signed by eligible electors equal in number to at least 5 percent of the persons in the whole county who voted at the last preceding state general election. Each petition shall include:

(1) A statement in substantially the following form: We the undersigned eligible electors of _____ County hereby request imposition of a local vehicle tax at a rate of _____ dollar(s) per vehicle with the following classes (if any) to be exempt: _____.

(2) Each person signing the petition shall add the person's address (including street numbers, if any) and the date that the person signed the petition.

b. Within 30 days after receipt of the petition, the supervisors shall provide written notice to the county commissioner of elections directing that an election be held to present to the voters of the entire county the question of imposition of a local vehicle tax. In the notice the supervisors shall propose a specific date for the election.

c. The proposed election date shall be at least 75 days, but not more than 90 days, after the date upon which notice is given to the commissioner. The local option tax election may be held in conjunction with a state general election, or at a special election held at any time other than the time of a city regular election. However, if the date proposed by the supervisors conflicts with another scheduled election as defined in Iowa Code section 47.6(2), the commissioner shall notify the supervisors of this fact. The supervisors shall propose another date for the special election within 7 days of receiving notice from the commissioner.

21.802(2) Notice of local vehicle tax election. Not less than 60 days before the date that a local vehicle tax election will be held, the county commissioner of elections shall publish notice of the ballot proposition. The notice does not need to include a sample ballot, but shall include all of the information that will appear on the ballot. The notice of election provided for in Iowa Code section 49.53 shall also be published at the time and in the manner specified in that section.

721—21.803(82GA,HF2663) Revenue purpose statement ballots. When a school district wishes to adopt, amend or extend the revenue purpose statement specifying the uses of the funds received from the secure an advanced vision for education fund, which is also referred to as the "penny sales and services tax for schools," the following ballot formats shall be used.

21.803(1) *Ballot to propose a revenue purpose statement.* The ballot for an election to propose a revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

◯ YES

◯ NO

Summary: To adopt a revenue purpose statement specifying the use of money from the penny sales and services tax for schools received by _____ School District.

In the _____ School District, the following revenue purpose statement, which specifies the use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) shall be adopted:

(Insert here the revenue purpose statement that was adopted by the school board and that states the intended uses of the funds by the school district. The use or uses must be among the approved uses of the tax that are authorized by 2008 Iowa Acts, House File 2663, section 29.)

21.803(2) *Ballot to amend a revenue purpose statement.* The ballot for an election to decide a change in the revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES
⬭ NO

Summary: To authorize a change in the use of money from the penny sales and services tax for schools received by _____ School District.

In the _____ School District, the revenue purpose statement, which specifies the use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) shall be changed.

Proposed uses. If the change is approved, the revenue purpose statement shall read as follows:

(Insert here the revenue purpose statement that was adopted by the school board and that states the intended uses of the funds by the school district. The use or uses must be among the approved uses of the tax that are authorized by 2008 Iowa Acts, House File 2663, section 29.)

Current uses. If the change is not approved, the funds shall continue to be used as follows:

(Insert here the current revenue purpose statement or list the current voter-approved uses of the funds by the school district, if the school infrastructure local option tax was adopted before the revenue purpose statement was required.)

21.803(3) *Ballot to extend a revenue purpose statement.* The ballot for an election to extend a revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES
⬭ NO

Summary: To authorize _____ School District to continue to spend money from the penny sales and services tax for schools for the previously approved uses until (specify date or insert amended date).

_____ School District is authorized to extend the current revenue purpose statement which specifies use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) received from (date) until (specify date or insert amended date). If an extension is not approved, the current revenue purpose statement will expire on (date). If an extension is approved, the revenue purpose statement will read as follows:

(Insert here the revenue purpose statement, including the new expiration date, or an explanation that the revenue purpose statement will remain in effect until it is changed.)

This rule is intended to implement 2008 Iowa Acts, House File 2663, section 29.

721—21.804 to **21.809** Reserved.

721—21.810(34A) Referendum on enhanced 911 emergency telephone communication system funding.

21.810(1) *Form of ballot.* The ballot for the E911 referendum shall be in substantially the following form:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a monthly surcharge of (an amount to be determined by the local joint E911 service board of up to one dollar) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within (description of the proposed service area).

A map may be used to show the proposed E911 service area. If a map is used the public measure shall read as follows:

"Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a monthly surcharge of (an amount to be determined by the local joint E911 service board of up to one dollar) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within the proposed E911 service area shown on the map below."

21.810(2) *Cost of election.* The E911 service board shall pay the costs of the referendum election.

21.810(3) *Enhanced 911 emergency service funding referendum held in conjunction with a scheduled election.*

a. Notice to commissioner. The joint E911 service board shall notify the commissioner in writing, no later than the last day upon which nomination papers may be filed, of their intention to conduct the referendum with the scheduled election. The notice shall contain the complete text of the referendum question including the description of the proposed E911 service area. If a map is to be used on the ballot to describe the proposed E911 service area, the map shall be included. If the E911 service area includes more than one county, the service board shall notify the commissioner of each of the counties.

b. Conduct of election. All qualified electors in a precinct which is to be served, in whole or in part, by the proposed E911 service area, shall be permitted to vote on the question. The results of the referendum shall be canvassed by the board of supervisors at the time of the canvass of the scheduled election. The commissioner shall immediately certify the results to the joint E911 board.

c. Service board duties. If subscribers from more than one county are included within the proposed service area, the E911 service board shall meet as a board of canvassers to compile the results from the counties. The canvass shall be held on the tenth day following the election at a time established by the E911 service board. The service board shall prepare an abstract showing in words and numbers the number of votes cast for and against the question and, if a simple majority of those voting on the question has voted in the affirmative, the board shall declare that the surcharge has been adopted. Votes cast and not counted as a vote for or against the question shall not be used in computing the total vote cast for and against the question.

21.810(4) *Form of ballot for alternative surcharge.* The ballot for elections conducted pursuant to Iowa Code section 34A.6A shall be in the following form:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a temporary monthly surcharge increase to (an amount between one dollar and two dollars and fifty cents to be determined by the local joint E911 service board) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within (description of the proposed service area). The surcharge shall be collected for not more than 24 months, after which the surcharge shall revert to one dollar per month for each line.

A map may be used to show the proposed E911 service area. If a map is used the public measure shall read as follows:

"Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a temporary monthly surcharge increase to (an amount between one dollar and two dollars and fifty cents to be determined by the local joint E911 service board) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within the proposed E911 service area shown on

the map below. The surcharge shall be collected for not more than 24 months, after which the surcharge shall revert to one dollar per month for each line."

This rule is intended to implement Iowa Code sections 34A.6 and 34A.6A.

721—21.811 to **21.819** Reserved.

721—21.820(99F) Gambling elections.

21.820(1) Petitions requesting elections to approve or disapprove the conduct of gambling games on an excursion gambling boat or at a gambling structure shall be filed with the county board of supervisors.

a. The petition shall be signed by eligible electors of the county equal in number to at least 10 percent of the votes cast in the county for the office of President of the United States or governor at the preceding general election.

b. Each petition shall be in substantially the following form:

STATE OF IOWA
PETITION REQUESTING ELECTION
_____ County

We, the undersigned eligible electors of _____ County, hereby request that an election be held on the proposition to approve or disapprove gambling games on an excursion gambling boat or at a gambling structure in the county.

Signature	Address, including street and number, if any	Date signed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		

page _____ of _____

c. Within 10 days after receipt of a valid petition, the supervisors shall provide written notice to the county commissioner of elections directing the commissioner to submit to the qualified electors of the county a proposition to approve or disapprove the conduct of gambling games on an excursion gambling boat or at a gambling structure in the county. The election shall be held within 70 days of the receipt of the petition.

d. If a regularly scheduled or special election is to be held in the county on the date selected by the supervisors, notice shall be given to the commissioner no later than the last day upon which nomination papers may be filed for that election. If the excursion gambling boat or the gambling structure election is to be held with a local option tax election, the supervisors shall provide the commissioner at least 60 days' written notice. Otherwise, the supervisors shall give at least 32 days' written notice. If the commissioner finds that the date selected by the supervisors conflicts with another election to be held that day, the commissioner shall immediately notify the supervisors in writing. Within 7 days, the supervisors shall select another date and notify the commissioner in writing.

21.820(2) Form of ballot for election called by petition. Ballots shall be in substantially the following form:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

YES

NO

Gambling games on an excursion gambling boat or at a gambling structure in _____ County are approved.

21.820(3) Form of ballot for elections to continue gambling games on an excursion gambling boat or at a gambling structure:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

YES

NO

Summary: Gambling games on an excursion gambling boat or at a gambling structure in _____ County are approved.

Gambling games, with no wager or loss limits, on an excursion gambling boat or at a gambling structure in _____ County are approved. If approved by a majority of the voters, operation of gambling games with no wager or loss limits may continue until the question is voted upon again at the general election held in 2010. If disapproved by a majority of the voters, the operation of gambling games on an excursion gambling boat or at a gambling structure will end within 60 days of this election. (Iowa Code section 99F.7(10)*"c"*)

21.820(4) Ballot form to permit gambling games at existing pari-mutuel racetracks:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

YES

NO

The operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved.

21.820(5) Canvass of votes. The canvass of votes for a special election regarding excursion boat gambling shall be held on the Monday following the election. A copy of the abstract of votes of the election shall be sent to the state racing and gaming commission.

21.820(6) Ballot form for general election for continuing operation of gambling games at pari-mutuel racetracks:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

YES

NO

Summary: The continued operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved.

The continued operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved. If approved by a majority of the voters, operation of gambling games may continue at (name of pari-mutuel racetrack) in _____ County until the question is voted on again at the general election in eight years. If disapproved by a majority of the voters, gambling games at (name of pari-mutuel racetrack) in _____ County will end.

21.820(7) Ballot form for general election for continuing gambling games on an excursion gambling boat or at a gambling structure:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

◯ YES

◯ NO

Summary: The continued operation of gambling games on an excursion gambling boat or at a gambling structure in _____ County is approved.

The continued operation of gambling games on an excursion gambling boat or at a gambling structure in _____ County is approved. If approved by a majority of the voters, operation of gambling games may continue on an excursion gambling boat or at a gambling structure in _____ County until the question is voted on again at the general election in eight years. If disapproved by a majority of voters, gambling games on an excursion gambling boat or at a gambling structure in _____ County will end nine years from the date of the original issue of the license to the current licensee.

This rule is intended to implement Iowa Code section 99F.7 and Iowa Code Supplement section 99F.4D.

721—21.821 to **21.829** Reserved.

721—21.830(357E) Benefited recreational lake district elections. Elections for benefited recreational lake districts shall be conducted according to the following procedures.

21.830(1) *Conduct of election.* It is not mandatory for the county commissioner of elections to conduct elections for a benefited recreational lake district. However, if both a public measure and a candidate election will be held on the same day in a benefited recreational lake district, the same person shall be responsible for conducting both elections. All elections must be held on a Tuesday.

21.830(2) *Ballots.* Ballots for benefited recreational lake district trustee elections shall be printed on opaque white paper, 8 by 11 inches in size. The ballots for the initial election for the office of trustee shall be in substantially the following form:

OFFICIAL BALLOT
BENEFITED RECREATIONAL LAKE DISTRICT
Election date
(facsimile signature of person responsible for printing ballots)

FOR TRUSTEE:

To vote: Neatly print the names of at least three people you would like to see elected to the office of Trustee of the Benefited Recreational Lake District. You may vote for as many people as you wish, but you must vote for at least three.

(At the bottom of the ballot a space shall be included for the endorsement of the precinct election official, like this:)

Precinct official's endorsement: _____

21.830(3) *Canvass of votes.* On the Monday following the election, the board of supervisors shall canvass the votes cast at the election. At the initial election the supervisors shall choose three trustees from among the five persons who received the most votes. The results of benefited recreational lake district elections shall be certified to the district board of trustees.

This rule is intended to implement Iowa Code section 357E.8.

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CHAPTER 1
ORGANIZATION AND PROCEDURES

1.1(35,35A,35D) Definitions
1.2(35,35A,35D) Commission
1.3(35,35A) Executive director
1.4(35A,35D) Commandant
1.5 and 1.6 Reserved

ARMED FORCES GRAVES REGISTRATION

1.7(35A,35B) Armed forces graves registration
1.8 and 1.9 Reserved

WAR ORPHANS EDUCATIONAL AID

1.10 Reserved

MERCHANT MARINE WAR BONUS

1.11(35) Merchant marine war bonus
1.12 to 1.14 Reserved

TRAINING FOR COUNTY COMMISSIONS

1.15(35A,35B) Training for county commissions

CHAPTER 2
PETITION FOR RULE MAKING
(Uniform Rules)

2.1(17A) Petition for rule making
2.3(17A) Inquiries

CHAPTER 3
DECLARATORY RULINGS
(Uniform Rules)

3.1(17A) Petition for declaratory ruling
3.3(17A) Inquiries

CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

4.3(17A) Public rule-making docket
4.4(17A) Notice of proposed rule making
4.5(17A) Public participation
4.6(17A) Regulatory flexibility analysis
4.11(17A) Concise statement of reasons
4.13(17A) Agency rule-making record
4.14(17A,35D) Uniform waiver rule
4.15(17A,35D) Procedures for granting waivers

CHAPTER 5
Reserved

CHAPTER 6
FAIR INFORMATION PRACTICES
(Uniform Rules)

6.1(17A,22)	Definitions
6.3(17A,22)	Request for access to records
6.6(17A,22)	Procedure by which additions, dissents, or objections may be entered into certain records
6.7(17A,22)	Consent to disclosure by the subject of a confidential record
6.8(17A,22)	Notice to suppliers of information
6.9(17A,22)	Release to subject
6.10(17A,22)	Disclosure without consent of the subject
6.11(17A,21,22)	Availability of records
6.12(17A,22)	Personally identifiable information
6.13(17A,22)	Other groups of records
6.14(17A,22)	Data processing system
6.15(17A,22)	Applicability

CHAPTER 7
Reserved

CHAPTER 8
CONTESTED CASES

8.1(17A,35)	Scope and applicability
8.2(17A,35)	Definitions
8.3(17A,35)	Complaint procedure

CHAPTER 9
WAR ORPHANS EDUCATIONAL ASSISTANCE FUND

9.1(35)	War orphans educational assistance fund
9.2(35)	Program for children of veterans who died before September 11, 2001
9.3(35)	Program for children of veterans who died on or after September 11, 2001
9.4(35)	General requirements
9.5(35)	Application process

CHAPTER 10
IOWA VETERANS HOME

10.1(35D)	Definitions relevant to Iowa Veterans Home
10.2(35D)	Eligibility requirements
10.3(35D)	Application
10.4(35D)	Application processing
10.5(35D)	Applicant's responsibilities
10.6(35D)	Admission to IVH
10.7 to 10.10	Reserved
10.11(35D)	Member rights
10.12(35D)	Member responsibilities
10.13	Reserved
10.14(35D)	Computation of member support
10.15(35D)	Per diems
10.16(35D)	Assets
10.17(35D)	Divestment of assets
10.18(35D)	Commencement of civil action
10.19(35D)	Income
10.20(35D)	Other income

10.21(35D) Fraud
10.22(35D) Overcharges
10.23(35D) Penalty
10.24 to 10.29 Reserved
10.30(35D) Incentive therapy and nonprofit rehabilitative programs
10.31 to 10.34 Reserved
10.35(35D) Handling of pension money and other funds
10.36(35D) Passes, furloughs, and room retention
10.37 to 10.39 Reserved
10.40(35D) Requirements for member conduct
10.41(35D) County of settlement upon discharge
10.42(35D) Disposition of personal property and funds
10.43 and 10.44 Reserved

APPEAL PROCESS

10.45(35A,35D) Applicant appeal process
10.46(35A,35D) Member appeal process
10.47 to 10.49 Reserved

GROUNDS AND FACILITY ADMINISTRATION

10.50(35D) Visitors
10.51(35D) Mail
10.52(35D) Interviews and statements
10.53(35D) Donations
10.54(35D) Photographing and recording of members and use of cameras
10.55(35D) Use of grounds and facilities
10.56(35D) Nonmember use of cottages
10.57(35D) Operating motor vehicles on grounds

CHAPTER 11
INJURED VETERANS GRANT PROGRAM

11.1(35A) Purpose
11.2(35A) Grant amounts
11.3(35A) Eligible veterans
11.4(35A) Notification and application procedures
11.5(35A) Taxability

CHAPTER 12
COUNTY GRANT PROGRAM FOR VETERANS

12.1(82GA,SF2425) Purpose
12.2(82GA,SF2425) Grant amounts
12.3(82GA,SF2425) Application procedure
12.4(82GA,SF2425) Assessment of applications
12.5(82GA,SF2425) Application decision
12.6(82GA,SF2425) Grant agreement
12.7(82GA,SF2425) Appeals
12.8(82GA,SF2425) Recovery of funds

CHAPTER 13
VIETNAM CONFLICT VETERANS BONUS

13.1(35A) Bonus for persons serving in the Vietnam service area
13.2(35A) Bonus for persons serving outside the Vietnam service area
13.3(35A) Other Vietnam veterans compensation
13.4(35A) Definition of active duty

13.5(35A) Survivor compensation
13.6(35A) Persons not eligible for compensation
13.7(35A) Penalties
13.8(35A) Tax exemption
13.9(35A) Application procedures and determination of eligibility
13.10(35A) Bonus restrictions and limitations

CHAPTER 14
VETERANS TRUST FUND

14.1(35A) Purpose
14.2(35A) Definition
14.3(35A) Eligibility
14.4(35A) Benefits available
14.5(35A) Application procedure
14.6(35A) Recovery of erroneous payments
14.7(35A) Appeal rights

CHAPTER 15
VETERANS COMMEMORATIVE PROPERTY

15.1(37A) Purpose
15.2(37A) Definitions
15.3(37A) Notification procedure
15.4(37A) Transaction approval
15.5(37A) Appeals
15.6(37A) Penalty

CHAPTER 16
LIMITED RESIDENCY VIETNAM CONFLICT VETERANS BONUS

16.1(82GA,HF2283) Bonus for persons serving in the Vietnam service area
16.2(82GA,HF2283) Bonus for persons serving outside the Vietnam service area
16.3(82GA,HF2283) Definition of active duty
16.4(82GA,HF2283) Survivor compensation
16.5(82GA,HF2283) Penalties
16.6(82GA,HF2283) Tax exemption
16.7(82GA,HF2283) Application procedures and determination of eligibility
16.8(82GA,HF2388) Bonus restrictions and limitations

CHAPTER 14
VETERANS TRUST FUND

801—14.1(35A) Purpose. These rules establish the requirements for veterans or their spouses or dependents to receive benefits from the veterans trust fund.

801—14.2(35A) Definition. For purposes of this chapter, "veteran" means the same as defined in Iowa Code section 35.1, or a resident of Iowa who served in the armed forces of the United States, completed a minimum aggregate of 90 days of active federal service, and was discharged under honorable conditions, or a former member of the national guard, reserve, or regular component of the armed forces of the United States who was honorably discharged due to injuries incurred while on active federal service that precluded completion of a minimum aggregate of 90 days of active federal service.

801—14.3(35A) Eligibility. Veterans, their spouses, and their dependents applying for benefits available under subrules 14.4(1) through 14.4(9) must meet the following threshold requirements.

14.3(1) *Income.* For the purposes of this chapter, an applicant's household income, excluding VA pension benefits and service-connected disability income, shall not exceed 300 percent of the federal poverty guidelines for the number of family members living in the primary residence in effect on the date the application is received by the county director of veterans affairs. Federal poverty guidelines shall be those guidelines established by the Iowa department of human services for the veteran's family size. The commission shall adjust the guidelines on July 1 of each year to reflect the most recent federal poverty guidelines.

14.3(2) *Resources.* The department may not pay benefits under this chapter if the available liquid assets of the veteran are in excess of $15,000. For the purposes of this chapter, "available liquid assets" means cash on hand, cash in a checking or savings account, stocks, bonds, certificates of deposit, treasury bills, money market funds and other liquid investments owned individually or jointly by the applicant and the applicant's spouse, unless the applicant and spouse are separated or are in the process of obtaining a divorce, but does not include funds deposited in IRAs, Keogh plans or deferred compensation plans, unless the veteran is eligible to withdraw such funds without incurring a penalty. Cash surrender value of life insurance policies, real property, established burial account, or a personal vehicle shall not be included as available liquid assets.

14.3(3) *Funding from other sources.* Applications shall not be approved if the applicant is eligible to receive aid from other sources to meet the purposes authorized in this chapter.

14.3(4) *Additional requirements and limitations.* Applicants must meet any additional requirements and are subject to any limitations which may be set out in this chapter or which may be established for a particular benefit.

801—14.4(35A) Benefits available. Applications may be approved for any of the following purposes.

14.4(1) *Travel expenses for wounded veterans, and their spouses, directly related to follow-up medical care.* Travel expenses under this subrule include the unreimbursed cost of airfare, lodging, and a per diem of $25 per day for required out-of-state medical travel. Spouses may be reimbursed for in-state lodging and a per diem of $25 per day when visiting a veteran who is in a hospital for medical care related to a service-connected disability. The veteran or the veteran's spouse shall provide such evidence as the commission may require, which includes but is not limited to evidence the injury or disability is service-connected, the necessity of treatment in a particular facility, and documentation of expenses. The maximum amount for lodging reimbursement shall be $90. The maximum amount of aid payable in a consecutive 12-month period under this subrule is $1,000.

14.4(2) *Job training or college tuition assistance for job retraining.*

a. The commission may pay a veteran not more than $3,000 for retraining or postsecondary education to enable the veteran to obtain gainful employment. The commission may provide aid under this subrule if all of the following apply:

(1) The veteran is enrolled in a training course in a technical college or school, is enrolled in an accredited postsecondary institution, or is engaged in a structured on-the-job training program.

(2) The veteran is unemployed, underemployed, or has received a notice of termination of employment.

(3) The commission determines that the veteran's proposed program, or current program, will provide retraining or initial training that could enable the veteran to find gainful employment. In making its determination, the commission shall consider whether the proposed program, or current program, provides adequate employment skills and is in an occupation for which favorable employment opportunities are anticipated.

(4) The veteran requesting aid has not received full reimbursement or payment from any other retraining or education scholarship programs and the veteran does not have other assets or income available to meet retraining or initial training expenses. Applicants requesting aid under this subrule will only be granted the unpaid portion of their tuition statement, and the payment will be made directly to the institution.

b. The veteran shall provide such evidence as the commission may require to satisfy the requirements of this subrule.

14.4(3) *Unemployment or underemployment assistance during a period of unemployment or underemployment due to prolonged physical or mental illness or disability resulting from military service.* The commission may provide subsistence payments only to a veteran who has suffered a loss of income due to prolonged physical or mental illness or disability resulting from military service. The commission may provide subsistence payments of up to $500 per month of unemployment or underemployment to a veteran. No payment may be made under this subrule if the veteran has other assets or income available to meet basic subsistence needs. The veteran shall provide such evidence as the commission may require, which includes but is not limited to evidence that the mental illness or disability is service-connected and evidence that the veteran is unemployed or underemployed for the period of payments. To qualify as underemployed, the applicant must be currently working at an income that is below 300 percent of federal poverty guidelines due to limitations caused by the applicant's service-connected disability or illness. The maximum amount of aid payable in a consecutive 12-month period under this subrule is $3,000 and a lifetime maximum of $6,000.

14.4(4) *Expenses related to hearing care, dental care, vision care, or prescription drugs.*

a. The commission may provide health care aid to a veteran for dental care, including dentures; vision care, including eyeglass frames and lenses; hearing care, including hearing aids; and prescription drugs that are not covered by the Veterans Affairs Medical Center.

b. The maximum amount that may be paid under this subrule for any consecutive 12-month period may not exceed $2,500 for dental care, $500 for vision care, $1,500 per ear for hearing care, and $1,500 for prescription drugs.

c. The commission shall not provide health care aid under this subrule unless the aid recipient's health care provider agrees to accept, as full payment for the health care provided, the amount of the payment; the amount of the recipient's health insurance or other third-party payments, if any; and the amount that the commission determines the veteran is capable of paying. Payment under this subrule will be provided directly to the health care provider. The commission shall not pay health care aid under this subrule if the available liquid assets of the veteran are in excess of $5,000.

d. Applicants for assistance under this subrule will be required to provide the commission with an unpaid bill for service or an estimated cost of service from the health care provider and documentation of the need for the service. For prescription drugs, the applicant must produce documentation of the need for the prescribed drug and documentation stating whether a generic drug is available or appropriate. The commission payment will not exceed an estimated cost of service by a health care provider.

14.4(5) *Expenses relating to the purchase of durable equipment or services to allow veterans to remain in their homes.*

a. The commission may make reimbursement payments to veterans for the purchase of durable equipment that allows the veterans to remain in their homes or allows them the ability to utilize more of their home.

b. Individuals requesting reimbursement under this subrule will be required to provide verification of the purchase and installation of the equipment and information relating to the need for the equipment. Individuals may also provide a product and installation cost estimate to the commission for approval, with the understanding that the commission will pay no more than the cost estimate to the supplier or installer. Applicants needing durable equipment as a medical necessity should provide information from a physician.

c. Assistance under this subrule cannot duplicate assistance from other entities, and the maximum amount that may be paid may not exceed $2,500.

d. The commission shall not pay a reimbursement under this subrule if the available liquid assets of the veteran are in excess of $5,000.

14.4(6) *Individual counseling or family counseling programs.*

a. The commission may make mental health, substance abuse, and family counseling available to veterans and their families. Individual family members are eligible for counseling.

b. The assistance may include appropriate counseling and treatment programs for veterans and their families in need of services.

c. Any assistance provided under this subrule shall not duplicate other services readily available to veterans and their families. Veterans who are eligible for VA mental health services must initially visit their nearest VA medical facility for initial consultation and continued psychiatric treatment. Payment under this subrule will be made for additional services for the veteran in a location closer to the veteran's home and at a greater frequency than the VA medical center can accommodate.

d. The commission may provide up to $150 per hour and $75 per half-hour for outpatient counseling visits to providers who will accept as full payment for the counseling services the amount provided. Counseling and substance abuse services provided in a group setting may be paid up to $40 per hour. Counseling and substance abuse services may also be provided in an inpatient setting, subject to the maximum amount eligible under 14.4(6)*"f."*

e. The maximum amount that may be paid under this subrule for any consecutive 12-month period shall not exceed $5,000. Individuals seeking counseling services are eligible for up to $2,500, individuals seeking substance abuse treatment and counseling combined are eligible for up to $3,500, and families seeking counseling services that may also include individual counseling and substance abuse services are eligible for up to $5,000.

f. The commission may not provide counseling under this subrule unless the aid recipient's counseling service provider agrees to accept, as full payment for the counseling services provided, the amount of the payment; the amount of the recipient's health insurance or other third-party payments, if any; and the amount that the commission determines the veteran is capable of paying. The commission will make payment directly to the entity providing counseling and substance abuse services. The commission shall not pay for counseling under this subrule if the available liquid assets of the veteran are in excess of $5,000.

14.4(7) *Expenses relating to ambulance and emergency room services for veterans who are trauma patients.*

a. The commission may provide assistance to veterans for expenses related to ambulance trips, including air ambulance transportation, and emergency room visits for trauma patients or VA healthcare patients that cannot indicate to emergency personnel that they are to be presented to a VA medical center.

b. Funding through this subrule shall be paid directly to the entity providing the emergency service or transportation after the commission is provided with an unpaid bill. All efforts should be made to utilize all other methods of payment prior to accessing assistance under this subrule.

c. The maximum amount that may be paid under this subrule may not exceed $5,000.

14.4(8) *Emergency expenses related to vehicle repair, housing repair, or temporary housing assistance.*

a. The commission may provide assistance to veterans for emergency vehicle repair, emergency housing repair, and temporary housing.

b. Assistance for vehicle repair is limited to expenses that are required for continued use of the vehicle. This assistance will only be granted in cases where the vehicle is needed for travel to and

from work-related activities, the applicant is over the age of 65, or substantial hardship will occur if the vehicle is not repaired. Assistance may be provided in situations where the applicant does not have sufficient means to pay an insurance deductible. Assistance will be paid directly to the entity performing the maintenance or the insurance company owed the deductible. Assistance will not be provided for damage caused during the commission of a crime, for cosmetic needs, for damage resulting in an auto accident when automobile insurance has not been purchased, or for routine maintenance.

c. Assistance for home repair is limited to repairs that are required to improve the conditions and integrity of the home and are necessary for the safety and security of the residents. Applicants with homeowners insurance may request assistance for payment of a deductible. Assistance may be provided for applicants in disaster situations, home accidents, vandalism, or other situations as determined by the commission. In situations where a home is damaged beyond repair, assistance under this subrule is available to assist the applicant in purchasing a new home.

d. Assistance for transitional housing may be provided to applicants who are displaced from their home during a period of repairs related to a disaster, vandalism, home accident, or other reason that makes staying in the home hazardous to the health of the residents. Any refunded security deposits paid for under this subrule shall be returned to the Iowa veterans trust fund.

e. The maximum amount that may be paid under this subrule for any consecutive 12-month period may not exceed $2,500 for vehicle repair, $3,000 for housing repair, and $1,000 for transitional housing.

f. The commission shall not pay a reimbursement under this subrule if the available liquid assets of the veteran are in excess of $3,000.

14.4(9) *Expenses related to establishing whether a minor child is a dependent of a deceased veteran.*

a. The commission may provide assistance to the family of veterans who are killed while serving on active federal service, for expenses related to paternity or maternity tests or the cost of procuring additional DNA samples from the deceased veteran. This assistance is available to determine whether a child is eligible for United States Department of Veterans Affairs war orphan benefits.

b. Applicants are required to provide the results of the paternity or maternity exams to the commission upon completion of the tests. Where the deceased veteran is not the parent of the child, the applicant will be required to repay the assistance received as provided in 801—14.6(35A).

c. The maximum amount that may be paid under this subrule is $2,500.

14.4(10) *Family support group programs or programs for children of members of the military.*

a. The commission may award grants to unit family readiness/support groups, family support offices, and other such organizations providing support and programs to families and children of family members.

b. The grant shall be only for projects or programs which are not funded from any other source. The commission shall determine if the applicant's proposed project or program will provide the intended support. In making its determination, the commission shall consider whether the proposed program will provide anticipated favorable results.

c. The maximum amount of aid payable in a consecutive 12-month period under this subrule to a family readiness/support group is $500.

14.4(11) *Honor guard services.*

a. The commission may reimburse veterans organizations for providing military funeral honors as follows:

(1) If a single veterans organization provides basic honors, $25.

(2) If a single veterans organization provides full honors, $50.

(3) If two or more veterans organizations participate in providing full honors and one of the organizations provides a firing detail, $50. The organizations may request that the commission split the reimbursement.

(4) If two or more veterans organizations participate in providing basic honors, $25. Payment shall be to one veterans organization, as determined by the commission.

b. Notwithstanding paragraph *"a,"* the commission shall not reimburse a veterans organization if federal funding is available to reimburse the veterans organization for providing military funeral honors.

The veterans organization shall request reimbursement from federal sources. If a veterans organization receives federal funding for providing military funeral honors at the reimbursement rate of one funeral per day, the department shall reimburse the organization for the provision of military funeral honors at any additional funerals on that day.

c. The maximum amount of aid payable in a consecutive 12-month period under this subrule to a veterans organization is $500.

d. Veterans service organizations that are not currently providing honor guard services may apply for a $500, up-front grant, for the use of creating a new honor guard within their organization. Applicants must present the commission with an estimated cost for purchasing uniforms and firearms for providing military honors and an estimated number of members who will be available to perform honor guard services. Organizations should also provide information regarding how they plan to pay for additional expenses that may occur outside of trust fund assistance. Applicants will be eligible for reimbursements under 14.4(11)*"a"* to *"c"* 12 months after the receipt of their original $500 grant.

14.4(12) *Matching funds to veterans service organizations to provide for accredited veteran service officers.*

a. The commission may provide matching funds to veterans service organizations for maintaining accredited veteran service officers located at the Des Moines Veterans Affairs Regional Office.

b. Funding for all service organizations combined is available up to 20 percent of the interest and earnings on the trust fund balance during the fiscal year or $150,000, whichever is less.

c. Service organizations requesting funding from the trust fund must provide financial data on the level of organizational funding for the staffing and operation of an office in the Des Moines Veterans Affairs Regional Office. Of the available amount outlined in this subrule, assistance will be split evenly among the service organizations eligible for the trust fund assistance. If the service organization's expenditures are less than their share of the grant, the grant amount will be reduced to the amount of their previous fiscal year's expenditures.

d. Service organizations will be required to maintain the same level of expenditures in the year they receive funding as in the previous year. Funding will be recaptured by the treasurer of the state of Iowa if this funding is used to supplant funding from an individual veterans service organization. Trust fund assistance will not be included in future fiscal year maintenance of effort requirements. A report on the previous fiscal year's expenditures will be required to determine the maintenance of effort for the organization.

801—14.5(35A) Application procedure. Applications for benefits from the veterans trust fund may be obtained at any county veterans affairs office. The county director of veterans affairs shall date-stamp the application and submit it to the Iowa Department of Veterans Affairs, Camp Dodge, Bldg. A6A, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824.

14.5(1) *Application process.* A person who wishes to apply shall complete an Application for Veterans Trust Fund form and provide such documentation or other evidence as the commission may require in order to determine the awarding or denial of the benefits available under this chapter.

14.5(2) *Date of application.* The date of the application shall be the date the signed application and written verification are received by the county director of veterans affairs.

14.5(3) *Eligibility determination.*

a. The county director of veterans affairs or members of the county commission shall make a recommendation to the Iowa commission of veterans affairs as to whether to approve or deny the application. The Iowa commission of veterans affairs or a subcommittee appointed by the chair shall approve or deny all applications. Applications that are denied by the subcommittee will be forwarded to the Iowa commission of veterans affairs and will be processed at its quarterly meetings as set forth in 801—paragraph 1.2(2)*"a"* or during a conference call for the sole purpose of voting on a trust fund expenditure. Applications must be approved by a majority vote of the commission membership. The director of the Iowa department of veterans affairs shall notify an applicant within 15 days of the commission's decision. An explanation of the reasons for rejection of an application will accompany denials.

b. Applications for honor guard reimbursements under subrule 14.4(11) shall be processed solely by the Iowa department of veterans affairs and do not need commission approval for expenditure of trust fund interest balance funds for this purpose.

14.5(4) *Waiting list.* After all veterans trust fund moneys have been obligated, the commission shall deny pending applications.

a. The denial notice shall state either that the applicant meets eligibility requirements but no funds are available and the applicant will be placed on the waiting list or that the applicant does not meet eligibility requirements.

b. Applicants not awarded funding who meet the eligibility requirements shall be placed on a statewide waiting list according to the order in which the completed applications and verification were received by the county commission of veteran affairs. In the event that more than one application is received at one time, the applicant shall be entered on the waiting list on the basis of the day of the month of the person's birthday, the 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.

c. When funding allows additional applicants to be approved, their names shall be taken from the statewide waiting list, and their need and eligibility shall be redetermined at that time. An application packet, which includes instructions and necessary forms for verification of continuing eligibility, shall be sent to each applicant for completion. Packets shall be returned to the Iowa department of veterans affairs within time lines specified by the department. If the signed application and verification of continuing eligibility are not received by the time line specified by the department, the applicant shall not be considered for funding.

801—14.6(35A) Recovery of erroneous payments.

14.6(1) *Erroneous payments.* The commission may recover payments made as a grant under this chapter if any of the following apply:

a. The information provided by the applicant is inaccurate.

b. The commission incorrectly calculated the grant amount.

c. The applicant is not entitled to a grant or is entitled to a lower grant amount as a result of a change in circumstances that affects the applicant's eligibility to receive the grant.

14.6(2) *Amount of recovery.* The commission may recover only the portion of the grant to which the applicant would not have been entitled if the correct information had been provided or if the grant had been properly calculated or as a change in circumstances warrants.

14.6(3) *Remedies.* The commission may request repayment of the amount due under subrule 14.6(2). In lieu of a lump-sum payment, the commission may enter into an agreement under which the applicant may repay the amount due within a 12-month period. If the applicant fails to repay the amount due within 30 days of a request for repayment or fails to comply with the terms of a repayment agreement, the commission may offset future grants that the applicant may be entitled to under this chapter until the amount due has been recovered. The commission may also suspend other benefits available to the applicant until the amount due has been recovered.

14.6(4) *Waiver.* The commission may temporarily or permanently waive its authority to recover payments under subrule 14.6(1) or suspend benefits under subrule 14.6(3) if the applicant's household income is totally exempt from Iowa garnishment law.

14.6(5) *Appeal.* Any commission decision under this chapter is subject to appeal under rule 801—14.7(35A).

801—14.7(35A) Appeal rights.

14.7(1) *Final agency action.* The approval or denial of an application by the commission or the department shall be the final decision of the agency.

14.7(2) *Judicial review.* Judicial review of the commission's final decisions may be sought in accordance with Iowa Code section 17A.19.

These rules are intended to implement Iowa Code section 35A.13 as amended by 2007 Iowa Acts, House File 817, section 7.

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CHAPTER 16
LIMITED RESIDENCY VIETNAM CONFLICT VETERANS BONUS

801—16.1(82GA,HF2283) Bonus for persons serving in the Vietnam service area.

16.1(1) *Service requirement.* A person who served on active duty for not less than 120 days in the armed forces of the United States at any time between July 1, 1958, and May 31, 1975, both dates inclusive, and who was inducted into active duty service from the state of Iowa and was honorably discharged or separated from active duty service, or is still in active service in an honorable status, or has been retired, or has been furloughed to a reserve, or has been placed on inactive status is entitled to receive from moneys appropriated for that purpose the sum of $17.50 for each month that the person was on active duty service in the Vietnam service area, within the dates specified in this subrule, if the veteran earned either a Vietnam service medal or an armed forces expeditionary medal-Vietnam or can otherwise establish service in the Vietnam service area during that period.

16.1(2) *Limited eligibility requirements.* A person eligible to receive compensation pursuant to 16.1(1) shall be entitled to compensation pursuant to this rule only if all of the following requirements are met:

a. The person has not received a bonus or compensation similar to that provided in this chapter from this state or another state.

b. The person was on active duty service after July 1, 1958, and the person did not refuse on conscientious, political, religious, or other grounds, to be subject to military discipline.

c. The person made application for a bonus or compensation similar to that provided in this chapter from this state and was denied compensation because the person did not meet the applicable residency requirements.

d. The person files an application for compensation under this chapter in a manner determined by the department of veterans affairs by July 1, 2010.

16.1(3) *Compensation.* Compensation for persons who served in the Vietnam service area shall be as follows:

a. The amount of compensation shall be the sum of $17.50 for each month that the person was on active duty service in the Vietnam service area, within the dates specified in subrule 16.1(1).

b. In addition, the person shall receive compensation at the sum of $12.50 for each month that the person was on active duty service within the dates specified in subrule 16.1(1) and was not in the Vietnam service area. For example, a person who served six months in the Vietnam service area and six months not in the Vietnam service area will receive compensation for six months at $17.50 per month, which is $105, and six months at $12.50 per month, which is $75, for a total compensation payment of $180.

c. Compensation under this subrule shall not exceed a total sum of $500. Compensation for a fraction of a month shall not be considered unless the fraction is 16 days or more, in which case the fraction shall be computed as a full month.

801—16.2(82GA,HF2283) Bonus for persons serving outside the Vietnam service area.

16.2(1) *Service requirement.* A person serving outside the Vietnam service area is a person otherwise qualified under subrule 16.1(1) except that the person did not earn either a Vietnam service medal or an armed forces expeditionary medal-Vietnam and did not serve in the Vietnam service area during the period between July 1, 1958, and May 31, 1975, both dates inclusive.

16.2(2) *Limited eligibility requirements.* A person eligible to receive compensation pursuant to 16.2(1) shall be entitled to compensation pursuant to this rule only if all of the following requirements are met:

a. The person has not received a bonus or compensation similar to that provided in this chapter from this state or another state.

b. The person was on active duty service after July 1, 1958, and the person did not refuse on conscientious, political, religious, or other grounds, to be subject to military discipline.

c. The person made application for a bonus or compensation similar to that provided in this chapter from this state and was denied compensation because the person did not meet the applicable residency requirements.

d. The person files an application for compensation under this chapter in a manner determined by the department of veterans affairs by July 1, 2010.

16.2(3) *Compensation.* Compensation shall be the sum of $12.50 for each month that the person was on active duty service within the dates specified in subrule 16.2(1). Compensation under this subrule shall not exceed a total sum of $300. Compensation for a fraction of a month shall not be considered unless the fraction is 16 days or more, in which case the fraction shall be computed as a full month.

801—16.3(82GA,HF2283) Definition of active duty. "Active duty" means full-time duty in the armed forces of the United States, excluding active duty for training purposes only and excluding any period a person was assigned by the armed forces to a civilian institution for a course of education or training which was substantially the same as established courses offered to civilians, or as a cadet or midshipman, however enrolled, at one of the service academies.

801—16.4(82GA,HF2283) Survivor compensation. The surviving unremarried widow or widower, child or children, mother, father, or person standing in loco parentis, in the order named and none other, of any deceased person shall be paid the compensation that the deceased person would be entitled to pursuant to this chapter, if living. However, if any person dies or is disabled from service-connected causes incurred during the period and in the area from which the person is entitled to receive compensation pursuant to this chapter, the person or the first survivor as designated by this rule, and in the order named, shall be paid $500 or $300, whichever maximum amount would have applied pursuant to rule 801—16.1(82GA,HF2283) or 801—16.2(82GA,HF2283), regardless of the length of service.

801—16.5(82GA,HF2283) Penalties. A person who knowingly makes a false statement relating to a material fact in supporting an application under this chapter is guilty of a serious misdemeanor. A person convicted under 2008 Iowa Acts, Senate File 2283, section 4, shall forfeit all benefits to which the person may have been entitled under this chapter.

801—16.6(82GA,HF2283) Tax exemption. All payments and allowances made under this chapter shall be exempt from taxation, levy, and sale on execution.

801—16.7(82GA,HF2283) Application procedures and determination of eligibility.

16.7(1) *Application procedures.* Application shall be made on forms provided by the Iowa department of veterans affairs. Applications may be obtained from the department at the address listed in subrule 16.7(4) or from the department's Web site at www.iowava.org. The applicant shall provide the information requested on the application and include any additional documentation required (for example, a copy of the applicant's DD Form 214). The completed application, including documentation, shall be returned to the department at the address listed in subrule 16.7(4).

16.7(2) *Department processing and investigation.* The executive director of the Iowa department of veterans affairs will approve or disapprove the application.

16.7(3) *Appeals procedure.* Decisions of the executive director are subject to review by the commission pursuant to 801—Chapter 8. Applicants may appeal the decisions of the commission as provided by Iowa Code section 17A.19.

16.7(4) *Office address.* Persons may contact the Iowa Department of Veterans Affairs, Camp Dodge, Bldg. A6A, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824; telephone (515)242-5331 or 1-800-838-4692; fax (515)242-5659. The department's Web address is www.iowava.org.

801—16.8(82GA,HF2388) Bonus restrictions and limitations. All bonuses under the program are subject to funding availability. Bonuses will be awarded in the order in which completed applications are received.

These rules are intended to implement 2008 Iowa Acts, House File 2283.

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CAFETERIAS
See FOOD: Service Establishments

CAMERAS AND RECORDING DEVICES
See also VIDEOS
Boards
Economic development department **261**—1.3(2)*d*,*e*
Elevator safety **875**—65.4(8)
Energy independence **350**—3.3(2)*b*
Professional licensure, *see specific profession subheading Board: Meetings*

Commission meetings **429**—1.3(2)*e*; **431**—1.3(2)*e*; **433**—1.3(2)*e*; **434**—1.1(4)*d*; **567**—1.5(3)
Juvenile justice advisory council meetings **428**—1.5(1)*d*
Surveillance, gambling boats/racetrack enclosures **491**—5.4(7), 12.17, 12.18(4)*e*,*f*; **661**—ch 141

CAMPAIGN FINANCE DISCLOSURE
See ETHICS AND CAMPAIGN DISCLOSURE

CAMPS
Athletic, coaches **281**—36.15(6)
Backpack **571**—62.3(3), 62.4(2)*d*, 62.5(5)
Disabilities, parking permits **571**—61.2, 61.4(5)*j*
Fairgrounds, state **371**—ch 3, 7.15
Fees **571**—61.3(4), 61.4(1), 61.5(1)*g*,*h*, 61.5(4), 62.4(4), 62.5(2,4)
Forests, state **571**—ch 62
Game management areas **571**—51.12
Medical assistance providers **441**—77.30(5), 77.33(6), 77.34(5), 77.37(15), 77.39(14), 77.46(5), 78.43(3), 79.1(2)p.6, 79.1(15)
Memberships, sales, operators **61**—2.15(6), ch 25
Migratory labor **641**—ch 81
Parks/recreation areas, state **571**—61.2–61.4, 61.5(1)*g*,*h*, 61.5(3), 61.8(4), 63.3, 63.4
Prohibitions/restrictions **571**—51.12, 61.4(5), 61.7(9,10), 61.8(4), 62.6–62.9, 62.12, 63.4
Reservations, centralized **571**—61.2, 62.2, 62.4
Signs
Game management areas **571**—51.12
Interstates **761**—118.4(6), 131.4
Off-highway **571**—62.3(2,3); **761**—131.7
Reservation sites **571**—61.3(2)*b*(2,3)

Taxation
Generally **701**—18.43, 26.58
Summer recreation **701**—17.1(5)*h*

CAPITAL INVESTMENT BOARD
Address **123**—1.4
Definitions **123**—2.2, 3.2, 4.2
Duties **123**—1.3, 1.6
Membership **123**—1.2
Taxation credits, investment
Contingent **123**—ch 4
Community-based seed capital/qualifying businesses **123**—ch 2
Venture capital **123**—ch 3; **701**—42.18(2), 52.12“2,” 52.21(2), 58.11(2)

CAPITOL COMPLEX
See ADMINISTRATIVE SERVICES DEPARTMENT (DAS): General Services Enterprise

CARE FACILITIES
Child **441**—chs 109, 110, 118, 159, 168, 170; **661**—5.500–5.502, *see also CHILDREN*
County, expense reimbursement exclusion **441**—151.22(2)*b*(8), *see also HEALTH CARE FACILITIES*
Day services, adult **321**—ch 24, *see also HUMAN SERVICES DEPARTMENT: Medical Assistance (Medicaid)*
Family-life homes **441**—ch 111
Foster care **441**—chs 112–117, 156, 202, *see also FOSTER CARE*
Hospice, *see HOSPICE*
Hospitals, *see HOSPITALS*
Intermediate, *see HEALTH CARE FACILITIES*
Juveniles, shelter/detention **441**—chs 105, 167
Long-term, *see ELDER AFFAIRS DEPARTMENT; HEALTH CARE FACILITIES*
Mentally ill, *see MENTAL HEALTH*
Mental retardation **441**—ch 116, *see also HEALTH CARE FACILITIES; MENTALLY RETARDED*
Nursing, *see HEALTH CARE FACILITIES*
Ombudsman program, *see ELDER AFFAIRS DEPARTMENT*
Residential, *see HEALTH CARE FACILITIES; RESIDENTIAL CARE FACILITIES*
Respite care, *see HUMAN SERVICES DEPARTMENT*

CARNIVALS
See AMUSEMENTS AND AMUSEMENT PARKS

CARRIERS
See also BUSES; MOTOR VEHICLES
Beverage sales **567**—107.8(1)
Commercial vehicles **701**—32.10; **761**—ch 520, 524.11(4), 602.1(1,3), chs 605, 607
Common
  Cigarettes **701**—81.4(10), 83.8(2)
  Liquor **185**—8.1
  Student transportation **281**—43.44
Contract **701**—63.25(3), 64.3"5"(d), 64.19, 64.22, 65.15, 68.8(4), 69.13(2)
Definitions **761**—500.1, 505.1, 513.1, 520.2, 524.2(2), 524.14(1), 529.3
Dimensions, highway restrictions **761**—500.24, ch 511
Emergencies, movement waivers **761**—500.3
Fees/penalties **761**—505.3(4,9), 505.4(8), 511.5, 511.15(2)*i*, *see also Motor: Intrastate, For-Hire: Tariffs below; Registration below*
Flammable liquids **661**—51.350
Freight **761**—524.13
Hazardous materials **567**—131.2, ch 140, 141.4, 141.12; **661**—51.350, ch 231; **761**—ch 520, 605.4, 607.17(1,5), *see also RADIATION MACHINES AND RADIOACTIVE MATERIALS*
Insurance **761**—511.6(1), 524.7, 524.8
Interstate **567**—107.8(1); **701**—17.8, 32.4, 32.9, 33.7, 34.5(8); **761**—1.8(5)*g*, chs 500, 505, 524.7(2), 524.12(2), ch 529
Job creation program, high quality **261**—ch 68
Leases **701**—32.9, 33.7, 34.5(8); **761**—505.1, 505.3(10), 524.14
Licenses, fuel **761**—ch 505, *see also Permits below; MOTOR VEHICLES: Licenses: Driver's*
Motor
  Generally **761**—chs 520, 524
  Intrastate, for-hire
    Bills of lading **761**—524.13
    Certificates/permits **761**—524.2–524.6, 524.11(4), 524.16
    Fees **761**—524.3(2), 524.11(4), *see also Tariffs this subheading below*
    Household goods **761**—524.15

CARRIERS (cont'd)
Motor
Intrastate, for-hire

Insurance/bonds **761**—524.7, 524.8
Leases **761**—524.14
Liquid commodities, bulk **761**—524.3(3), 524.10, 524.11, 524.16
Marking **761**—524.12, 524.14(3)
Operating authority **761**—1.8(5)*g*
Safety **761**—524.9, 524.11
Tariffs **761**—524.3(3)*e*, 524.15

Registration **761**—ch 500, 529.2
Services, office **761**—400.5(3,4)

Operation, temporary, *see Registration below*
Permits
All-system **761**—511.9, 511.12(1,5)
Annual **761**—511.4, 511.5(1), 511.7, 511.8, 511.12(1,2,5)
Charter **761**—524.16
Escort load **761**—511.15
Explosives **661**—ch 231
Fuel, temporary **761**—ch 505, *see also TAXATION: Motor Fuel*
Motor carrier, for-hire intrastate **761**—524.3–524.6, 524.16, 524.17
Oversize vehicles/loads **761**—ch 511
Rubbish vehicles **761**—ch 513
Trip **761**—500.2(3)*b*(2), 500.24, 511.4, 511.5(4,5), 511.10, 511.11, 511.12(3–5), *see also Fuel, Temporary this subheading above*

Radioactive materials, *see Hazardous Materials above; RADIATION MACHINES AND RADIOACTIVE MATERIALS: Transportation/Packaging*
Railroads, motor fuel transport **701**—64.19, *see also RAILROADS*
Records/reports **701**—32.4, 64.19, 64.22; **761**—500.23, 500.25, 505.4–505.6
Registration
Address **761**—400.6(2,3), 500.2(1), 529.2
Cancellation **761**—500.11
Equipment, special mobile **761**—ch 410
Expiration **761**—500.21
Fees **761**—500.2(3), 500.4(2), 500.5–500.20
Fleet changes **761**—500.9, 500.10, 500.12
Nonresidents **761**—500.2(3)*a*
Permits, *see Permits above*
Prorate **761**—500.2(3)*b*
Reciprocity **761**—500.2(3)
Storage **761**—500.4(2)*b*, 500.5
Suspension **761**—500.18, 500.19
Temporary **761**—500.1, 500.9, 500.11
Title, non-Iowa **761**—500.22

Safety, *see Hazardous Materials above; Motor above*
Tariffs, *see Motor: Intrastate, For-Hire above*
Taxation
Cigarette transport **701**—81.4(10), 83.8(2,3)
Corporations, apportionment **701**—54.7(2)
Exemptions **701**—17.8, 32.4, 32.9, 32.10
Fuel, motor vehicle
Dealers/distributors/users **701**—chs 63–65, *see also TAXATION: Motor Fuel*
Evasion **761**—505.6
Exemption, urban transit **701**—18.38
Records, audit **761**—505.5
Refunds **701**—18.37; **761**—505.4
Reports **761**—505.4

Income, nonresident employees **701**—40.16(2), 46.4(2)"12"

Sales, retail **701**—16.24, 16.25
Trailers/semitrailers, exemption **701**—32.4, 32.9

Telecommunications **199**—ch 39
Transport, liquid, *see Motor: Intrastate, For-Hire: Liquid Commodities, Bulk above*
Truck operators, *see MOTOR VEHICLES*
Weight restrictions **761**—400.47, 500.24, ch 511, *see also MOTOR VEHICLES*

CARS
See MOTOR VEHICLES

CASINOS
See RACING AND GAMING

CASKETS
Sales, *see FUNERALS: Prearrangement*

CATERERS
See FOOD

CATHODE RAY TUBES (CRT)
Disposal **567**—ch 122, 144.3(2)*n*

CATS
See ANIMALS

CATTLE
See DAIRIES; LIVESTOCK

CEBA (COMMUNITY ECONOMIC BETTERMENT ACCOUNT)
See ECONOMIC DEVELOPMENT DEPARTMENT

CEMENT
Contractors
Construction **701**—19.3, 19.7, 219.3, 219.8
Unemployment contributions **871**—23.82(2)*e*(3)

Definitions **567**—39.3
Disposal, landfills **567**—101.14(2)*a*, 113.3
Emissions control
Kilns **567**—23.1(4)*bc*,*bl*, 23.1(5)*b*(2)"7," 23.4(3)
Plants, Portland **567**—22.5(1)*c*, 22.100 p.33, 23.1(2)*c*, 23.1(4)*bl*, 23.4(11)

CEMETERIES
Ancient **685**—chs 11, 12
Disinterment **641**—101.7; **645**—100.9
Graves
Cremated remains **645**—100.11(6)*a*
Depth **641**—101.6(4)
Excavation contractors **871**—23.82(2)*n*(6)
Registration **801**—1.7, 6.12(2)
Veterans, commemorative property **801**—ch 15

Merchandise sales, *see FUNERALS: Prearrangement/Preneed Contracts*
Perpetual care **191**—ch 18
Purchase, trust funds **191**—101.1
Sexton **641**—101.7(1)
Taxation, sales
Funeral services **701**—18.21
Lawn care **701**—17.4, 26.61

CENSUS
Data, annexed territory **721**—21.30
Employees, income exemption **441**—41.27(7)*ak*, 75.57(7)*ah*

Registry, deaf **429**—2.3(13)
Types, local option tax distribution **701**—107.10"2"

CERTIFICATES OF TITLE
See also MOBILE HOMES; MOTOR VEHICLES: Registration
Boats **571**—20.8

CERTIFIED PUBLIC ACCOUNTANT (CPA)
See ACCOUNTANCY, ACCOUNTANTS

CERVIDAE
See LIVESTOCK

CHARITY
Bingo receipts, distribution **481**—103.13, 103.14
Campaign, state **11**—ch 71
Contributions
  Election funds **351**—4.25(1)*w*
  Payroll deduction, *see Payroll Deductions below*
  Real estate transactions **193E**—11.6(6)
  Taxation, *see Taxation below*

Drug repository program **641**—ch 109
Food
  Commodity distribution **441**—ch 66
  Coupons (stamps) **701**—ch 20
  HUSH (help us stop hunger) program **571**—ch 116

Fund-raisers
  Gambling, license requirements **481**—100.3(8)*c*
  Political, goods/services, disclosure **351**—4.14(7), 4.17(7), 4.25(1)*h*, 4.30(4)
  Professional registration **61**—ch 24

Gambling receipts, distribution **481**—100.34, 106.3(8)
Grants, endow Iowa program **261**—chs 46, 47
HAWK-I (healthy and well kids in Iowa) program, donations **441**—86.17
Individual development accounts (IDAs) **441**—ch 10
Institutions, food establishment inspections **481**—1.5"2"
Medical services, volunteers **641**—ch 88
Payroll deductions **11**—chs 43, 71; **681**—16.9(2)*f*
Solicitation, regents institutions **681**—12.7(3), 13.15(2), 14.2, 15.8, 16.9
Taxation
  Deductions **223**—37.1
  Exemptions **701**—17.1, 17.5, 80.4

Volunteer health care providers **641**—ch 88

CHECKOFFS
Agricultural commodities
  Excise tax assessments **101**—ch 3; **301**—ch 4; **741**—ch 4
  Referendums **21**—ch 20

Income tax **351**—3.1, 3.2; **701**—43.4, *see also TAXATION: Income Tax, Individual: Donations*

CHEMICALS
See also DRUGS; EXPLOSIVES; FEED, COMMERCIAL; FERTILIZERS; FUEL; HERBICIDES; PESTICIDES; POISONS; RADIATION MACHINES AND RADIOACTIVE MATERIALS; SOIL: Conditioners
Agricultural **21**—chs 43–45, 51; **567**—62.4(55), 141.3; **701**—17.4, 17.9(3), 17.10; **761**—607.49; **875**—110.1(5), *see also FERTILIZERS; HERBICIDES; PESTICIDES*

Antifreeze standards **21**—85.33
Dead animal disposal **21**—61.19, 61.24, 61.29
Embalmers, use **645**—100.6(1,3,4); **701**—18.21
Hazardous
Classification, groups defined **567**—137.2
Right-to-know **605**—103.3(3,4), ch 104; **875**—2.2(1)*c*, 2.4, chs 110, 130, 140
Waste, *see ENVIRONMENTAL PROTECTION COMMISSION*
Household, retailer requirements **567**—ch 144
Industries, *see INDUSTRY subheadings Pollution; Waste Disposal*
Pharmacists **657**—7.6
Refrigerants **567**—ch 118; **661**—226.3
Research, controlled substances **657**—ch 10
Sales/use tax **701**—17.4, 17.9(3), 17.10, 17.14, 18.3, 18.21, 18.47, 211.1, 225.5, 230.4, 230.9
Soil, land recycling program **567**—137.5(5), 137.6(6)
Wastes, *see ENVIRONMENTAL PROTECTION COMMISSION subheadings Hazardous Waste; Solid Waste Management/Disposal*
Water
See also ENVIRONMENTAL PROTECTION COMMISSION: Groundwater; Water Quality: Supply; WATER
Surface, standards **567**—61.2(5)*c*(2), 61.3(3), 137.5(6,8)
Swimming pools, *see PUBLIC HEALTH DEPARTMENT*

CHICKENS
See POULTRY

CHILDREN
See also BIRTH; DISABILITIES; EDUCATION; HUMAN SERVICES DEPARTMENT; JUVENILES; SCHOOLS
Abduction, information **661**—ch 89
Abuse
Adoption **441**—107.4(5), 107.8(1), 108.6(3), 108.9(4)*d*,*e*, 157.3(1)*a*(16), 157.3(1)*b*, 200.4(1)*b*,*d*, 200.11(1)
Assessment **441**—175.21–175.37
Care
See also Services this subheading below; Care Services below
Community **441**—ch 186
Emergency assistance **441**—ch 133
Consultants **441**—175.28, 175.29
Criminal records, check/evaluation **441**—7.1"8," 82.2(2)*d*, 105.3(3)*f–j*, 105.5, 107.4(5), 107.8(1)*c*,*d*, 108.8(1)*c*(13), 108.9(4)*d*,*e*, 109.2(4–6), 109.6(6), 110.3, 110.5(2)*c*(1), 110.5(2)*d*(1), 110.7(3), 112.5(1)*d*, 112.6(1)*d*, 113.13, 114.7(3), 114.8(1), ch 119, 157.3(1)*b*, 157.3(1)*d*(1), 170.4(3)*h*, 175.40(3), 200.4(1)*b*,*d*; **481**—41.15; **641**—155.21(9), 162.20(7); **657**—8.13, *see also Care Services: Development Homes below; HEALTH CARE FACILITIES subheadings Personnel; Residents*
Definitions **441**—175.21
Education **441**—175.37, *see also Identification, Training this subheading below*
Foster care facilities **441**—108.8(1)*c*(13), 112.5(1)*d*, 112.6(1), 112.10, 113.13, 114.7(3), 114.8(1), 114.19, 117.7(2), 202.13(1)*c*
Founded **441**—175.39, *see also Criminal Records, Check/Evaluation this subheading above*
Identification, training **441**—77.37(1)*e*(4), 77.37(1)*h*, 77.37(23)*b*(3)"1," 109.14(3)*b*(2); **645**—31.10(4), 240.1, 240.12(4), 280.9(3); **650**—10.6(2), 25.2(9); **653**—9.1, 10.1, 11.1, 11.4(1)*c*, 11.5; **655**—3.7(3), *see also Reports this subheading below; Care Services: Development Homes below; specific profession*
Information, release **441**—9.4(6), 9.7(2)*d*, 9.10(12), 9.10(17)*b*, 175.30, 175.32, 175.38, 175.41, 175.42, 175.43(7,10)
Investigations **441**—9.10(12), 101.16, 103.16, 114.7(3)*a*(3), 130.3(1)*e*, 175.29, 175.30, 175.34; **641**—73.11(2)*a*
Parental, abortion notification exception **641**—89.22(4)
Prevention programs **349**—ch 1; **441**—130.3(1)*e*, ch 155; **641**—ch 87
Protection centers, *see Care Services below*

Records/registry **441**—9.4(6), 9.7(2)*d*, 9.10(12,17), 9.11, 9.12(1)*b*(3,6), 175.25(7), 175.31(2), 175.32, 175.33, 175.36, 175.38–175.42; **481**—51.7, *see also Criminal Records, Check/Evaluation this subheading above*
Rehabilitative treatment, staff training **441**—185.10(7)
Reports **61**—9.29(5); **282**—26.3"10"; **441**—77.37(7), 77.37(23)*f*(3)"5," 109.4(3,4), 112.10, 150.3(3)*g*, 150.5(3)*g*, 175.22–175.27, 175.32, 175.33, 175.35–175.37, 175.39, 175.40, 200.11(1); **481**—51.7(4); **641**—ch 93; **645**—180.5(3), *see also Care Services: Development Homes below*
Services **441**—78.9(9)*b*(7), 78.9(9)*d*(1), 130.3(1)*e*, ch 133, 170.1, 175.25(8), 175.26(1)*e*, chs 172, 182, 186; **641**—80.3(2)*c*, 80.10(9)*c*, *see also Care Services: Protective Care below*
Sexual **281**—ch 102; **282**—11.35(2), 25.3(1); **441**—175.22(2)*b*; **641**—89.22(5)
Teachers/administrators/school employees **281**—ch 102; **282**—17.13(3), 19.5(1), 25.3(1), 26.3"10"; **441**—118.3(1)*b*(5), *see also Corporal Punishment below; TEACHERS*
Adolescents
See also JUVENILES
Driver's licenses, *see MOTOR VEHICLES: Licenses: Minors*
Employment programs **281**—ch 21 Div. IX, ch 66; **871**—23.18(5); **877**—8.6, chs 10, 12
Monitoring/outreach services **441**—133.1, 133.3(4)*f*, ch 151 Div. III
Pregnancy/parenting
Abortion **641**—ch 89
Family investment program (FIP) benefits, eligibility **441**—41.22(15–19)
Prevention program **441**—ch 163
Adoption **191**—35.26(4)*b*; **441**—9.10(14), 9.11, 9.12(1)*b*(5,7), chs 107, 108, 130.3(1)*e*, chs 142, 157, 160, 200, 201, 203; **641**—ch 107; **701**—41.5(3), *see also ADOPTION*
Aid to dependent children (ADC), *see FAMILY INVESTMENT PROGRAM (FIP)*
Aliens, *see ALIENS*
Apartment living, supervised **441**—108.1, 108.10, 150.3(3)*j*(2), 150.3(5)*p*(2), 156.8(2,6), 156.12, 156.15, 156.20(1)*b*, 156.20(2), 202.3(3)*c*, 202.9
At-risk, services **281**—12.5(13), chs 64, 65, 67, 97.3; **349**—1.10(3)*a*(7); **441**—chs 133, 168
Baby-sitters, minimum wage **875**—215.4(14), 219.2(2), 219.5, 219.103–219.106, 219.109(2)
Benefits
Burial **441**—156.8(5), 201.6(1)*a*(8)
Insurance, *see Insurance below; Support: Medical below*
Medicaid, *see HUMAN SERVICES DEPARTMENT: Medical Assistance (Medicaid)*
Overissuance/overpayment **441**—7.5(9), 170.9
Peace officers **661**—402.203, 402.211
Brain injury **441**—83.81, 83.82(2)*c*
Care services
Abuse/crime, *see Abuse above; subheadings Care Centers below; Development Homes below*
Adopted **441**—201.6(1)*a*(4)
Agreement, denial/termination **441**—170.5
Attorney general, assistance **61**—1.3(1)*a*
Care centers
Abuse/crime/transgressions **441**—109.2(4,5), 109.4(4), 109.6(6)
Complaints/inspections **441**—109.3
Definitions **441**—109.1, 118.1, 170.4(7)*a*(1)
Directors/supervisors **441**—109.6, 109.10(16), 109.11(3)*d*, 118.3(2)
Facilities **441**—109.11, 109.15
Fire safety **441**—109.10(11,15); **661**—ch 5 Table 8-A p.35, 5.5(2), 5.500–5.502
Food requirements **441**—109.15
Health/safety requirements **441**—109.10, 109.11, 109.12(4,5), 109.15(4–6), 118.3(3), *see also Immunizations below*
Licenses **441**—109.2, 109.3, 109.4(5,6), 170.4(3)*a*
Medical monitoring/treatment, interim **441**—77.30(8), 77.37(22), 77.39(25), 78.34(8), 78.41(9), 78.43(14), 79.1(2)p.8

CHILDREN (cont'd)
Care services
Care centers

Parents **441**—109.5, 109.10(10)
Personnel **441**—109.6, 109.9(1), 109.10(7,16)
Programs/plans **441**—109.1, 109.4, 109.5, 109.12, 170.4(6)
Rates **441**—170.4(7)*a*
Records **441**—109.9, 109.10(10,15), 109.11(3)*d*, 109.12(3)
Respite care, *see Respite Care below*
Training, first-aid **441**—109.6(1)*d*, 109.7
Transportation **441**—109.10(12); **761**—ch 911

Case management providers **441**—77.29(2), 78.33, 80.2(2)*g*
Community care **441**—ch 186
Definitions **441**—109.1, 110.1, 118.1, 153.1, 159.1, 168.1, 170.1
Development homes
Generally **441**—ch 110, 170.4(3)
Abuse/crime/transgressions
Identification/reporting **441**—110.5(2)*b*(1), 110.5(2)*c*(4), 110.5(2)*d*(4)
Record checks **441**—110.3, 110.5(2)*c*(1), 110.5(2)*d*(1), 110.7(3)

Activities **441**—110.5(3)
Capacity **441**—110.4, 110.8(1), 110.9(1), 110.10(1)
Categories **441**—110.8–110.10
Certification **441**—118.4
Complaints **441**—110.11
Definitions **441**—110.1, 170.4(7)*a*(1)
Discipline **441**—110.5(6)
Fire safety **441**—110.5(1)*e,f,j–o*
Health/safety **441**—110.5(1), 118.4(3)
Illnesses/injuries **441**—110.5(1)*u–w*, 110.9(3)*b*, 110.10(3)*b*
Medical monitoring/treatment, interim **441**—77.30(8), 77.37(22), 77.39(25), 78.34(8), 78.41(9), 78.43(14), 79.1(2)p.8
Parents, access **441**—110.5(5)
Providers/staff, qualifications/training **441**—110.5(2)*b,d*, 110.7(3)*d*(3), 110.8(2), 110.9(2), 110.10(2), 118.4, *see also Medical Monitoring/Treatment, Interim this subheading above*
Rates **441**—170.4(7)
Records **441**—110.4(3)*d*, 110.5(2,8), 110.5(10)*e*
Registration
Application **441**—110.2
Certificate **441**—110.1, 110.5(4), 170.4(3)*b*
Compliance **441**—110.6
Denial/revocation **441**—110.7, 110.12, 110.14
Exceptions, transition **441**—110.13
Renewal **441**—110.3, 110.13

Respite care, *see Respite Care below*
Standards **441**—110.5, 118.4

Fees, *see Payments this subheading below*
Fire safety, *see subheadings Care Centers above; Development Homes above*
Foster care, *see FOSTER CARE*
Funds
See also Grants below
Assistance, *generally* **441**—chs 130, 170
Eligibility **441**—130.2(5), 130.3(1)*d,e,* 168.3(2), 170.2, 170.3
Foster parents **441**—156.8(8)*b*
Prioritization **441**—170.2(3)

Get-well centers **441**—109.1, 109.14
Grant programs, *see Grants below*
Hearings/appeals **441**—7.5(9), 159.10, 168.6, 170.6; **481**—1.6"1"
Immunization **441**—109.9(3), 110.5(8)*g*; **641**—ch 7
In-home **441**—170.4(3)*e*
Inspections, lead paint **641**—70.6
Nonregistered **441**—110.14, 170.4(3)*e,f,h,* 170.4(7)*a*
Payments **441**—170.4(2), 170.4(3)*f,g*, 170.4(7), 170.5, 170.7, 170.9
PROMISE JOBS participants, *see WORK AND TRAINING PROGRAMS*
Protective care **441**—130.3(1)*e*, 133.1, 133.3(4), ch 170, 175.33, 175.43; **641**—80.2, ch 94
Referral service **441**—61.5(11)*g*, ch 159, *see also Support below*
Refugees **441**—61.5(11)*g*
Relatives **441**—170.1
Respite care, *see Respite Care below*
Taxation credit **701**—39.1(7), 40.15, 41.3(1)*d*, 42.9, 42.24, 46.3(2)*b*(4)
Transportation **441**—151.3(3), 151.22(1)*a*, 170.1, 170.4(4), *see also WORK AND TRAINING PROGRAMS: PROMISE JOBS*
Water systems **567**—41.2(1)*c*(1)"5," 41.3(1)*a*

Child development coordinating council **281**—ch 64
Corporal punishment **281**—ch 103
Counseling **281**—ch 66; **441**—182.2(4)*b*, 185.10(1)*a*, 185.105(1)*f*, 185.106(4)*c*, 185.126(2), *see also EDUCATION: Counselors*
Court-ordered services **441**—98.22–98.24, 98.33, 98.35, 98.43–98.45, ch 99, 150.3(6)*b*, ch 151, 175.31(1), 200.7, 200.10(1), *see also Care Services: Protective Care*
Crime
See also Abuse above
Dependent care, compensation **61**—9.35(13)
Schools, unsafe **281**—ch 11
Sex offenders
Definitions **201**—38.2
Registry **441**—110.7(3)*a*(2); **661**—ch 83
Victims, criminal parole **205**—ch 7, 13.2

Day care, *see Care Services above; WORK AND TRAINING PROGRAMS: PROMISE JOBS: Child Care/Transportation*
Deaf **681**—ch 16, *see also DEAF*
Death
Autopsies **641**—127.1"9," 127.3(1)*d*, 127.3(2), 127.3(4)*b*, 127.4(2)*e*
Burial benefits, *see Benefits above*
Review teams/committee **641**—chs 90–92

Delinquency, *see JUVENILES*
Developmental disability, *see DISABILITIES*
Disabled, *see DISABILITIES*
Driver's licenses, *see MOTOR VEHICLES: Licenses: Driver's: Minors*
Education, *see EDUCATION; SCHOOLS*
Employment, *see Adolescents above; Labor Laws below*
Family services
See also Support below; ADOPTION; FOSTER CARE
Emergency assistance **441**—9.10(4)*f*, chs 58, 133
Empowerment, community **349**—ch 1
Family-centered **441**—130.2(5), chs 172, 182, 185.102(2)*e*
Family development/self-sufficiency program **441**—ch 165

Family investment program, *see FAMILY INVESTMENT PROGRAM (FIP)*
Family support subsidy **441**—ch 184 Div. I
Healthy opportunities for parents to experience success—healthy families Iowa (HOPES-HFI) program **641**—ch 87
Preservation services **441**—ch 181
Rehabilitative treatment **441**—ch 185

Food programs
Assistance benefits **441**—65.1, 65.22(1)*g*, 65.24, 65.28(2)*a*,*d*, 65.28(11)
Women/infants/children (WIC) **21**—ch 50; **441**—78.1(14), 78.18(7), 78.31(4)*h*; **641**—ch 73

Foster care, *see FOSTER CARE*
Funds
See also Care Services above; Grants below
Empowerment areas **349**—ch 1; **441**—ch 169
Innovation zones **417**—ch 20
Lead poisoning prevention **641**—ch 72, 175.14(4)*d*
Welfare/juvenile justice, decategorization **441**—ch 153 Div. II

Gambling
Bingo **481**—103.5
Pari-mutuel **491**—8.2(21)

Goldfinch, historical magazine **223**—15.4
Grants
See also Funds above
Abuse prevention **441**—ch 155
Adolescent pregnancy **441**—163.3
Adoption **441**—ch 160
Care services **441**—chs 153, 159, 168, 169
Child development, at-risk, *see At-Risk, Services above*
Early ACCESS, early intervention services **281**—ch 120
Foster care, *see FOSTER CARE*
Love our kids program **641**—ch 141
Maternal/child health (MCH) **641**—ch 76
Protection centers **641**—ch 94

Guardianship program **441**—75.1(11), ch 204
Health care
See also Mental Health below
Early intervention services **281**—120.14
Empowerment, community, *see Family Services above*
Healthy and well kids in Iowa (HAWK-I) board **441**—1.10, 76.1, 76.11(4), ch 86
Healthy opportunities for parents to experience success—healthy families Iowa (HOPES-HFI) program **641**—ch 87
Home health agencies **441**—78.9(9)*c*,*d*
Immunization, *see Immunizations below*
Intermediate care facilities **441**—82.2
Maternal/child health (MCH) **641**—ch 76
Newborn/obstetrical **191**—35.20(8), 35.34, 40.24, 71.22, 75.7, 75.15, 80, 81; **441**—96.6(5); **641**—chs 4, 75, *see also Insurance below*; *HUMAN SERVICES DEPARTMENT: Medical Assistance (Medicaid)*
Prenatal, *see WOMEN: Pregnancy*
Screening **441**—ch 84; **641**—ch 3
Special needs subsidy **441**—ch 184 Div. I
Youth services program **281**—ch 66

Health care facilities, *see HEALTH CARE FACILITIES*
Homeless **281**—ch 33, 41.19; **427**—ch 23; **441**—ch 58 Div. II, 65.19(20)*d*

Hospitals
Certificate of need **641**—203.2(2)*f*, 203.2(3), 203.2(6)*d*, 203.9, 203.10
Foster/shelter facility residents **441**—156.10
Medicaid, *see HOSPITALS*
Mental health services, *see MENTAL HEALTH*
Nurseries **481**—51.32; **641**—203.9
Pediatric units **481**—51.34; **641**—203.2, 203.10

Hunting/fishing licenses **571**—15.1(4)*b*, 91.6
Immunizations
Need determination **641**—96.6(5)
Schools/care services **281**—31.2(1)*a*(7), 31.4(1)*e*, 33.5; **441**—109.9(3), 110.5(8)*g*; **641**—ch 7

Infants
See also Grants: Early ACCESS, Early Intervention above; Health Care above
Autopsies **641**—127.3(1)*d*
Birth defects **641**—ch 4
Care services **441**—109.12(5)
Eye treatment, newborns **641**—1.7
Hearing, screenings **641**—ch 3
Medical assistance, *see HUMAN SERVICES DEPARTMENT*
WIC program **641**—73.9(3)*k*

Injury prevention, agricultural **641**—ch 141
Inmates
Home care program **201**—20.17(1,6)
Visits **201**—20.3(3)*b*(3)

Insurance **191**—35.26(4)*b*, 38.4(4)III, 71.14(7), 75.15, ch 80; **281**—120.81, 120.82; **441**—ch 86, 151.3(3)*d*, 151.21(3), ch 158, *see also Health Care: Newborn/Obstetrical above; Support: Medical below*
Juveniles, *see JUVENILES*
Labor laws **875**—ch 32, 216.33(6); **877**—8.6
Lead exposure, abatement/inspections/tests **441**—78.44, 84.3(6); **641**—70.6, ch 72
Lottery tickets **531**—14.28
Medical assistance (Medicaid) **281**—120.81, 120.82, 120.83(3), *see also HUMAN SERVICES DEPARTMENT*
Mental health, *see DISABILITIES: Developmental; MENTAL HEALTH*
Mental retardation **441**—82.2, 83.61(1), 83.61(2)*g*(4), 83.61(3,4), 83.62(3)*g*, 83.70, ch 116, 202.2(5); **481**—ch 40, *see also MENTALLY RETARDED*
Placement agencies, *see Apartment Living, Supervised above; Guardianship Program above; ADOPTION; FOSTER CARE*
Political contributions **351**—4.29
Pornography, corrections facilities **201**—20.6(4)
Pregnancy, adolescent, *see Adolescents above*
Radiation exposure **641**—40.21, 40.37, 41.2(14)*f*; **875**—32.8(5)
Refugees **441**—60.1(2), 60.7, 61.1, 61.14, 156.20(1)*b*(3)
Residential care **441**—53.3, 77.37(23), 78.41(10), 79.1(15), 83.61(1)*a*,*k*, 83.62(3)*g*, 83.70(3), chs 115, 116, 156.19; **481**—40.1, 57.13(1)*j*, 62.10"9," 63.13(1)*j*, *see also RESIDENTIAL CARE FACILITIES*
Respite care **441**—77.30(5), 77.34(5), 77.37(15), 77.39(14), 156.8(7)
Runaways **441**—85.25(2)*c*, ch 143, 156.10(1)*c*, 156.10(2)*c*; **661**—ch 89
Shelter care/detention facilities **441**—85.25(2)*c*, ch 105, 143.5, 150.3(5)*a*(8), 150.3(5)*p*, 151.22(1)*b*(5), 156.10(3), 156.11(3), ch 167, 182.3(4)*b*,*c*; **481**—ch 40
Special needs, *see HUMAN SERVICES DEPARTMENT*
Substance abuse, *see SUBSTANCE ABUSE*

Support
See also FAMILY INVESTMENT PROGRAM (FIP)
Appeals/hearings **441**—7.1"7," 95.13, 98.81(3), 98.97(3), 99.41(7,8), 99.61, 99.86(2), 100.7; **871**—24.59(7)
Collections
See also Nonpayment; Overpayment this subheading below
Accounts **441**—95.24
Contractors/attorneys, referral, costs **441**—95.15, 98.121, 98.122
Credits **441**—95.3, 99.4(5)
Lump sum settlements **441**—95.5
Services center, payments **441**—ch 97
Definitions **441**—95.1, 97.1, 98.1, 99.36, 99.61, 99.81, 99.101, 100.1
Emancipation verification **441**—95.25
Establishment **441**—99.41
Family investment program (FIP) eligibility **441**—41.22(4–9), 41.27(6)*u*, 95.3, 95.23
Food assistance benefits, income deductions **441**—65.22(1)*g*
Foster care **441**—98.24(2)*d*, 99.4, 99.5(4)
Income considerations
Deductions **441**—99.2, 99.5(3,4), *see also Food Assistance Benefits, Income Deductions this subheading above*
Determination **441**—98.104, 99.1(2)
Estimates **441**—99.1(4)
Exemptions **441**—99.1(1)
Fluctuating **441**—99.1(6)
Guidelines, supreme court **441**—99.2, 99.4, 99.5
Net **441**—99.3
Self-employment **441**—99.1(5)
Verification **441**—99.1(3), 99.85, 99.87
Withholdings, disabled/low-income **441**—98.24(5), 98.43(2)*e*, 98.45(6), 98.47
Information **21**—6.17; **61**—2.14(15); **282**—10.3; **441**—95.12, 95.16, ch 96, 99.64, 99.67, 99.85, 99.89; **481**—5.11(4); **491**—3.11(3); **531**—1.5(4); **641**—192.3; **653**—2.13(4); **657**—25.4; **661**—25.14; **701**—6.3(1)"3"; **811**—5.17; **871**—24.59(1)
Medical **441**—75.14, 95.19, 95.20, 98.1–98.8, 98.39, 99.2(3,5), 99.21, 99.41, 99.62(1,3), 99.64(3), 99.66, 99.68, 99.83(6), 99.85(3), 99.90, 99.101, 99.105
Modification **441**—95.19, 95.20, 98.45, 98.104(3), ch 99 Div. V, 100.2
Nonpayment
Administrative levy **441**—ch 98 Div. VII
Certificates, noncompliance **441**—98.103(3), 98.104(2), 98.105(2), 98.106, 98.107, *see also Licenses/Permits/Registrations/Certifications, Denial/Revocation this subheading below*
Employment orders **441**—98.71–98.76
Income/benefits, withholdings **441**—95.3(1), 95.8, 98.5, 98.8, ch 98 Div. II, 100.2(3), 100.2(4)*c*; **871**—24.59, *see also subheadings Income Considerations above; Medical above*
Licenses/permits/registrations/certifications, denial/revocation **21**—ch 7, 66.20; **61**—ch 24, 25.4(15); **187**—18.4(4)*f*, 18.21; **191**—10.20, 50.52, 103.7; **193**—7.43, ch 8; **193A**—2.7(4); **193D**—1.9; **193E**—1.8; **282**—ch 10, 25.3(7); **441**—96.2(1)*a*, ch 98 Div. VIII, 107.4(6), 110.12; **481**—8.1; **491**—3.11(3), 6.11; **501**—ch 12; **531**—12.1(3), 12.2, 12.4(7), 12.7, 12.12(1)*p*, 12.14, 14.8, 14.13(1), 14.16; **567**—81.17(4), 134.4(2,6), 134.17, 134.19(1), 134.28(2)*g*; **571**—15.6(9); **591**—6.6, 6.7, 6.14; **641**—ch 192; **650**—11.11, 20.13, ch 33; **655**—ch 17; **657**—ch 25, 36.1(4)*x*; **661**—5.866, 121.21, 275.7(5), 372.5(4), 503.5; **701**—13.7, 13.16, 13.17, 30.1(4), 67.23(3,4), 81.12(1,2), 81.13(3,4); **761**—600.4(8), 615.24(1), 615.45(1)*k*; **811**—ch 13; **875**—155.8(1)*e*
Names, publication **441**—98.61, 98.62
Reasons, validity **441**—98.74, 98.102
Taxation refunds, offsets **11**—40.6; **441**—95.3, 95.6, 95.7, 98.81; **701**—43.3(3)
Obligations, parental, review/adjustment **441**—98.45(5), 98.104(3), 99.25, ch 99 Div. IV, ch 100
Overpayment **441**—ch 46, 98.46, 98.97(2)

Paternity **441**—75.14, 95.19, 95.20, ch 99 Div. II, 99.83(2)*b*
Pilot projects **441**—ch 100
Records **61**—2.14(14); **441**—9.10(4)*b*, 9.10(10), 9.11, 9.12(1)*d*, ch 96, 97.2, 97.3, 99.39, 100.6(2)
Referrals, recovery unit **441**—41.22(5), 75.14(5)
Services
Attorneys **441**—95.15, 98.122
Fees **441**—95.22, 99.68, 99.90
Modification, obligations, *see Modification this subheading above*
Nonassistance recipients **441**—95.2(2–4), 95.14(4), 95.18, 95.21, 98.2(1)
Termination **441**—95.14, 95.18(2,3), 95.21
Suspensions/reinstatements **441**—99.101–99.110
Temporary **441**—99.10
Swimming pools **641**—15.4(6)*d*
Taxation
Credits
Child care, *see Care Services above*
Tuition/textbook/extracurricular activities **701**—42.2(8), 42.22, 42.23"2,6," 42.29
Deductions, adoption expense **701**—41.5(3)
War orphans, educational assistance **801**—1.2(3)*g*, 6.12(6), ch 9; **871**—24.23(24)
Women/infants/children (WIC), food program, *see Food Programs above*

CHILD SUPPORT RECOVERY
See CHILDREN: Support

CHIROPRACTORS
Abuse report, child/dependent adult, *see Continuing Education below*
Acupuncture **645**—43.1, 43.5, 44.3(2)*a*(3)
Address/name change **645**—40.4, 41.2(5), 45.2(24)
Adjunctive procedures **645**—43.7
Advertising **645**—45.2(5)
Board, chiropractic
*See also PROFESSIONAL LICENSURE DIVISION**
Address **645**—40.4
Colleges, approval **645**—42.2
Discipline **645**—40.2(3), 40.3(8)*f*, ch 45
Duties **645**—40.2, 40.3
Hearings **645**—41.13, 45.5(3,4), 46.1(9)
Investigations **645**—40.3(8)*e*
Meetings **645**—40.3(3–6), 40.3(8)*d*, 40.6
Office **645**—40.4, 40.5
Public health department authority **641**—170.4(1)
Utilization/cost control review (U.C.C.R.) **645**—43.3
Certificates, temporary **645**—5.4(2), 41.5, 46.1(2)
Child support noncompliance **641**—ch 192
Colleges **645**—41.2(1)*d*, 42.2
Competency **645**—43.2(5), 45.2(2)
Complaints **645**—40.3(8)*e,i*
Conduct **645**—43.2, 45.2
Confidentiality **645**—43.2(9), 45.5(5)

*Rules **645**—6–18 apply to all professional licensure boards

Continuing education
Generally **645**—40.2(2), 40.3(8), 44.7
Abuse identification/reporting **645**—41.8(4), 44.3(2)*a*(4)
Exemptions **645**—44.5, 44.6
Hours **645**—41.6(2)*f*,*g*, 41.14, 44.1, 44.2, 44.3(1)*e*, 44.3(2)
Presenters **645**—44.3(2)*b*(3), 44.3(3)
Records/reports **645**—44.4, 45.2(21)
Standards **645**—44.3
Definitions **645**—40.1, 42.1, 43.1, 44.1, 45.1
Discipline, *see Board, Chiropractic above; Malpractice below*
Education, *see Colleges above; Continuing Education above*
Ethics, *see Conduct above*
Fees **645**—43.10(8), 43.11(7–9), *see also Licenses below*
Impaired practitioner review committee **641**—ch 193; **645**—45.2(30)
Inactive practitioners **645**—41.1, 41.8(8), 41.14, 44.1, 45.2(25)
Insurance
Consultants **645**—43.4
Coverage **191**—36.7(1)*l*, 71.14(4), 75.10(3); **645**—43.11(7)
Interns/residents, *see Preceptorship below*
Licenses
Applications **645**—41.2, 41.5(3), 41.6, 45.2(1), *see also subheadings Reinstatement below; Renewal below*
Certificates/wallet cards **645**—41.8(5,6), 41.11, 41.12, 46.1(6)
Denial **283**—37.1; **641**—192.1, 195.2; **645**—41.13
Display **645**—41.2(4), 41.8(6)
Duplicate **645**—46.1(6)
Examinations **645**—41.2(1)*f*, 41.3, 41.6(2)*d*,*g*, 43.7, 44.3(2)*b*(5), 45.5
Fees **641**—192.2(5); **645**—5.4, 41.2(1)*c*, 41.6(2)*b*, 41.8(7), ch 46
Reactivation **645**—41.1, 41.8(3), 41.14, 46.1(5)
Reciprocity **645**—41.7
Reinstatement **641**—192.2(5,7); **645**—41.1, 41.15, 46.1(5)
Renewal **283**—37.1; **641**—192.2(5), 195.2, 195.3(7); **645**—41.2(2), 41.8, 44.2(3), 46.1(3,4), *see also Continuing Education above*
Suspension/revocation **283**—37.1; **641**—192.2, 195.3; **645**—45.2(13,25), 45.3"1,2"
Loans, student **283**—chs 32, 37; **641**—ch 195
Malpractice **645**—43.1, 45.2(16)
Medical assistance **441**—77.8, 78.8, 79.1(2)p.3, 79.1(13)*b*
National Board of Chiropractic Examiners **645**—41.3
Physical examinations **281**—12.4(14), 36.14(1), 43.15; **645**—43.8, *see also X-ray Requirements below*
Practice, discontinuance/retirement **645**—43.10(9)
Preceptorship **645**—42.1, 42.3–42.6
Prescription devices, taxation **701**—20.7(2)*h*, 20.9(4)*g*
Records **645**—43.10, 43.11, 45.2(2)*g*
Reports **645**—44.4, 45.2(14–16,21,22,24)
Scope of practice **645**—45.2(4)
Violations, *see Board, Chiropractic: Discipline above*
Volunteer services **641**—ch 88
X-ray requirements **441**—78.8(3); **641**—38.8(1), 41.1(3)*a*"1," 42.2(4), 42.3(3)*c*, 42.3(4); **645**—43.9, *see also X-RAYS*

CHOLERA
Hog **21**—61.30, 64.5, 64.17
Human **641**—1.3(1)*a*(2), 1.4(1)*a*

CHORE SERVICE
Generally **441**—77.30(7)*d*, 77.33(7), 77.33(15)*d*, 77.34(8)*d*, 77.37(21)*d*, 77.39(24)*d*, 78.37(7), 79.1(2)p.6, 83.26; **641**—ch 80

CHURCHES
See RELIGION

CIGARETTES AND TOBACCO
See also SMOKING; TAXATION
Manufacturers, escrow accounts **61**—ch 5
Master Settlement Agreement (MSA) **701**—ch 85
Risk pool fund **441**—25.71–25.76
Use, control/prevention, funding **641**—chs 151, 152

CITIES
Airport development/improvement **761**—chs 710, 715, 717, 720
Annexation, *see Council: Boundaries, Change below; Development Board: Boundary Changes below; ANNEXATION*
Assessors **263**—8.3(5); **661**—210.3(3); **701**—chs 71, 72, 80, *see also ASSESSORS*
Attorneys
  Assessment equalization, protest **701**—71.14
  Benefits, retirement **495**—5.2(3)
Audits **81**—ch 21, 25.4(4), 25.8, 25.9
Bikeway/walkway construction **761**—150.4(3,4)
Boundaries **721**—21.30, 21.400, *see also Development Board below*
Bridge construction/replacement/preservation **761**—chs 160, 161, 163.7(1)*b*, 164.6(1)*b*, ch 180
Budgets **541**—1.4, 1.5; **543**—2.1, ch 5; **545**—chs 2–4, *see also Development Board below*
Buildings
  Burning, controlled **567**—23.2(3)*j*
  Energy conservation/management **565**—ch 6
  Historic, *see Grants below; Loans below*
  Public improvement contracts **761**—ch 180
Business development **261**—chs 58, 59, 65, 68, 172
Clerk
  Nomination papers **721**—21.403(2), 21.404(2,3)
  Records **567**—23.2(3)*j*(10)
Community economic betterment account (CEBA) program **261**—ch 53
Conference boards **701**—71.19(2,3), 72.11, 120.2
Conservation fund, land/water (LWCF) **571**—ch 27
Convention/visitors bureaus (CVBs), athletic event funds **261**—ch 38
Council
  Assessment equalization, protest **701**—71.14
  Assessors, ordinance repeal **701**—71.19(1)*b*
  Boundaries, change **263**—ch 7, 8.3, 10.5(2); **721**—21.30
  Elections, special **721**—21.403, 21.404
  Emergency management commission **605**—7.3
  Enterprise zones **261**—59.3(5)*a*(3), 59.4(1)*b*(3,6), *see also Enterprise Zones below*
  Grants, community development **261**—ch 44
  Hazardous waste facilities, commission **567**—150.4
  Health department, district, withdrawal **641**—78.5
  Members, election **721**—21.400, 21.401
  Sports authority districts, regional, board **261**—ch 38
  Taxation
    See also Taxation below
    Cigarettes/tobacco, permits/licenses, *see Taxation below*
    Hotel/motel **701**—103.1(4), 105.1
    Local option **701**—107.14; **721**—21.800(3)
    Property
      Annexations **263**—7.2(2)*h,i*, 8.3(5,13,17)
      Boards, review **701**—71.20(1)

CITIES (cont'd)
Council
Taxation
Property
Buildings, speculative **701**—80.5(1)
Industrial, exemption **701**—80.6
Small business, credit, underground storage tanks **701**—80.10
Urban revitalization, exemption **701**—80.8
Wind energy conversion **701**—80.13

Crime, juvenile **428**—ch 3
Cultural/entertainment districts, development **221**—ch 9
Deer management zones **571**—105.5
Depositories, public funds **781**—ch 3
Development board
Boundary changes
Involuntary **263**—chs 8–10
Voluntary **263**—ch 7

Budget **261**—ch 37
Declaratory orders **263**—ch 4
Islands **263**—8.3(18), ch 11
Meetings **263**—1.4, 8.8, 9.2, 9.11
Members, appointment **263**—1.3, 8.11
Organization **261**—ch 37; **263**—ch 1
Records, public/fair information **263**—ch 5
Report, annual **261**—37.1(1)
Rule making **261**—37.1; **263**—chs 2, 3, 6

Docks, permits **571**—16.2, 16.6, 16.12, 16.13
Elections
See also Taxation: Local Option below
Campaign committees **351**—4.3(1), 4.9(4,10), 4.21(2), 4.59(2), *see also ETHICS AND CAMPAIGN DISCLOSURE: Committees*
Charter commission, appointment **721**—21.402
Conduct, clerks' duties **721**—20.2
Forms **721**—4.3
Recounts, report **721**—26.107
Redistricting/reprecincting, census data **721**—21.30
Signature requirements **721**—21.400, 21.401
Special **721**—21.403, 21.404
Electric transmission lines **199**—ch 11
Emergencies
Air pollution **567**—ch 26
Fuel set-aside **565**—3.13(2)*b*
Management, local **605**—ch 7
Shelters (ESG) **261**—ch 24

Employees **191**—35.20; **495**—chs 4–6; **545**—ch 4; **875**—ch 220, *see also PUBLIC EMPLOYEES' RETIREMENT SYSTEM (IPERS)*
Enterprise zones **261**—ch 59, 168.102
Fairs **701**—16.26(2)*c*
Finance committee
Budgets
Amendments **545**—ch 2
Forms **545**—3.1
Transfers, fund **545**—2.1, 2.3–2.5

Declaratory orders **545**—ch 6
Definitions **545**—2.1
Employee benefits **545**—ch 4

Law enforcement training reimbursement **545**—ch 9
Operations **545**—ch 1
Records, *generally*, public/fair information **545**—ch 8
Rule making **545**—chs 5, 7
Tax rate, appeals **545**—ch 10

Fire
See also FIRE AND FIRE PROTECTION
Firefighters, retirement **495**—4.6(4)*d*, 5.2(6)*a*,*b*,*e*, 5.2(27); **545**—4.3
Investigation **661**—5.6
Protection, water
Backflow prevention **641**—25.5(1)*c*, 25.5(4)*d*
Costs **199**—21.8

Services, annexation impact **263**—8.3(11,12,14)

Flood plain management **567**—ch 75
Food/food service establishments, inspection **481**—30.10, 31.8, ch 35
Funds **261**—chs 171, 172; **761**—chs 164, 174, 830; **781**—chs 3, 12–15, *see also Budgets above; Grants below; Loans below; Transit Systems below*
Gambling **481**—100.11; **641**—ch 162, *see also GAMBLING*
Grants
Generally **261**—ch 21
Athletics, regional sports authority districts **261**—ch 38
Block
Community development **261**—chs 21, 23, 25
Community services **427**—ch 22
Juvenile accountability incentive (JAIBG) program **428**—3.1, 3.7

Brownfield redevelopment program **261**—ch 65
COG assistance (Council of Government) **261**—ch 44
Community attraction/tourism **261**—chs 211, 212
Community development **261**—ch 41
Community economic betterment account (CEBA) program **261**—ch 53
Cultural, Iowa community (ICCG) **221**—ch 6, 9.7(2)
Dams, low-head, public hazard program **571**—ch 30 Div. II
Endow Iowa program **261**—ch 46
Energy conservation, *see Buildings: Energy Conservation/Management above*
Forestry development **571**—33.40(1), ch 34
Health boards/agencies **641**—ch 80
Historic preservation **221**—ch 6; **223**—chs 35, 36, 50; **261**—ch 39
Housing
See also Housing below; Loans below; Shelters this subheading below
Community action agencies **427**—chs 22, 23
Community development **261**—23.4(3), ch 25
Economic development programs **261**—chs 23, 25, 28, 29, 59.8
HOME investment partnership program **261**—ch 25

Job training/workforce development **261**—23.4(4), 23.7, 23.9
Local government innovation **541**—ch 15
Parks/preserves **571**—33.40
Port authority program **261**—ch 70
Public facilities, set-aside (PFSA) **261**—23.2, 23.4(4), 23.8
REAP, *see Resource Enhancement and Protection (REAP) this subheading below*
Recreation **261**—chs 211, 212; **571**—chs 27, 29, 30, 33, *see also Athletics, Regional Sports Authority Districts this subheading above*
Resource enhancement and protection (REAP) **571**—ch 33 Parts 1, 3

RISE (revitalize Iowa's sound economy) program **761**—ch 163
Set-aside programs (EDSA/PFSA) **261**—23.2, 23.4(4), 23.7, 23.8
Sewer construction **261**—23.4(6,8), 23.6, *see also Sewers below*
Shelters **261**—21.2(2,4), chs 24, 29; **265**—ch 14; **427**—23.5(6); **571**—33.40(1)
Vision Iowa program **261**—ch 212
Waste, hazardous **567**—chs 211, 214
Wastewater treatment **265**—ch 28
Water supply **261**—23.4(6,8), 23.6; **641**—ch 20
Water trails development program **571**—ch 30 Div. II

Health
Boards **21**—61.23, 64.3, 64.17; **641**—15.6, 15.12, 15.13, chs 68, 72, 77, 78, 80
Services, department support **641**—170.4(4)

Highways, *see Roads below*
Historic development **221**—9.7(1), *see also Grants above; Loans below*
Homeland security, *see Emergencies: Management, Local above*
Homeless, *see Grants: Shelters above*
Hotels/motels, inspection **481**—chs 35, 37
Housing **261**—ch 26; **265**—ch 19; **701**—80.4, *see also Grants above; Loans below*
Hunting, deer **571**—105.5
Incorporation/consolidation, *see Development Board: Boundary Changes above*
Inspections/licenses **481**—ch 35
Jails **201**—ch 50; **611**—1.1
Liquor ordinances **185**—4.3
Loans
Brownfield redevelopment program **261**—ch 65
Community attraction/tourism development **261**—chs 211, 212
Community economic betterment account (CEBA) program **261**—ch 53
Energy conservation, *see Buildings: Energy Conservation/Management above*
Historic buildings, restoration **223**—ch 46; **265**—ch 11
Housing **261**—chs 25, 28; **265**—ch 11
Local government innovation **541**—ch 15
RISE (revitalize Iowa's sound economy) program **761**—163.1, 163.5
Set-aside programs, economic development (EDSA/PFSA) **261**—23.2, 23.4(4), 23.7, 23.8
Sewers **567**—chs 90, 92
Vision Iowa program **261**—ch 212
Waste, solid **567**—ch 209
Wastewater treatment/water pollution control **265**—ch 26; **567**—chs 90–93

Mayors **495**—5.2(9); **605**—7.3(1)*b*(3); **701**—71.19(2,3); **877**—7.5
Motor vehicles
Dealer establishments, licenses **761**—425.10(7)*a*
Sales, city-owned **761**—425.20(4)*a*

Open burning **567**—23.2
Parking facilities **761**—ch 180
Parks **571**—33.40
Pesticide application, notification **21**—45.50
Police
Services, annexation impact **263**—8.3(11,12,14)
Training reimbursement **545**—ch 9

Pseudoephedrine sales violations, report **661**—ch 174
Railroads **261**—59.3(4)
REAP (resource enhancement and protection) **571**—ch 33

Retirement, employees (IPERS) **495**—chs 4–6
Review boards, real estate assessment **701**—71.2
RISE (revitalize Iowa's sound economy) program **761**—ch 163
Roads
Access rights **761**—112.4(6), 112.4(7)*d*, 112.11(3,6)
Closure **761**—151.1
Construction **261**—53.5; **761**—150.3(1), chs 163, 178, 180; **871**—23.82(2)*d*
Detours **761**—151.1
Enterprise zones **261**—59.3(4)
Extensions, primary **761**—150.4, 151.1
Funding, farm-to-market **761**—ch 174
Lighting **761**—150.3(3)
Maintenance **263**—8.3(15); **761**—150.2(2), 150.3(2)
Railroad crossings **761**—812.4
Right-of-way **263**—8.3(4); **761**—150.2(1), 150.3(1)
RISE (revitalize Iowa's sound economy) program **761**—ch 163
Safety program **661**—ch 20; **761**—ch 164
Scenic byways **761**—ch 132
Signs/signals **761**—ch 117, 119.6, chs 131, 143, 150.2(4), 150.3(2,4), 150.4(1,2), ch 180
Vehicle operation restrictions **761**—150.3(5)
Sewers **261**—23.4(6,8), 23.6, ch 61; **263**—8.3(11); **567**—chs 9, 90, 91.8(1)*a*,*d*; **761**—150.2(1)*b*, 150.3(1)*d*, 150.3(2)*a*(1), 150.3(2)*c*(3), 163.7(1)*h*, ch 180, *see also Taxation below; SEWERS*
Sidewalks/overpasses/underpasses **761**—150.3(2)*b*,*c*, 150.4(3,4), ch 180
Signals/signs, traffic, *see Roads above*
Soil conservation, public improvement contracts **27**—ch 6
Streets, *see Roads above*
Swimming pools/spas **641**—ch 15, *see also PUBLIC HEALTH DEPARTMENT*
Targeted jobs withholding tax credit program **261**—ch 71
Taxation
Appeals, rate suspension **545**—ch 10
Cigarette permits **701**—81.12(1), 81.13(4), 83.13–83.15
Construction, exemption **701**—19.12
Credit, *see Targeted Jobs Withholding Tax Credit Program above*
Enterprise zone businesses **261**—59.6(3), 59.8(2)
Franchise tax allocation **701**—58.7
Fuel **701**—64.3"4," 64.15, 65.15, 68.8(3), *see also Transit Systems below*
Hotel/motel **701**—103.1(4), 103.14, 103.15, 104.7, ch 105
Local option **481**—100.11; **701**—ch 105, 107.10, 107.14, 108.2(4), 108.9, 109.8; **721**—21.800, 21.801
Property
Credit, small business, underground storage tank cleanup **701**—80.10
Exemption
Annexations **263**—7.2(2)*h*,*i*, 8.3(17); **701**—80.6(4), 80.21
Low-rent housing **701**—80.4, 80.19
Military service **701**—80.2
Reimbursement, resource enhancement and protection (REAP) **571**—33.19
Urban revitalization **701**—18.45(4), 80.8
Value-added **261**—58.4(2), 59.6(3)*b*; **701**—80.5, 80.6, 80.8
Housing, tax increment financing **261**—ch 26
Wind energy conversion **701**—80.13
Sewage services **701**—14.3(9), 18.5(3), 18.39, 26.72
Storage, agricultural products/household goods **701**—26.42(7)
Utilities **701**—14.3(9), 16.20, 16.50, 18.5(3), 18.39, 18.45(3)
Telecommunications **261**—chs 41, 61; **751**—7.4(6–8), 7.5"12," 7.6"11–15," 7.7(1)*k–n*,*r*

Trails, recreational **571**—ch 28, 33.40(1); **761**—chs 165, 180
Transit systems
See also BUSES
Financial assistance **261**—ch 61; **761**—chs 920–923
Fuel taxation **701**—18.38, 64.3"5," 65.15, 68.8(2)
Provider certification **761**—ch 910
Underground storage tanks, cleanup claims **591**—11.2(11)
Urban revitalization **261**—chs 26, 71; **591**—11.2(11); **701**—18.45(4), 80.8
Utilities
Definition **701**—77.1(1)
Funds
Physical infrastructure assistance program (PIAP) **261**—ch 61
Surplus **545**—2.5(5)
Relocation/removal **761**—150.4(5)
Right-of-way **761**—115.4(1)*b*(2), 115.8(1)*b*, 115.12(3)*c*, 115.13(2)*b*, 115.17, 115.18(2)*c*
Taxation **701**—14.3(9), 16.20, 16.50, 18.5(3), 18.39, 18.45(3)
Waste
Burning, open **567**—23.2
Hazardous **567**—150.4, chs 211, 214
Solid **567**—23.1(5)*a*, 23.2(3)*j*(12), chs 101, 105, 112, 113, 209; **701**—14.3(9), 18.5(3), 18.39, 26.71(3–5)
Yard **567**—ch 105
Wastewater **567**—23.2(3)*j*(12), 63.4, 64.3(4)*b*, *see also Loans above; Sewers above*
Water supplies **261**—23.4(6,8), 23.6, ch 61; **263**—8.3(11); **567**—chs 41–44; **641**—ch 20, 25.5, *see also ENVIRONMENTAL PROTECTION COMMISSION*

CITIZENS' AIDE (OMBUDSMAN)
See also ELDER AFFAIRS DEPARTMENT: Advocate/Ombudsman Program
Address **141**—1.2
Complaints **141**—1.3(1)*d*,*e*, ch 2
Declaratory orders **141**—3.12(7), ch 6
Duties **141**—chs 1, 2, 4
Hearings **141**—2.10
Immunities **141**—2.15
Investigations **141**—1.3(1)*d*,*e*, 2.5–2.8, 2.12
Purchasing **541**—ch 10, *see also ADMINISTRATIVE SERVICES DEPARTMENT (DAS)*
Records, *generally*, public/fair information **141**—ch 3
Reports **141**—2.12, 2.13; **541**—10.3
Rule making **141**—3.12(6), 3.13(4), chs 4, 5
Violations **141**—2.16

CITIZENSHIP
See also ALIENS; IMMIGRATION; REFUGEES
Family investment program (FIP) recipients **441**—41.23(5)
Foreign-born children, adoption **641**—100.3(2)*c*
Foster care requirements **441**—202.2(6)
Medical assistance eligibility **441**—58.45, 75.11(2), 75.11(3)*b*
Parolees/inmates, former **201**—45.6(2,3); **205**—14.3(3)

CITY DEVELOPMENT BOARD
See CITIES: Development Board

CITY FINANCE COMMITTEE
See CITIES: Finance Committee

CIVIL AIR PATROL
Emergency services, agreement **605**—9.3

CIVIL RIGHTS
Act, compliance **261**—24.11(1), 29.10; **441**—81.13(4), 150.3(3), 150.5(3), 150.7(3); **641**—73.16
Appeals **161**—4.22, 4.23, 4.25
Attorney general representation **61**—1.3(3)*e*
Commission
  Administration/organization **161**—1.1
  Contested cases **161**—3.13(4), ch 4
  Declaratory orders **161**—1.4
  Forms **161**—1.5
  Hearings **161**—3.13(4), ch 4
  Meetings, electronic attendance **161**—1.1(3)
  Purchasing **541**—ch 10, *see also ADMINISTRATIVE SERVICES DEPARTMENT (DAS)*
  Records, *generally*, public/fair information **161**—ch 11
  Referral/deferral agencies **161**—1.6
  Rule making **161**—1.2, 1.3, 11.14(4), ch 15
Complaints/investigations **161**—ch 3
Credit **161**—ch 6
Definitions **161**—1.6(2), 2.1, 6.1, 8.1
Employment
  Affirmative action, *see DISCRIMINATION*
  Agencies/services **161**—8.2, 8.49, 8.65(5)
  Discrimination
    See also DISCRIMINATION
    Age **161**—8.15–8.18
    Disability **161**—8.26–8.32, 8.55
    Sexist **161**—8.46–8.57
  State government **161**—8.65
  Tests **161**—8.1–8.4
Housing, discrimination **161**—ch 9
Public accommodations **161**—ch 10
Schools **701**—41.5(5)

CLAIMS
See also INSURANCE
Accidents, highway damages **761**—40.6
Appeal board **541**—1.5(1); **543**—chs 1, 3, *see also APPEAL BOARD, STATE*
Audits **11**—ch 41; **571**—26.7(3)
Commodity distribution program, losses **441**—66.7
Employees
  Human services **441**—ch 8
  Public safety **661**—ch 41
  Second injury fund **781**—2.14(10), ch 10
  Travel **11**—ch 41
  Unemployment **871**—chs 24, 25; **877**—28.1, *see also EMPLOYMENT*
Employers, benefits/contributions **871**—22.13, 23.31(3), 23.37, 23.38, 23.44; **877**—28.1
Gambling, pari-mutuel **491**—8.2(4,6)
General **541**—1.5(1); **543**—ch 3
Human services, *see HUMAN SERVICES DEPARTMENT*
Indemnification fund, grain **21**—1.2(4), 93.3, ch 94
Indigent defense, reimbursement **481**—ch 9; **493**—ch 12–14
IPERS benefits, *see PUBLIC EMPLOYEES' RETIREMENT SYSTEM (IPERS)*

Juvenile care providers, reimbursement **441**—151.3(4,5), 151.4, 151.31(5)*b*, 151.31(7), 167.5
Medical service injuries, volunteer health care providers **641**—88.5, 88.11, 88.12
Natural resource commission, relocation assistance **571**—26.7
Property, abandoned **781**—ch 9
Public defender, state **493**—7.1, chs 12, 13
Tanks, underground storage **567**—135.17, 136.8(2)*a*(2)"5,7," 136.8(2)*b*(2)"5,7," 136.21(2,3); **591**—ch 11
Taxation, credit/refund, *see specific tax under TAXATION*
Tort **61**—1.3(1)*d*, 2.14(7); **541**—1.5(1); **543**—ch 1
Vehicle registration refunds **761**—400.50
Workers' compensation **876**—3.1, 4.6

CLERGY
See RELIGION

CLINICS
Athletic **281**—36.15(6)
Biological agents **641**—ch 112
Genetic services **641**—4.5, 4.6
Hospitals, drug therapy management **657**—ch 13
Medical assistance, *see HUMAN SERVICES DEPARTMENT*
Neuromuscular outreach **641**—4.6
Pregnancy terminations, reports **641**—ch 106
Repositories, prescription drug donation **641**—ch 109

CLUBS, PRIVATE
See also GOLF
Health, registration **61**—ch 26
Licenses, liquor, *see BEER AND LIQUOR*
Smoking **641**—153.4(5)
Spas/pools **641**—ch 15
Taxation, sales/use **701**—16.37, 26.24
Unemployment compensation **871**—23.25(1,4,7–9)

COAL
Mines
See also SOIL CONSERVATION DIVISION: Coal Mining/Reclamation
Bureau **21**—1.4(3)

Pollution control
Effluent standards **567**—62.4(34)
Emissions **567**—23.1(2)*a*,*v*, 25.1, 26.3, 26.4 Tables III–V, *see also ENVIRONMENTAL PROTECTION COMMISSION: Air Quality*
Permits, exemptions **567**—22.1(2)*b*
Taxation, property exemptions **567**—11.6(3)*b*(6); **701**—80.3

Residue (by-product), combustion
Landfill requirements **567**—ch 103
Use, beneficial **567**—108.3, 108.4(4), 108.7(1)*c*, 108.8(2)

Slurries, pipeline construction **199**—ch 13

COAST GUARD
See also MILITARY
Inspections, moored vessels **571**—48.4
Taxation exemption, property **701**—80.2(2)*c*

COLLECTIONS
See DEBTS; TAXATION: Sales and Use subheadings Antiques/Curios/Stamps; Coins/Currency

COLLECTIVE BARGAINING
See ADMINISTRATIVE SERVICES DEPARTMENT (DAS): Human Resources Enterprise; PUBLIC EMPLOYMENT RELATIONS BOARD (PERB)

COLLEGES AND UNIVERSITIES
See also COLLEGE STUDENT AID COMMISSION; REGENTS BOARD
ACE, *see Grants below*
Advisory committee, postsecondary approval **283**—21.1
Advisory councils, student aid **283**—1.2(7)
Authorizations, coach **282**—ch 19
Barber, *see BARBERS*
Chiropractic **283**—ch 32; **645**—41.4, 42.2
Community colleges
Accelerated career education (ACE) program **261**—9.6(2), 9.7, ch 20; **283**—ch 19
Accreditation **281**—21.3(3), 21.3(6)*a*(8), 21.10, 21.11, ch 24
Administration **281**—21.2
Admissions **281**—21.2(8)
Adult education **281**—21.4(3), ch 23
Affirmative action/equal opportunity **281**—ch 95
Apprenticeship programs **261**—ch 11; **281**—21.72–21.74
Approvals **281**—21.9
Building/site **281**—21.9
Career academies **281**—ch 47
CEBA (community economic betterment account), *see Grants below*
Coach authorizations, course approval **282**—19.3
Councils **281**—1.1(7), 1.2(7)
Curriculum/evaluation **281**—21.4, 24.1
Disabilities **281**—21.4(4), 21.8, 21.9(5,7), 24.1"9," 24.5(3), 24.5(4)*c,g*
Division **281**—1.4(1)*b*
Driver instruction, drinking offenders **281**—21.30–21.33
Energy conservation, *see Energy Conservation/Management below*
Equipment/software, training fund **261**—ch 106
Facilities **281**—21.5, 21.7–21.9
Faculty
See also Curriculum/Evaluation this subheading above; PUBLIC EMPLOYEES' RETIREMENT SYSTEM (IPERS): Membership; TEACHERS
Arbitration **621**—7.5
Committee, quality plan **281**—21.3(6)
Definitions **281**—21.3(7)*a*
Libraries/learning centers **281**—21.5(2)
Licenses/endorsements **281**—21.3(1)*a*, 24.5(1)
Salaries **281**—21.3(7)
Standards **281**—21.3(1,2), 21.12, 24.5, 47.2(5)
Workload **281**—21.3(4)
Funds **261**—7.4–7.10, 7.12, 7.17, 7.19, 7.28–7.33, ch 9, 11.3(8,11), chs 53, 106, 165.1, 165.4, 165.4(5); **281**—21.3(7), 21.45, 21.57–21.63, 21.65, 21.67–21.70, 47.2(2); **283**—ch 18; **350**—4.4(4); **781**—ch 16, *see also Grants below*
Job training programs **261**—chs 5, 7–9, 20
Lead professionals, certification **641**—70.5(7)
Libraries **281**—21.5; **286**—9.4(3)
Motor vehicle dealer education program **281**—21.75
Paraeducator certification **281**—ch 80
Postsecondary education, high school students, *see Vocational Education this subheading below; Enrollment, High School Students below*

Procurements, bid solicitation **261**—54.10
Program/administrative sharing initiative **281**—21.64–21.71
Quality instructional center initiative **281**—21.57–21.63
Records **281**—5.15(20–22), 21.3(6)*a*(4,7)
Scholarship program **283**—11.1(6)
Telecommunications **751**—7.4(1), chs 9, 14
Vocational education **261**—9.6(4,6), 9.7, ch 20; **281**—21.4(2,6), 21.12, 24.1"2,5,9,11," 24.5(4), chs 46, 47; **283**—ch 13

Continuing education sponsors, approval, *see specific profession*
Cosmetology, *see COSMETOLOGY AND COSMETOLOGISTS*
Dental, *see DENTISTS AND DENTISTRY*
Driving instructor authorization **282**—ch 21
Emergency declarations **681**—9.1(4)
Employees, *see Personnel below*
Energy conservation/management **565**—ch 6
Enrollment, high school students **281**—ch 22, 24.1, 97.2(5); **681**—1.1(6)
Evaluator approval training programs **282**—ch 20
Financial assistance, *see GRANTS*
Fire standards, *see FIRE AND FIRE PROTECTION*
Food service inspections **481**—1.5"2"
Fraternities/sororities **701**—18.15
Funds **261**—165.1, 165.4, 165.4(2); **283**—ch 18; **801**—1.2(3)*g*, 6.12(6), ch 9, *see also Community Colleges above; Grants below; Scholarship Program below*
Grants
Generally **283**—ch 4, 6.12
Community colleges
See also Community Colleges: Funds above
ACE (career education, accelerated) **261**—ch 20; **283**—ch 19
CEBA (community economic betterment account) **261**—ch 53
Disabilities program **261**—ch 30
Minorities **283**—ch 22; **681**—1.6(2)*c*(3,4)
Piano major/minor **11**—ch 116
Tuition **261**—11.3(8,11); **283**—chs 8, 9, 12–14, 20, 22, 27, *see also State Universities below*

Insurance **191**—35.3
Loans, student, *see COLLEGE STUDENT AID COMMISSION; HIGHER EDUCATION LOAN AUTHORITY*
Nursing education **655**—ch 2
Out-of-state schools, approval **283**—ch 21
Paraeducators, certification programs **281**—ch 80
Personnel
See also Community Colleges: Faculty above
Administration **681**—ch 3
Affirmative action/equality **281**—ch 95; **681**—ch 7
Grievances **681**—12.9–12.11
IPERS, benefits, *see PUBLIC EMPLOYEES' RETIREMENT SYSTEM (IPERS): Membership*
Unemployment compensation **871**—23.25, 23.27(7)

Pharmacy, internship programs **657**—4.3–4.6
Physician assistant program **645**—326.15, 326.16
Practitioner preparation, school personnel **281**—ch 79
Radioactive material, decommissioning **641**—ch 39 Appendix J, *see also RADIATION MACHINES AND RADIOACTIVE MATERIALS: Decommissioning*
Registration, fee **721**—ch 31

Research
Animal, *see ANIMALS*
Technology
Networking events, targeted industries **261**—ch 107
Utilization program **261**—ch 63

Residency **283**—12.1(3), 13.1(2), 14.1; **681**—1.4
Scholarship programs **11**—ch 116; **222**—ch 9; **283**—ch 4, 6.12, ch 8, 11.1(2,5,6), 14.3, ch 36
School to career program **261**—ch 11; **281**—ch 48
Security officers, weapons **661**—121.18
State universities
See also REGENTS BOARD
Generally **681**—chs 1–5, 7–14
Admissions
Generally **681**—chs 1, 2
Accounts, delinquent **681**—1.5
High school entries **681**—1.1
Residents/nonresidents **681**—1.1(3), 1.4
Transfers **681**—1.2, 1.3, 9.2

College-bound program **681**—1.6
Competition, private enterprise **681**—9.4
Emergency declarations **681**—9.1(4)
Hygienic laboratory **681**—ch 5, 12.1(3)
Iowa State University **681**—2.25–2.27, 4.25–4.32, 9.5(3), ch 13, *see also IOWA STATE UNIVERSITY (AMES)*
Personnel, *see Personnel above*
Program/administrative sharing initiative **281**—21.64–21.71
Purchasing **681**—ch 8
Records **681**—1.6(2)*c*(1), ch 10
Riots **681**—9.1(2)*h*
Telecommunications **681**—9.4(6)*f*, 9.5; **751**—7.4(1), chs 9, 11, 14
Tuition **261**—11.3(8,11); **681**—1.4(2), 9.6, *see also Grants above; Scholarship Programs above; Trust, Educational Savings Plan below*
University of Iowa **681**—2.1, 2.3–2.12, 4.1–4.8, 9.5(2), ch 12, *see also UNIVERSITY OF IOWA (IOWA CITY)*
University of Northern Iowa **681**—2.35, 2.37, 2.38, 4.66–4.73, 9.5(4), ch 14, *see also UNIVERSITY OF NORTHERN IOWA (CEDAR FALLS)*

Taxation, sales, exemption **701**—17.11
Teacher education, *see TEACHERS*
Trust, educational savings plan **701**—40.53, 53.21, 59.22; **781**—ch 16
Tuition, *see Grants above; State Universities above*
Veterans, training **281**—ch 52
War orphans educational assistance **801**—ch 9
WIA (workforce investment Act) program, federal funds **877**—7.16–7.18
Wildlife education projects **571**—111.4
Work-study program **283**—ch 18

COLLEGE STUDENT AID COMMISSION
Address **283**—1.2(1)
Advisory council **283**—1.2(7)
Appeals **283**—ch 4, 5.25, 5.27
Committee, advisory, postsecondary registration **283**—21.1
Contested cases **283**—ch 5
Declaratory orders **283**—ch 3, 6.12

Grants
Accelerated career education (ACE) program **261**—ch 20; **283**—ch 19
Eligibility, appeals **283**—ch 4
Foster care, all opportunity program **283**—ch 9
IMAGES (minority for economic success, Iowa) **283**—ch 22
Records **283**—6.12
State-supported **283**— chs 14, 27
Tuition **283**—chs 8, 9, 12–14, 20, 22, 27, *see also Scholarships below*
Vocational/technical **283**—ch 13

Hearings, *see Contested Cases above*
IMAGES, *see Grants above*
Loans
See also Grants above
Chiropractic, *see Physicians this subheading below*
Default **191**—10.22, 50.53, 103.8; **193**—7.44, 8.2; **193D**—1.9; **193E**—1.8; **193G**—1.12; **282**—ch 9; **283**—8.5, 9.7, 10.2, 12.1(7), 13.1(7), 14.2(12), 14.3(8), 18.11, 19.1(7), 22.1(5), 27.1(10), 32.1(9), 34.6, 35.6, 36.1(5), ch 37; **481**—8.2, 8.3; **641**—110.21, ch 195; **653**—23.1(32), ch 16; **657**—ch 31, 36.1(4)*y*; **701**—43.4(2); **761**—400.45(3), 600.4(9), 615.24(2), 615.45(1); **811**—6.8, 10.6(24)
Family education **283**—ch 10
Guaranteed, *see Science/Mathematics this subheading below*
Nurses **283**—ch 34
Physicians
Chiropractic **283**—6.12, ch 32
Osteopathic **283**—ch 14

Records **283**—6.12
Science/mathematics **283**—ch 15
Teacher shortage forgiveness program **283**—ch 35

Organization **283**—ch 1
Osteopathy, *see Loans: Physicians above*
Records, *generally*, public/fair information **283**—1.2(5,6), 2.13, ch 6
Residency **283**—11.1(2), 12.1(3), 13.1(2), 14.1, 19.1(2), 22.1(1), 27.1(2), 32.1(2), 36.1(2)
Rule making **283**—ch 2, 6.12, ch 7
Scholarships **283**—ch 4, 6.12, chs 8, 11, 14.3, ch 36
Tuition, *see Grants above; Loans above*
Work-study program **283**—ch 18

COMMERCE DEPARTMENT
Address **181**—1.6, 2.3, 3.1
Declaratory orders **181**—1.7(2), ch 3
Definitions **181**—1.5
Director **181**—1.5, 2.3
Divisions
See also Utilities Division below; BANKS AND BANKING; BEER AND LIQUOR; CREDIT UNIONS; INSURANCE: Division; PROFESSIONAL LICENSING AND REGULATION BUREAU; SAVINGS AND LOAN ASSOCIATIONS
Generally **181**—1.4, 1.6, 1.7
Administrators **181**—1.5, 1.8

Procurements **541**—ch 10, *see also ADMINISTRATIVE SERVICES DEPARTMENT (DAS)*
Records **181**—1.7

Rule making **181**—1.2, 1.3, 1.7(2), 1.8, ch 2
Utilities division
Generally **181**—1.4(6), 1.6(5); **199**—1.4, 1.5
Accounting **199**—ch 16
Address **199**—1.8(1), 19.4(15)*d*(3)"9," 20.4(15)*d*(3)"9," 21.4(1), 22.4(1)
Assessments **199**—ch 17
Authority **199**—1.4, 9.1(1), 19.1, 20.1, 21.1, 22.1, 24.1, 25.1
Complaints **199**— 1.5(3)*b*, 2.2(7–11), ch 6, 7.2, 7.4(4)*a*, 7.9(2), 8.2, 37.5, 40.6, 42.17–42.21, *see also specific utility*
Confidential information **199**—1.9, 30.2, 43.7
Conflict of interest **199**—1.6
Counsel **199**—1.5(2)
Declaratory orders **181**—1.7(2); **199**—2.2(6), ch 4, 32.3
Electric **199**—ch 15, 16.2, 18.2, 18.4, 18.5, ch 20, 23.2(1), chs 24–26, 29.3(2), chs 35, 40, 42, *see also ELECTRIC UTILITIES*
Employees
Benefits **199**—16.9
Sale/lease of goods/services **199**—1.6
Energy
Efficiency plan **199**—ch 35
Wind/renewable, production, taxation credits **199**—15.18–15.21, *see also TAXATION subheadings Franchise: Credits; Income Tax, Corporation: Credits; Income Tax, Individual: Credits*
Filings **199**—1.8
Forms **199**—ch 2, 26.5(1)*c*(1)
Gas **199**—ch 10, 16.3, 18.2, 18.6, ch 19, 23.2(2), 23.3(2), 29.3(3), chs 35, 42, *see also GAS UTILITIES*
Hearings
Generally **199**—1.8, chs 5–7, 26.9
Civil penalties **199**—ch 8
Communications service **199**—ch 5
Construction, electric generating facilities **199**—24.5–24.9
Definitions **199**—7.2
Forms **199**—ch 2
Pipeline route **199**—10.4, 10.6, 10.7, 13.3, 13.4, 13.6, 13.9
Right-of-way disputes, railroad **199**—42.22–42.25
Lines, electric/communications **199**—1.4, 1.5(3)*f*, 2.4, ch 11, 20.1(1,3), ch 25, 42.3(2), 42.6
Officials, sale/lease of goods/services **199**—1.6
Organization **199**—ch 1
Penalties, *see Violations/Penalties this subheading below*
Pipelines **199**—1.4, 1.5(3)*f*, 1.8(4)*d*, 2.4"6–9," chs 9, 10, 12, 13, 42.3(3), 42.7, *see also PIPELINES*
Procurement
Plan, electric fuel **199**—20.13
Targeted small businesses **541**—ch 10, *see also ADMINISTRATIVE SERVICES DEPARTMENT (DAS)*
Railroad right-of-way **199**—ch 42
Records **181**—1.7; **199**—1.5(3), 1.9, ch 18, 31.5(2), *see also specific utility*
Reorganization, asset/stock disposal **199**—ch 32
Reports, annual **199**—1.9(4)*e*, ch 23; **541**—10.3, *see also specific utility*
Rule making **181**—1.7(2); **199**—1.3, 1.9(4)*d*, 2.2(1,4,5), ch 3, 19.1, 20.1, 21.1, 22.1
Service discontinuance **199**—7.1(6), *see also specific utility*
Standards, management efficiency **199**—ch 29
Tariffs **199**—1.5(3)*c*, 1.9(4)*f*, 7.4(4), ch 26, *see also specific utility*
Tax liability **199**—ch 30, 42.13
Telecommunications **199**—1.5(3)*g*, chs 37–39, 42, 43

Telegraph, *see TELEGRAPH COMPANIES*
Telephone **199**—ch 5, 7.4(1)*b*, 16.5, 18.8, ch 22, 23.2(4), 23.3(3), 29.3(4), ch 42, *see also TELEPHONE COMPANIES*
Violations/penalties **199**—ch 8, *see also Complaints this subheading above; specific utility*
Water **199**—16.4, 18.7, ch 21, 23.2(5), 29.3(5), ch 42, *see also WATER UTILITIES*

COMMODITIES
See also FOOD
Administrative services department, *see ADMINISTRATIVE SERVICES DEPARTMENT (DAS): General Services Enterprise: Procurement, Goods/Services*
Agricultural
Financial assistance, value-added production, *see ECONOMIC DEVELOPMENT DEPARTMENT*
Referendums **21**—ch 20
Warehouses, *see WAREHOUSES: Agricultural Products*

COMMUNICABLE DISEASES
See DISEASE

COMMUNICATIONS
See INTERNET COMMUNICATIONS; RADIO; TAXATION: Sales/Use;TELECOMMUNICATIONS; TELECOMMUNICATIONS AND TECHNOLOGY COMMISSION; TELEGRAPH COMPANIES; TELEPHONE COMPANIES; TELEVISION

COMMUNITY ACTION AGENCIES
Address **427**—5.5, 10.16
Appeals **427**—8.21, 10.15
Attendant care services, consumer-directed, *see HUMAN SERVICES DEPARTMENT: Medical Assistance (Medicaid)*
Contested cases **427**—ch 7
Declaratory orders **427**—ch 6
Grants
Community services block **427**—chs 22, 24, *see also GRANTS*
Emergency community services homeless program (EHP) **427**—ch 23
Heating programs, low-income **427**—chs 10, 11
Weatherization assistance **427**—ch 5
Medical assistance providers, *see HUMAN SERVICES DEPARTMENT: Medical Assistance (Medicaid)*
Records/reports **427**—ch 2, 5.5, 8.17, 10.11, 10.16, 22.10, 23.9, 23.10, 23.12, *see also HUMAN RIGHTS DEPARTMENT*
Rule making **427**—chs 3, 4, 8
Taxation exemption **701**—17.40

COMMUNITY COLLEGES
See COLLEGES AND UNIVERSITIES

COMMUNITY ECONOMIC BETTERMENT ACCOUNT (CEBA)
See ECONOMIC DEVELOPMENT DEPARTMENT

COMPACTS
Child placement **441**—9.12(1)*b*(7), ch 142, 200.9, 200.10(2)
Citations, traffic, nonresident violator compact **761**—615.18, 615.45(1)*h*
Juveniles **441**—ch 143
Parolees/probationers **201**—ch 46; **205**—8.2(4), 11.9
Wildlife violator **571**—15.13

COMPENSATION
See also WAGES
Deferred compensation program, *see ADMINISTRATIVE SERVICES DEPARTMENT (DAS)*
Unemployment, *see EMPLOYMENT*

Victims, crime, *see CRIME*
Workers', *see WORKERS' COMPENSATION*

COMPETITION
Extracurricular interscholastic **281**—ch 36
Private enterprise
Regents institutions **681**—9.4
Transportation department **761**—ch 25

State agency procurements, *see BIDS AND BIDDING*

COMPOSTING FACILITIES
See ENVIRONMENTAL PROTECTION COMMISSION: Solid Waste Management/Disposal

COMPUTERS
See also ADMINISTRATIVE SERVICES DEPARTMENT (DAS): Information Technology Enterprise; INTERNET COMMUNICATIONS; TELECOMMUNICATIONS
Criminal justice information **661**—ch 8
Elections, *see ELECTIONS subheadings Ballots: Tabulation; Voting: Equipment; VOTER REGISTRATION COMMISSION*
Electronic transfer, funds, *see BANKS AND BANKING; CREDIT UNIONS; SAVINGS AND LOAN ASSOCIATIONS*
Gambling
Multilink (wide area progressive system) **491**—11.12(8)
Surveillance **661**—ch 141
Library access **286**—3.1, chs 6, 7
Pharmacies **657**—ch 21
Records, *see specific agencies subheading Records: Data Processing*
Taxation
Assessment **701**—71.1(5,7), 80.7
Electronic transmissions **701**—12.2, 12.3(2)*d*, 39.13
Forms, substitute **701**—8.3(1)*c*
Local option exemption **701**—107.9"3"
Maintenance contracts **701**—18.34(2)*j*
New jobs program, property **261**—58.4(4); **701**—80.7(7)
On-line service **701**—18.20(5)
Operators **701**—26.28
Records, retailers **701**—11.4
Sales/rental **701**—18.34, 18.45, 18.58, 26.81
Software development, job creation program incentives **261**—ch 68
Urban renewal project funding **701**—80.7(7)

CONCESSIONS
See AMUSEMENTS AND AMUSEMENT PARKS; FAIR BOARD; FOOD; NATURAL RESOURCES DEPARTMENT

CONDOMINIUMS
Swimming pools, *see PUBLIC HEALTH DEPARTMENT*
Taxation **701**—71.1(4,5)
Utility service, meters **199**—19.3(1)*b*(4), 20.3(1)*b*(4); **701**—17.38

CONFINEMENT FEEDING OPERATIONS
See LIVESTOCK: Feedlots

CONFLICTS OF INTEREST
Employees, regulatory agencies, prohibitions
Accountancy examining board **193**—ch 11; **193A**—2.7(7), 15.4
Administrative services department (DAS) **11**—ch 66
Architectural examining board **193**—ch 11; **193B**—4.1(3)
Corrections department **201**—50.10(3), 51.9(3)

Dental board **650**—ch 8
Developmental disabilities (DD) council **441**—38.12
Disabilities division, persons with **431**—1.3(9)
Engineering/land surveying examining board **193**—ch 11; **193C**—8.2(4)
Environmental protection commission **567**—1.11
Ethics and campaign disclosure board **351**—1.4(9,11), 6.12(2)*e*, 8.15–8.17
Inspections and appeals department **481**—ch 7
Interior design examining board **193**—ch 11; **193G**—1.9, 4.1(2)
Landscape architectural examining board **193**—ch 11; **193D**—1.6, 4.1(3), 4.1(6)*c*
Medicine board, Iowa physician health committee (IPHC) **653**—1.10
Natural resource commission **571**—1.11, 12.7
Petroleum underground storage tank fund board **591**—1.5
Pharmacy board **657**—ch 29
Professional licensing and regulation **193**—ch 11, *see also specific profession*
Public health department **641**—55.6
Real estate appraisers examining board **193**—ch 11; **193F**—1.9
Real estate commission **193**—ch 11; **193E**—1.11, 18.5
Regents board **681**—8.9
Revenue department **701**—6.7
Utilities division **199**—1.6

Insurance, health, purchasing cooperatives (HIPC) **191**—73.14

CONSTITUTION OF IOWA
Depository **721**—1.7

CONSTRUCTION
See also BRIDGES; BUILDINGS; CAMPS: Sanitation; CONTRACTORS/CONTRACTS; ELECTRIC UTILITIES; ELEVATORS; ENVIRONMENTAL PROTECTION COMMISSION subheadings Permits; Tanks, Underground Storage (UST); Wastewater Treatment/Disposal; Water Quality: Supply; FLOOD CONTROL; GAS UTILITIES; HEALTH CARE FACILITIES; HIGHWAYS; HOSPITALS; LIVESTOCK: Feedlots; TAXATION: Sales and Use; TELEPHONE COMPANIES; WATER UTILITIES; WELLS subheadings Gas/Oil: Drilling; Water
Products, manufacturers, occupational safety **875**—32.8(12)

CONSULTANTS
See also HEALTH CARE FACILITIES: Nurses
Abuse, child **441**—175.28
Art, public **222**—13.7(3)
Deaf services **429**—1.2(3)*c*, 2.3(5)
Disabled, services **265**—ch 25; **431**—1.2(3)*b*
Education, *see TEACHERS: Special Education*
Genetics, payment **641**—4.5
Historic surveys **223**—ch 41
Insurance, chiropractors **645**—43.4
Labor services **875**—ch 8
Lottery authority **531**—1.7
Political **351**—4.19
Tanks, underground storage remediation **591**—13.6, 13.7
Transportation department **761**—20.8
Voting systems **721**—22.7

CONSUMER PROTECTION
Attorney general authority **61**—1.3(2)*b*, ch 10, *see also ATTORNEY GENERAL*
Campground memberships **61**—ch 25
Clubs, exercise **61**—26.7

Credit, *see ATTORNEY GENERAL*
Deaths, autopsies **641**—127.3(2)*f*
Hazardous chemicals, household **567**—ch 144
Inspections division, food/consumer safety bureau **481**—ch 30
Motor vehicles **61**—chs 27, 29, 30
Price gouging **61**—ch 31
Prize promotions **61**—ch 32
Records **61**—2.14(8,9,11), 2.15(2,6,7,14), 10.2, 10.6, 11.5(2)
Rental purchase agreements **61**—ch 19; **701**—18.53
Water treatment systems **641**—14.7

CONTRACEPTIVES
Clinics, family planning **441**—78.22
Insurance **191**—35.39, 71.14(6), 71.24, 75.10(4), 75.18
Medical assistance, sterilization **441**—78.1(16), 78.3(9), 78.22, 78.23, 78.26(2)
Prophylactics **641**—ch 6

CONTRACTORS/CONTRACTS
See also LEASES
Accounting systems, certification **81**—ch 26
Affirmative action, *see DISCRIMINATION*
Appeals, *see Registration below*
Area agencies on aging, *see ELDER AFFAIRS DEPARTMENT*
Asbestos, removal/abatement **875**—155.1, 155.6(5,10)
Auditors, unclaimed property **781**—9.15
Bond forfeiture, out-of-state **701**—7.27
Boxing **875**—97.26
Bus drivers, schools, *see BUSES*
Carriers, *see CARRIERS*
Construction
  Buildings **871**—23.82(2)*b*,*c*, *see also Taxation this subheading below*
  Definitions **871**—23.82
  Employment, corrections department offenders **201**—37.10; **877**—1.6
  Highways/roads **701**—18.17; **761**—ch 125; **871**—23.82(2)*d*
  Industrial, nonbuilding **871**—23.82(2)*e*(3)
  Out-of-state **701**—7.27, 19.5; **875**—1.3, 150.2, 150.10(1)*c*, 150.13
  Pipelines/mains/sewers **871**—23.82(2)*e*(1)
  Power/communication lines **871**—23.82(2)*e*(2)
  Procurement, state agencies **681**—7.7(3), 8.6(3,5); **877**—12.19(11), *see also ADMINISTRATIVE SERVICES DEPARTMENT (DAS): General Services Enterprise*
  Registration, *see Registration below*
  Taxation **261**—58.2, 58.4(6), 59.2, 59.6(3)*e*, 59.8(2)*b*, 64.4(1); **701**—52.10(5), 52.22(2), *see also TAXATION subheadings Local Option Sales/Services; Sales and Use; Use Tax*
  Wells, *see Well Construction/Inspection below*

Day services, adult **321**—24.18–24.20
Debt cancellation product sales, credit unions **189**—ch 5
Disclosure report **193E**—14.1(4)
Electrical, licensing **661**—chs 500, 503
Employment benefits
  Independent contractors **495**—11.5(1); **871**—23.18(1), 23.19
  Unemployment compensation, *see EMPLOYMENT: Employers, Contributions*

Fairgrounds **371**—ch 4
Federal, employer eligibility/awards **877**—8.8, 8.9
Fire extinguishing, certification **661**—ch 275

Food/food service establishments, inspections **481**—ch 35
Funerals, prearranged **191**—15.6, 101.6, ch 105
Governmental entities, public improvements **761**—ch 180
Health care facilities, *see ASSISTED LIVING: Facilities; HEALTH CARE FACILITIES*
Healthy opportunities for parents to experience success—healthy families Iowa (HOPES-HFI) program **641**—ch 87
Hospice **481**—53.17
Independent **495**—8.1(10), 11.5(1); **701**—18.5(3)*c*, 52.1(3)*w*, 54.1(4); **871**—23.18(1), 23.19; **875**—219.107
Insurance **371**—4.9; **661**—121.3(6); **681**—8.4; **875**—150.4(6), 150.8
Interest, public improvement funds **27**—ch 7
Investment advisors **191**—50.36(5)
Laborers, farm **875**—216.33(1,7); **877**—8.1, 8.3(6–12)
Land sales **263**—7.2(1)*a*(1); **701**—40.14
Lawn care, wages **875**—219.107
Lead, target housing projects **641**—69.3(2)*f,g*, 69.4(2)*e,f*, *see also LEAD: Abatement*
Minorities/women, small business **261**—ch 54; **321**—5.15(4); **541**—4.4, 4.5(4), 10.2(3)*b*; **681**—ch 7; **877**—12.19(11), *see also State Agencies: Small Business, Targeted below*
Petroleum, aboveground/underground storage **591**—11.2(4,7), 11.3(4,10), 11.5(1,3–6), 13.3, 13.4, 14.12
Racing, *see RACING AND GAMING*
Real estate, *see REAL ESTATE: Broker/Salesperson/Associate*
Registration
Generally **875**—1.3, ch 150
Appeals **486**—1.2(1)"5," ch 7; **875**—150.10(3), 150.11(8,9)
Records **875**—1.18(1)*g*, 1.23(15)
Revocation **875**—150.11
Schools, charter **281**—68.4(3), 68.5–68.7
Service contracts **11**—chs 106, 107; **191**—chs 23, 54; **701**—14.3(6,8), 18.25, 26.81
Small business, targeted, *see State Agencies below*
State agencies
See also Governmental Entities, Public Improvements above; BIDS AND BIDDING
Administrative services department (DAS), contracts/master agreements, *see ADMINISTRATIVE SERVICES DEPARTMENT (DAS) subheadings Accounting Enterprise; General Services Enterprise*
Arts division, *see ARTS*
Attorney general **61**—9.60, 9.62
Corrections department, Iowa state industries **201**—37.10
Criminal/juvenile justice planning division **428**—3.3, 3.6, 3.9, 3.10
Cultural affairs department, *see CULTURAL AFFAIRS DEPARTMENT: Grants*
Discrimination, *see DISCRIMINATION*
Economic development department **261**—34.4(7), chs 187, 188, 212.10, *see also ECONOMIC DEVELOPMENT DEPARTMENT*
Elder affairs department, *see ELDER AFFAIRS DEPARTMENT*
Environmental protection commission, *see ENVIRONMENTAL PROTECTION COMMISSION*
Fair board, *see FAIR BOARD*
Finance authority **265**—9.9, 14.7, 15.5
Human services department, *see HUMAN SERVICES DEPARTMENT*
Inspections and appeals department, *see INSPECTIONS AND APPEALS DEPARTMENT*
Lottery authority, *see LOTTERY AUTHORITY*
Natural resources department, *see NATURAL RESOURCES DEPARTMENT subheadings Contracts; Natural Resource Commission*
Pharmacy board, recovery program **657**—30.5, 30.6
Public defender **493**—4.14(3), ch 11

Public health department
Grant, local services **641**—ch 80
Health data **641**—177.2, 177.7
WIC program **641**—73.15, 73.20–73.23

Racing and gaming, *see RACING AND GAMING*
Regents board, *see REGENTS BOARD*
Small business, targeted **11**—105.2, 105.4(2), 105.5(7), 105.7(2), 106.12(1); **261**—ch 54; **321**—5.15(4); **481**—25.10; **541**—ch 10; **681**—7.1(1), 7.7, 8.1(2), 8.6(5); **761**—20.4(1)*a*, *see also Minorities/Women, Small Business above*
Soil conservation division, *see SOIL CONSERVATION DIVISION*
Transportation department, *see TRANSPORTATION DEPARTMENT*
Workforce development department, *see WORKFORCE DEVELOPMENT DEPARTMENT*

Taxation **701**—7.27, 15.13, 16.14, 16.30, 16.47, 18.5(3)*c*, 18.17, 18.43, 18.52, 40.14, 52.1(3)*w*, 107.5, *see also Construction above; Service Contracts above; TAXATION: Sales and Use*
Underground storage tank cleanup, *see Petroleum, Aboveground/Underground Storage above*
Utilities, *see specific utility*
Voting equipment, county purchase **721**—22.32
Waste disposal, hazardous **567**—123.2, 214.10
Well construction/inspection **567**—38.1, 38.8(3), 39.3, 39.6(2), 50.2, 54.5(3), 54.6(1), 54.7(2,4), ch 82; **871**—23.82(2)*m*
Workforce Investment Act (WIA) program, *see WORKFORCE DEVELOPMENT BOARD/CENTER ADMINISTRATION*

CONTRIBUTIONS
See also CHECKOFFS
Charitable, *see CHARITY*
Political campaigns, *see POLITICS*
Unemployment **871**—chs 22, 23, *see also EMPLOYMENT*

CONTROLLED SUBSTANCES
See DRUGS; SUBSTANCE ABUSE

CONVICTS
See CORRECTIONS DEPARTMENT

COOPERATIVES
See also ELECTRIC UTILITIES: Rural Cooperatives
Taxation credits **199**—15.19; **261**—64.4(3,4), 68.4(4)*c*; **701**—42.2(10)*b*, 42.27(2)*b*, 52.10(4), 52.28(2)*a*

CORN
See also CROPS; FUEL; GRAIN; SEEDS
Referendums **21**—ch 20

CORONER
See MEDICAL EXAMINERS

CORPORATIONS
See also INDUSTRY; SMALL BUSINESS
Generally **721**—1.2
Agriculture
See also Life Science Enterprises below
Land, political signs **351**—4.44(1)
Referendums **21**—20.2"2, 3," 20.3(1)*a*
Reports **721**—4.2(4)
Taxation **199**—15.19; **571**—ch 32; **701**—43.8, 52.5(2)*c*, 52.13, 53.11(2), 54.1, 59.8(2), 79.4
Warehouses, grain **21**—90.8(9)

Architects, practice authorization **193B**—2.10

Banks **187**—1.4, 2.1(5), 2.7
Capital investment corporation fund, investor's tax credits **123**—ch 4
Clearing corporations, deposits **191**—ch 32; **641**—201.13(2)*a*
Filings, document **721**—ch 40
Forms **721**—1.2(2), 4.1, 4.2(1–3)
Gambling devices, manufacturers/distributors, *see GAMBLING: Devices, Manufacturers/Distributors*
Health care facilities **481**—50.8(5)
Health maintenance organizations (HMOs) **191**—40.4
Health service **191**—chs 34, 70
Incorporation
  Banks, *see Banks above*
  Certificate reinstatement **721**—40.2
  Municipal **263**—ch 8
Industrial loan **187**—ch 16
Insurance
  Life, contracts **191**—30.7
  Real estate firms **193E**—19.2, 19.3
Life science enterprises **261**—ch 67
Loans
  Agricultural **25**—2.14, 4.3(7)*c*, 4.3(8)*c*, 4.4(1)*c*, 4.7(1,2)
  Housing/community development **261**—25.3; **265**—ch 11
  Student **283**—10.2(1)*b*
Lottery retailers **531**—12.16(4,5)
Motor vehicles
  Registration **761**—400.61(4)
  Transfers, mergers, taxation **701**—34.13
Municipal, utility hearings **199**—7.2(7)
Nonprofit
  Elder group homes **321**—ch 29
  Fees, document filing **721**—40.7
  Forms **721**—4.2(1)
  Incorporation **721**—40.2(3)
  Unemployment, *see Unemployment Fund below*
Political activity **351**—4.44–4.47, 4.49–4.52, 4.54
Racing/gaming licensees **491**—5.4(13)*a*(1), 6.17(2), 6.20
Real estate
  Insurance **193E**—19.3
  License **193E**—7.1(5), 7.2(1)
Records, state **721**—5.16"1," 40.3, 40.6(11,12)
Savings and loan associations **197**—chs 2–14, *see also SAVINGS AND LOAN ASSOCIATIONS*
Taxation, *see Agriculture above; TAXATION subheadings Income Tax, Corporation;Income Tax, Individual: Subchapter S Corporation; Property: Railroads; Property: Real Estate; Sales and Use*
Underground storage tank cleanup, financial inability **567**—135.17(3)
Unemployment fund
  Institutions **871**—23.27(2,7)
  Nonprofit **871**—23.70
  Officers **871**—22.3(5)*c*(4), 22.3(5)*d*, 23.3(2)*f*, 23.3(3)*a*, 23.18(2), 24.22(2)*n*
Value-added, *see also TAXATION: Income Tax, Corporation: Subchapter S*
Warehouses, assets **21**—90.8(9)

CORRECTIONS DEPARTMENT

See also CRIME; PAROLE; SUBSTANCE ABUSE: Treatment Programs: Licensure
Address **201**—1.3
Attorney general representation **61**—1.3(1)*d*; **201**—12.15
Community-based programs
  Accreditation **201**—40.1, 40.2
  Appeals **201**—43.1(6)
  Case plan/audit **201**—42.1(4), 43.1(19), 44.1(5)*c*,*d*, 45.1(2)*b*
  Directors
    Board **201**—40.1, 40.4
    Deputy **201**—40.1–40.3
    District **201**—40.1, 40.5
  Discharge **201**—42.1(7), 43.1(18), 44.7, 44.9(5), 45.6
  Discipline **201**—44.1, 47.2(9), 47.4(7)
  District authority **201**—40.4(11,12), 40.5(3), chs 41–45, 47
  Employment, residents **201**—40.5(10), 44.4, 44.8, 47.4(5,6)
  Escapes **201**—47.4(17)
  Fees, offenders **201**—47.3(4–6,9), *see also Parole/Probation: Restitution this subheading below*
  Firearms, officers/employees **201**—40.4(11,12)
  Funds
    See also Parole/Probation this subheading below
    Allocation **201**—40.2(4)*d*, 40.5(8)
    Earnings, surrender **201**—44.4, 47.3(6)
  Halfway houses **201**—ch 44, *see also HALFWAY HOUSES (WORK RELEASE)*
  ICON, database **201**—40.5(3)*b*
  Indigents, hospitalization **201**—45.1(6), 47.4(10)
  Information
    Data entry **201**—40.5(3)
    HIV, employee notification **661**—8.103
  Investigations **201**—40.3, 41.2
  OWI, *see Substance Abuse, OWI this subheading below*
  Parole/probation
    See also PAROLE
    Agreements **201**—45.1(2), 45.5, ch 46
    Clothing allowance **201**—45.1(5)
    Definition **201**—40.1
    Discharge **201**—42.1(7), 45.6
    Funds **201**—45.1(5)
    Grievances **201**—42.1(5), 45.1(8)
    Indigents, hospitalization **201**—45.1(6)
    Interstate **201**—ch 46
    Policies **201**—ch 42, 47.4(12)
    Restitution **201**—42.1(10), 45.3
    Revocation **201**—47.2(11)
    Supervision **201**—42.1(3,13–16), 45.1(1), 45.2, 45.6, 45.7, ch 46
    Violations **201**—42.1(6), 45.4, 46.4(4)
  Preconviction services **201**—ch 41
  Reports **201**—40.2(4)*d*, 40.5(6–8), 41.2(5), 47.4(11)
  Residential facilities **201**—40.1, chs 43, 47
  Restitution **201**—42.1(10), 44.3, 44.9(2), 45.3, 47.4(8)
  Right-to-know compliance **201**—40.5(3)*a*
  Standards **201**—40.2(4)*c*,*e*, 47.1(6)

Substance abuse, OWI **201**—ch 47
Transfers **201**—44.6(6,7), ch 46, 47.2
Visitors **201**—47.4(14)
Work release **201**—ch 44, 47.2(11)

Confidentiality
Mail, inmate **201**—20.4
Records/reports **201**—ch 5, 40.5(5), 41.2(5)

Crime victims, registration **201**—20.15
Deaths, autopsies **641**—127.3(1)*k*, 127.3(4)*b*(6)
Declaratory orders **201**—ch 11
Definitions **201**—1.1, 20.2, 20.18(2), 37.9(1), 37.10(1), 38.2, 40.1, 50.1, 51.1
Employment, offenders **201**—37.9, 37.10; **877**—1.5, 1.6
Funds, *see Community-Based Programs above*
Hearings **201**—7.9, ch 12, 20.15(8), 20.17(7,8), 38.3(5), 44.6(6), 50.21(4)
Holding facilities, temporary
Admissions **201**—51.11(1), 51.13(6), 51.19(4)
Building requirements **201**—51.4–51.7
Capacity **201**—51.2(1), 51.5(3)
Communications **201**—51.16, 51.20(5)*b*
Court access **201**—51.17
Deaths **201**—51.16(4), 51.19(13)
Definitions **201**—51.1
Disabilities **201**—51.11(1)*g*
Discipline **201**—51.18
Discrimination **201**—51.2(4,5)
Fire safety/emergency **201**—51.8, 51.10(1)*f*, 51.19(9), 51.20(5)*c*(6,9,10)
Food service **201**—51.14, 51.15
Inspection **201**—51.2–51.4, 51.6, 51.8(2), 51.11(2)*g*, 51.19(3)
Juveniles **201**—51.11(1)*b*(1), 51.11(1)*e*, 51.11(2)*a*(6), 51.20, *see also Jail Facilities: Juveniles below*
Manual, procedures **201**—51.11
Medical services **201**—51.10(1)*g*, 51.10(3), 51.13, 51.20(5)*a*
Noncitizens **201**—51.16(4)
Nonsecure holds **201**—51.20
Personnel **201**—51.9–51.11, 51.13, 51.20(4), 51.20(5)*d*; **501**—9.3; **661**—8.103(2)*b*
Procedures **201**—51.11
Records/reports **201**—51.13(8), 51.19, 51.20(5)*f*
Sanitation **201**—51.12, 51.15, 51.20(5)*c*
Security **201**—51.4(9), 51.7(3), 51.8(3), 51.10(2)*a*, 51.11
Waivers **201**—51.2(3)
Weapons **201**—51.1, 51.10(1)*d*,*e*, 51.11(2)*b*; **501**—9.3(2)

Inspections, facilities **481**—1.5"2," ch 30, *see also Holding Facilities, Temporary above; Institutions, Adult below; Jail Facilities below*
Institutions, adult
Complaints, ombudsman **141**—1.3(1)*d*
Definitions **201**—20.2, 20.18(2)
Discharges, victim notification **201**—20.15
Education programs **201**—20.17(1)*b*, 20.17(3)
Employment, community **201**—20.17(2,6)
Fees, incarceration **201**—20.10
Fire safety, occupancy **661**—ch 5 Table 8-A p.35
Furloughs **201**—20.2, 20.12, 20.15(2)*b*, 20.17(4)*c*
Gifts/donations **201**—20.9, 20.18(8)*e*,*i*
Home care program **201**—20.17(1,6)

Industries, state **201**—ch 37
Inspections **481**—1.5"2"
Interviews/photographs **201**—20.7, 20.13, 20.18(8)*g*,*l*
Legal assistance **201**—20.3(10)*b*
Mail/publications **201**—20.4, 20.6, 20.18(8)*d*,*f*
Medical and classification center **201**—1.8(1)*a*(3), 20.18(4–6), 47.2(5,9,11)
Money, inmates **201**—20.3(16), 20.5, 20.9, 20.18(8)*e*
Paroles **201**—20.13, 20.15, 20.18, 38.3(3)*c*, 38.4, *see also PAROLE*
Pharmacies, licenses **657**—ch 15
Placement, community **201**—20.17
Probation violators, *see Shock Probation this subheading below*
Restitution **201**—20.11
Security procedures **201**—20.3(14)
Sex offenders **201**—1.8(5)*i*, 20.3(4)*c*,*d*, 20.3(6)*d*, ch 38
Shock probation **201**—20.18
Strip search **201**—20.13(3)
Telephone system, inmate fund **201**—20.20
Transportation, offenders **201**—20.14
Visitors **201**—20.3, 20.8, 20.18(8)*c*
Work release, violators **201**—20.12(1)*k*, 20.18

Institutions, juvenile, *see JUVENILES*
Jail facilities
See also Holding Facilities, Temporary above
Activities **201**—50.18
Alternative **201**—50.23
Building requirements **201**—50.4–50.9
Capacity **201**—50.2(2), 50.5–50.7, 50.8(8), 50.25(4)
Classification, prisoners **201**—50.13(1), 50.25(1,3,8)
Deaths
Autopsies **641**—127.3(1)*k*, 127.3(4)*b*(6)
Noncitizens **201**—50.19(5)
Reports **201**—50.22(14)*d*

Definitions **201**—50.1
Direct supervision **201**—50.1, 50.25
Disabilities **201**—50.1, 50.13(1)*g*, 50.18(4)
Discipline/grievances **201**—50.21
Discrimination **201**—50.2(5,6)
Escapes **201**—50.13(2)*e*(4), 50.22(14)
Fire safety/emergency **201**—50.9, 50.22(10,14); **661**—ch 5 Table 8-A p.35, *see also subheadings Jailers: Training below; Security below*
Food services **201**—50.16, 50.17
Holds, nonsecure, *see Juveniles this subheading below*
Inspection **201**—1.8(6)*f*, 50.2(3), 50.3, 50.4(2), 50.13(2)*e*, 50.16(8), 50.22(3); **428**—1.2(2)*b*
Interviews, pretrial **201**—41.1(3)
Jailers
Retirement benefits (IPERS) **495**—4.6(4)*e*
Training **201**—50.11(2,3), 50.15(6)*c*, 51.10(2,3); **501**—ch 9

Juveniles
See also JUVENILES
Classification **201**—50.13(1)*b*,*e*, 50.25(1)*d*

CORRECTIONS DEPARTMENT (cont'd)
Jail facilities
Juveniles

Holds, nonsecure
Attendants **201**—50.24(4), 50.24(5)*d*
Care/treatment **201**—50.24(5)
Prohibitions **201**—50.24(3)
Records **201**—50.24(5)*f*
Standards **201**—50.24(1,6)

Supervision **201**—50.13(2), 50.24(1)*b*, 50.24(2), 50.24(5)*e*

Medical services **201**—50.11(3), 50.15, 50.22(12); **655**—6.6(5)
Personnel **201**—50.2(6), 50.10, 50.11, 50.13(1)*f*, 50.15, 50.22(11); **501**—ch 9; **661**—8.103(2)*d*
Prisoners, rights **201**—50.16(6), 50.18–50.21
Procedures/services **201**—50.12–50.17, 50.19, 50.21(4)
Property, prisoners **201**—50.13(2)*c*(1)
Records/reports **201**—50.15(7,8), 50.19(5), 50.22, 50.24(5)*f,g*
Security **201**—50.13(2)
Violations **201**—50.21(4)
Visitors **201**—50.19(3,4)
Weapons **201**—50.1, 50.11(1)*d*, 50.13(2)*b*; **501**—9.1(2), 9.3(2)
Work release **871**—24.22(2)*g*

Juveniles
See also Holding Facilities, Temporary above; Jail Facilities above
RIVERS program, probation violators **201**—20.18

Officers
Firearms **201**—40.4(11,12)
Retirement benefits **495**—4.6(4)*c*
Weapons, permit **201**—40.4(12)*b*; **661**—91.2

Offices **201**—1.3
Organization
See also Community-Based Programs: Directors above
Board of corrections **201**—1.6
Director/deputies **201**—1.1, 1.7, 1.8
Records **201**—ch 5

Parole, *see Community-Based Programs above; Institutions, Adult above*
Personnel **201**—ch 6, 20.3(4)*b*, 38.3(7); **495**—4.6(4)*c*; **661**—8.103(2), *see also Holding Facilities, Temporary above; Jail Facilities above; Organization above*
Prison industries
Advisory board **201**—37.8, 37.9(1,8)
Director, deputy **201**—1.8(4)
Product sales, state agency procurement **11**—100.6(6), 105.4(3)
Property, state, leasing **701**—78.6(1)*c*
Purchasing, contracts **201**—ch 37

Probation, *see Community-Based Programs; Institutions, Adult above; Juveniles above*
Purchasing
See also Prison Industries above
Services **201**—ch 4
Supplies **541**—ch 10, *see also ADMINISTRATIVE SERVICES DEPARTMENT (DAS)*

Records, *generally*, public/fair information **201**—ch 5
Rehabilitation, natural resources program **561**—1.3(2)*e*(1)
Restitution, *see Community-Based Programs above; Institutions, Adult above*
Rule making **201**—5.15"1," chs 7, 10
Sex offenders/victims **201**—20.3(4)*c,d*, 20.3(6)*d*, 20.12(1)*n*, ch 38
Transfer, inmate, *see Community-Based Programs above*

Web site **201**—1.4, 1.5
Work release, *see Community-Based Programs above; Institutions, Adult above; Jail Facilities above*

COSMETOLOGY AND COSMETOLOGISTS
Address/name change **645**—59.4(2), 61.2(5), 61.2(6)*e*, 61.7(5), 61.7(6)*d*, 65.2(24)
Advertising **641**—46.5(9)*k*; **645**—61.24, 65.2(4)
Board
  Address **645**—59.4, 60.2, 61.2
  Discipline **645**—59.2(3), 59.3(8)*f*, 60.4(9), 62.1(8), 64.6, ch 65
  Duties **645**—59.3(8)
  Hearings **645**—5.5(8), 60.16, 62.1(8), 65.5(4,5), 65.6(3–6)
  Meetings **645**—59.3(4,6), 59.6
  Penalties, civil **645**—65.5
  Public health department authority **641**—170.4(1)

Chemical peels, *see Laser Products/Chemical Peels/Intense Pulsed Light/Microdermabrasion below*
Child support noncompliance **641**—ch 192
Confidentiality **645**—65.2(32)*c*
Continuing education
  Exemptions **645**—60.8(1)*b*(5), 64.5, 64.9
  Hours **645**—60.4(2)*c*, 60.4(3)*f*, 60.4(4)*e*, 60.4(6), 60.8(7), 64.2, 64.3(1)*e*(2), 64.3(2)
  Independent study **645**—64.3(2)*d*
  Reports **645**—65.2(30)
  Standards **645**—64.3

Definitions **645**—59.1, 60.1, 61.1, 63.1, 64.1, 65.1
Demonstrators **645**—5.5(13), 60.9, 61.15(4)*c*, 62.1(18)
Discipline, *see Board above*
Disease transmission, prevention **645**—65.2(34), *see also Salons: Sanitation below*
Electrologists **645**—61.14, 63.10"5," 63.17(2), 63.24, *see also Licenses below*
Estheticians **645**—61.14, 63.24, *see also Licenses below*
Ethics **645**—65.2(32)
Forms, consent **645**—60.6
Hearings, *see Board above*
Hydrotherapy/foot spas **645**—63.25
Impaired practitioner review committee **641**—ch 193; **645**—65.2(35)
Inactive practitioners **645**—60.8(6), 60.17, 61.4, 61.9, 62.1(4), 64.1, 65.2(26)
Independent contractors **645**—63.4(3)
Instructors, *see Licenses below; Schools below*
Laser products/chemical peels/intense pulsed light/microdermabrasion **645**—5.5(14,15), 60.1, 60.3(4), 60.4–60.6, 61.15(2), 62.1(19,20)
Licenses
  See also Permits below
  Applications **645**—60.2, 60.17(1), 61.2(1,4,5), 61.7(1,2,8), *see also Renewal this subheading below*
  Certificates/wallet cards **645**—60.8(4), 60.12, 60.15, 62.1(5), *see also Salons below; Schools below*
  Denial **283**—37.1; **641**—192.1, 195.2; **645**—60.16
  Display **645**—61.5, 61.10, 63.4(1)*c*
  Duplicate **645**—62.1(5)
  Electrologists **645**—ch 60, 61.15(1)
  Endorsements **645**—60.1, 60.7
  Estheticians **645**—ch 60, 61.15(1)
  Examinations **645**—60.1, 60.2, 61.21(2), 65.6
  Fees **641**—192.2(5); **645**—5.5, 60.2(3), 60.8(1)*b*(1), 60.12, 61.3(2,3), ch 62
  Instructors **645**—5.5(1), 60.2(2), 61.15, 62.1(1), 64.2(3)*b*, 64.3(2)*e*, *see also Schools below*
  Manicurists **645**—ch 60

Nail technologists **645**—ch 60, 61.15(1)
Practice, out-of-state **645**—64.2(3)*c*
Reactivation **645**—5.5(4), 60.1, 60.8(3)*a*, 60.17, 61.4, 61.9, 62.1(4)
Reciprocity **645**—5.5(1), 60.1, 62.1(1)
Reinstatement **641**—192.2(5,7); **645**—60.1, 60.18
Renewal **283**—37.1; **641**—192.1, 192.2(5), 195.2, 195.3(7); **645**—5.5(2,3,10,12), 60.2(3), 60.8, 61.3, 61.4, 61.8, 61.9, 62.1(2,3,15,17), 64.2, 64.6(3), *see also Continuing Education above*
Restrictions **645**—60.5
Salons, *see Salons below*
Schools, *see Schools below*
Suspension/revocation **283**—37.1; **641**—192.2, 195.3; **645**—65.2(14,26), 65.3

Loans, student, noncompliance **283**—ch 37; **641**—ch 195
Malpractice **645**—65.2(17)
Manicurists, *see Licenses above*
Mentoring program, *see Schools below*
Microdermabrasion, *see Laser Products/Chemical Peels/Intense Pulsed Light/Microdermabrasion above*
Nail technologists **645**—61.14, *see also Licenses above*
Penalties, civil, *see Board above*
Permits **645**—5.5(13), 60.9, 61.5(3), 62.1(18); **701**—26.9
Reports **645**—60.4(5,6), 63.25(7), 65.2(14,15,17,24,30,31), *see also Continuing Education above*
Salons
Certificates/wallet cards **645**—61.5, 61.6
Facilities **645**—63.5–63.8, 63.11, *see also TANNING FACILITIES*
Health care facilities **481**—60.6(6), 61.6(5)
License **283**—37.1; **641**—chs 192, 195; **645**—5.5(11), 61.1–61.5, 62.1(16,17), 65.2(25)
Owners, facility sales **645**—61.2(6), 63.4(1)
Prohibitions **645**—63.8, 63.18, 63.21, *see also Violations this subheading below*
Records **645**—61.2(4), 63.23, 63.25(5), 65.2(8)
Sanitation **645**—61.2(2), ch 63
Violations **645**—65.2

Sanitation, *see Salons above; Schools below*
Schools
See also Continuing Education above
Accelerated learning **645**—61.19
Advertising **645**—61.24
Attendance **645**—61.18
Certificates/wallet cards **645**—61.11
Curriculum **645**—61.14
Examinations **645**—61.18(1)*c*, 61.19, 61.21
Facilities **645**—61.10, 61.12, 61.13, 61.23, 61.24, 63.2, 63.4(1)*c*, 63.5, 63.11
Instructors **645**—61.15, 61.16, 61.22(2), *see also Licenses above*
Library **645**—61.12(4)
License **283**—37.1; **641**—chs 192, 195; **645**—5.5(9,10), 61.1, 61.7–61.10, 62.1(14,15)
Mentoring program **645**—60.1, 61.1, 61.7(1)*b*, 61.17(2)*a*,*b*, 61.20
Owners, facility sales **645**—61.7(6)
Records **645**—61.17(1), 61.18, 61.22, 63.23, 63.25(5), 65.2(8)
Sanitation **645**—ch 63
Students **645**—61.16–61.22, 63.8, 63.9
Veterans **281**—52.7, 52.13, 52.15

Scope of practice **645**—60.5, 63.4(1)*b*, 65.2(5)
Tanning facilities **701**—18.43, 26.65

Taxation, sales **701**—18.31, 18.43, 26.9, 26.65
Violations **645**—63.25(6), 65.2(35), *see also Board: Discipline above*

COUNSELORS
Addiction, day treatment centers **441**—78.16(7)*b*(1)"5"
Adoption **441**—200.2
Crime victims, services **61**—9.35(1)*b*, 9.35(3–8), 9.35(10)*g*; **641**—11.71, 11.72(4), 11.74(1,2,4)
Gambling **641**—ch 162
Hospice **481**—53.13, 53.15
Licensure, *see MARRIAGE: Therapists, Marital/Family; MENTAL HEALTH*
Maternal health centers **441**—77.23, 78.25
Medical assistance providers, *see HUMAN SERVICES DEPARTMENT: Medical Assistance (Medicaid)*
Nutrition, women/infants/children program **641**—73.10
Pharmacists, *see PHARMACISTS AND PHARMACY*
Rehabilitative treatment, children/families **441**—185.10(1)*a*, 185.105(1)*f*, 185.106(4)*e*
Residential group treatment **441**—185.126
Schools, *see EDUCATION*
Sexual exploitation **661**—83.2(10)
Training, violence counseling, homeless **427**—23.5(1)
Vocational rehabilitation **111**—2.1(2); **281**—56.5(3), 56.10, 56.15

COUNTIES
AIDS/HIV **441**—83.42(2); **641**—11.72(1–3), 11.74(4)
Airports, *see AIRPORTS*
Alternative diagnostic facility **441**—ch 34
Annexation, islands **263**—ch 11, *see also Boundary Adjustments below; ANNEXATION*
Assessments, real estate, *see Taxation: Property below*
Assessors, *see ASSESSORS*
Attorney
  Abuse
    Child **441**—175.27, 175.36
    Dependent adult **441**—176.4, 176.6(4,6)
  Area prosecutors **61**—1.3(3)*a*
  Assessment/equalization, protest **701**—71.14
  Criminal investigation report **661**—11.10
  Deaths/autopsies **641**—126.1
  Investigators, special, retirement benefits **495**—4.6(4)*m*
  Medical examiner advisory council **641**—ch 125
  Retirement, IPERS (Iowa public employees' retirement system) **495**—5.2(15)
  Sexual assault, HIV tests **641**—11.72(1–3), 11.74(4)
  Warrants, fraud **481**—74.3(2)*b*
Auditors
  Assessments **701**—71.1(2), 71.2, 71.15, 71.16, 71.25, 80.9(6)*c*
  Budgets
    Amendments **545**—2.2, 2.3
    Appeals **543**—5.5(4,5)
  Elections, duties **701**—105.2, 107.2(1), 108.2(5); **721**—20.1, 21.803(4), 23.11, ch 27, *see also Elections below*
  Fruit-tree/forest reservations **561**—1.3(2)*e*(2); **701**—80.9(6)*c*
  Funds, discontinued cities **263**—10.5(1)
  Records **263**—10.5(1); **721**—5.14(4)
  Risk pool board **441**—25.62

Surveyors, license revocation **193C**—9.6
Taxation
Credit, agricultural land **701**—80.16
Property **701**—80.2, 80.7(8)*c*, 80.9(6)*c*, 80.11(3)

Telephone service, E911 (enhanced) **605**—10.11(1)*c*
Audits **81**—ch 21, 25.4(3), 25.8, 25.9; **441**—57.3, 57.4; **701**—73.27(5), 73.30, 74.7
Autopsies, infant **641**—127.1"9," 127.3(1)*d*, 127.4(2)*e*
Bonds
Financial guaranty insurance exemption **191**—22.1(2)*e*
Private activity allocation **265**—ch 8

Boundary adjustments **263**—9.3, 10.1, 10.2
Brain injuries, services **441**—ch 25, 78.43(1), 83.82(2)*a*(4), 83.82(4), 83.90, *see also Mental Health/Retardation Services below*
Bridges, construction/replacement **761**—chs 160, 161, 163.7(1)*b*, 164.6(1)*b*, ch 180
Budgets
Amendments **545**—2.2, 2.3; **547**—4.4
Appeals **543**—2.1, 2.7, ch 5
Definitions **547**—1.1, 4.1
Management department authority **541**—1.4, 1.5
Reports **547**—ch 5
Road construction, secondary **761**—ch 173
Summaries **547**—4.2

Buildings
Burning **567**—23.2(3)*j*(2)
Energy management **565**—ch 6
Public improvement contracts **761**—ch 180

Business development **261**—chs 31, 41, 53, 58, 59, 61, 65, 68, 168, *see also Grants below*
Care facilities **481**—57.35(9), 57.49, 58.53, 62.24, 63.48, 64.59, 65.27, *see also Supervisors Board below*
Children
See also Attorney: Abuse above; Autopsies, Infant above; Juveniles below
Empowerment areas **349**—1.7
Funds
Decategorization **441**—78.33; **641**—ch 153 Div. II
Overpayment, recoupment **441**—170.9

Community economic betterment account (CEBA) program, *see Loans below*
Conference boards **701**—71.19(2), 71.20(1), 72.11, 72.14–72.16, ch 120
Conservation boards **571**—25.4, 25.5, 27.3(1), 33.21, 33.30, ch 35, 111.4; **701**—80.9
Courts, *see COURTS subheadings District; Juvenile*
Crime prevention, juvenile **428**—ch 3
Cultural/entertainment districts, development **221**—ch 9, *see also Grants: Cultural, Iowa Community (ICCG) below*
Debts
Credit, institutional **441**—28.13
Offset **441**—ch 14

Depositories **781**—3.1(2), 3.2, chs 12–15
Disability services
Funding/management **441**—ch 25
Waiver program **441**—83.2(2), 83.3, 83.102

Disaster services, public defense, *see Emergencies: Management below*
Docks, permits **571**—ch 16

Elections
Auditors' duties, *see Auditors above*
Commissioners, *see ELECTIONS*
Committees, *see ETHICS AND CAMPAIGN DISCLOSURE*
Forms **721**—4.3
Funds, voting equipment **721**—22.32
Gambling, boats/racetracks/structures **721**—21.820
Grants **721**—ch 27
Lakes, benefited recreational **721**—21.830
Redistricting/reprecincting, census data **721**—21.30
Referendum **21**—ch 20; **721**—ch 21
Registrars **721**—ch 28
Schools, penny sales and services tax **721**—21.803
Supervisors board, duties, *see Supervisors Board below*
Taxation, local option **701**—chs 105, 107, 108; **721**—21.800–21.802
Telephone service, E911 (enhanced) **721**—21.810
Emergencies
Air pollution **567**—ch 26 Table V"3"*e*
Disasters
Election postponement **721**—21.1(1–4)
Recovery **261**—23.14; **605**—7.6, ch 9
Flood relief, *see FLOOD CONTROL*
Management **441**—58.6; **605**—chs 1, 7, 9, 10, 102, 103, 104.1(2)
Medical services, planning **641**—chs 130, 140; **701**—42.11
Planning districts/committees **605**—chs 102, 103, 104.1(2)
Telephone service **605**—ch 10; **721**—21.810
Employees
Insurance plans **191**—35.20
Retirement, *see PUBLIC EMPLOYEES' RETIREMENT SYSTEM (IPERS)*
Employment programs
See also WORK AND TRAINING PROGRAMS
Community economic betterment account (CEBA) program, *see Loans below*
Family investment program (FIP) recipients, *see PROMISE JOBS this subheading below*
Job club/search, food assistance program **441**—65.28(8)
Job training/workforce development **261**—23.4(4)
PROMISE JOBS **441**—chs 47 Div. II, 93
Engineer
Instructions/reports, secondary roads **761**—chs 172, 173
Signing, primary roads **761**—131.1(2)
Enterprise zones, *see ECONOMIC DEVELOPMENT DEPARTMENT*
Fairs, *see FAIRS*
Family investment program, *see FAMILY INVESTMENT PROGRAM (FIP)*
Finance committee
Address **541**—1.6(3)
Budgets **547**—ch 4
Declaratory orders **547**—ch 7
Organization **541**—1.4, 1.5(4); **547**—ch 2
Records, *generally*, public/fair information **547**—ch 9
Reports **547**—chs 3, 5
Rule making **547**—chs 6, 8

Fishing **571**—ch 35, 80.2(5), chs 81, 83, 85
Flood plain management **567**—75.7
Food/food service establishments, inspection **481**—31.8, chs 34, 35
Funds
See also Auditors above; Grants below; Loans below
Contracts **221**—6.10; **261**—61.8; **641**—151.7(4); **761**—ch 180
Decategorization projects **441**—ch 153 Div. II
Economic development region initiatives **261**—chs 31, 32, 165.4(6)
Elections, *see Elections above*
Lead poisoning prevention **641**—ch 72
Railroads, *see Railroads below*
Social services programs, *see HUMAN SERVICES DEPARTMENT for specific programs*
Tobacco use, control/prevention **641**—ch 151

Gambling
Elections, *see Elections above*
Taxation, exemption **481**—100.11; **701**—17.1(5)*t*, 17.1(6)*e*(19)
Therapy, grants **641**—ch 162

Grants
Block
Community development **261**—chs 23, 25
Community services, action agencies **427**—ch 22
Human services **441**—ch 153
Juvenile accountability incentive (YANG) program **428**—3.1, 3.7

Brownfield redevelopment program **261**—ch 65, 171.2, chs 172–175, 187–189
Community attraction/tourism development **261**—ch 211
Community development **261**—ch 41
Crime prevention, juvenile **428**—ch 3
Cultural, Iowa community (ICCG) **221**—ch 6, 9.7(2)
Dams, low-head public hazard program **571**—ch 30 Div. II
Emergency management **605**—7.7, ch 8
Emergency medical services **641**—ch 140
EMPG, *see Emergency Management this subheading above*
Endow Iowa program **261**—chs 46, 47
Energy conservation/management **565**—ch 6
Fish habitats **571**—ch 35
Gambling, therapy **641**—ch 162
Health services
Boards/agencies, local **641**—ch 80
PRIMECARRE **641**—110.11

Historic preservation **221**— ch 6; **223**—chs 35, 36, 49, 50
Home care aide program **641**—80.8(2)*c*, 80.10
Homeless, *see Shelters, Homeless this subheading below*
Housing **261**—chs 23, 25, 28, 44, *see also Shelters, Homeless this subheading below*
Job training/workforce development **261**—23.4(4), 23.7, 23.8; **877**—ch 12
Lands/waters conservation fund **571**—ch 27
Lead poisoning prevention **641**—ch 72
Local government innovation **541**—ch 15
Mental health/retardation **441**—153.51–153.58, *see also Mental Health/Retardation Services below*
Public health nursing **641**—80.9
Railroads, *see Railroads below*
REAP (resource enhancement and protection) **571**—ch 33 Parts 1, 2

Recreational facilities **261**—ch 211; **571**—ch 29
Refugees **441**—61.17
RISE (revitalize Iowa's sound economy) **761**—ch 163
Self-sufficiency, PROMISE JOBS recipients **441**—ch 47 Div. II
Sewer/water projects **261**—23.4(6,8), 23.6
Shelters, homeless **261**—21.2(2,4), chs 24, 28, 29; **265**—ch 14
Solid waste, *see Waste Disposal, Hazardous this subheading below*
Technical assistance **261**—ch 44
Veterans **801**—ch 12
Voting equipment/facilities/personnel training **721**—ch 27
Waste disposal, hazardous **567**—chs 211, 214
Wastewater treatment **265**—ch 28
Water trails development **571**—ch 30 Div. II
Well sampling/closure **641**—ch 24

Graves, registration **801**—1.7
Health boards **21**—61.23, 64.3, 64.17; **567**—68.3, 68.6(3), 68.7; **641**—15.6, 15.12, 15.13, chs 68, 72, 77, 78, 80
Health care
See also Health Boards above; Medical Assistance below
HMOs, *see Health Maintenance Organizations (HMOs) below*
Hospitals, certificates of need **641**—ch 203
MediPASS, *see Medicaid Patient Management (MediPASS) below*
Plans, prepaid **441**—88.22–88.24
Public health association, PAC membership **641**—114.4(1)*e*
Services
Generally **641**—170.4(4)
Emergency medical **641**—ch 140; **701**—42.11
Healthy opportunities for parents to experience success—healthy families Iowa (HOPES-HFI) program **641**—ch 87
Home care aide **641**—ch 80
Indigents, *see Indigents below*
Maternal/child program **641**—75.5(7)
Medical decision-making boards **641**—ch 85
Mental health, *see Mental Health/Retardation Services below*
Nursing, public health **641**—ch 80
Rural/primary **641**—ch 110
Tobacco use prevention/control **641**—ch 151

Health maintenance organizations (HMOs) **441**—88.2, 88.3, 88.46(2), *see also Medicaid Patient Management (MediPASS) below*
Highways, *see Roads below*
Historic development **221**—9.7(1), *see also Grants above*
Home care aides, *see Health Care: Services above*
Homeless **261**—21.2(2,4), chs 24, 28, 29; **265**—ch 14
Hotels/motels, inspection **481**—chs 35, 37
Housing **261**—chs 26, 28; **265**—ch 19, *see also Grants subheadings Housing above; Shelters, Homeless above*
Hunting, *see HUNTING*
Indigents
Interim assistance **441**—ch 57, 80.6(2)
Juvenile defense, claimants, *see COURTS: Juvenile*
Obstetrical/newborn care program **641**—ch 75

Inspections, food establishments, contractors **481**—ch 35
Jails **201**—47.3(7,8), 50.23; **611**—1.1, *see also CORRECTIONS DEPARTMENT*

Juveniles **428**—ch 3; **441**—chs 105, 151, 153.11–153.19, ch 167; **481**—9.1, 9.4, *see also JUVENILES*
Liquor ordinances **185**—4.3
Livestock, disease
Indemnity, swine **21**—64.133
Test areas **21**—64.58, 64.68, 64.81, 64.153

Loans
Brownfield redevelopment program **261**—ch 65, 171.2, chs 172–175, 187–189
Community attraction/tourism development **261**—ch 211
Community economic betterment account (CEBA) program **261**—chs 53, 172–175, 187–189
Economic development region revolving fund **261**—chs 31, 32
Energy conservation/management **565**—ch 6
Housing/shelter **261**—ch 28
Local government innovation **541**—ch 15
Mental health/retardation **441**—25.61–25.66, 25.71–25.76
Physical infrastructure assistance program (PIAP) **261**—ch 61, 165.4(1), chs 172–175, 187–189
Property, reassessment fund **701**—ch 120
Railroad revolving fund **765**—ch 5
Vision Iowa program **261**—chs 212, 213
Waste, solid **567**—ch 209, *see also Grants above*
Wastewater treatment/water pollution control **265**—ch 26; **567**—chs 90–93

Medicaid patient management (MediPASS) **441**—88.3(7), 88.43, 88.46, *see also Health Maintenance Organizations (HMOs) above*
Medical assistance **441**—ch 76, 77.29, 78.27(12), 78.33, 80.6, 83.3, 83.42(2), 83.61(2–4), 83.67(6), 83.70, 83.90, 83.102(5), 88.2, 88.3, 88.22–88.24, 88.43, 88.46
Medical examiner, *see MEDICAL EXAMINERS*
Mental health/retardation services **441**—9.10(9), chs 15, 24, 25, 28.3(1), 28.11, 28.13, 29.4, ch 34, 77.29, 77.37(14)*e*, 78.27(12), 78.33, 79.1(25), 82.7(4), 82.16, 83.2(2), 83.61(2–4), 83.67(5,6), 83.70, 153.51–153.58; **495**—4.1(6), *see also Brain Injuries, Services above; Disability Services above; MENTAL HEALTH; MENTALLY RETARDED*
Motor vehicles/travel trailers
See also Treasurer below
Dealer establishments, licenses **761**—425.10(7)*b*
Exhibits/fairs, permits **761**—425.26, 425.29
Sales, county-owned **761**—425.20(4)*a*

Parks, *see PARKS/RECREATION AREAS*
Pesticide usage **21**—45.16, 45.20, 45.23, 45.27, 45.51
Pipelines, inspections **199**—9.4(2)*e,f*, 9.7
PROMISE JOBS, *see Employment Programs above*
Pseudoephedrine sales violations, report **661**—ch 174
Public health services, *see Health Care above*
Railroads **765**—ch 5
Recorder
Assessment **701**—71.10
Boats
Manufacturer's certificate of origin **571**—20.7, 20.8
Registration **571**—38.6(2), 38.11(2), 38.12, 39.4, ch 47
Reports **571**—38.26

Burning, open, waivers **567**—23.2(3)*b*
Corporations, document filing **721**—40.5
Feeding operations, waivers **567**—65.12(1)*c*
Groundwater hazard documentation, real property transfers **561**—ch 9
License, hunting/fishing **571**—15.3

Real estate transfer **561**—ch 9; **701**—79.1–79.3, 79.5(5,6)
Soil/water resource conservation plan **27**—22.40(3)
Snowmobiles/all-terrain vehicles, registration **571**—ch 46, 50.6, 50.12, 50.13
Surveyors, license revocation **193C**—9.6
Underground storage tanks, liens **591**—11.5(2)*g,i*
Unemployment compensation lien **871**—23.65, 23.66

Registrars **641**—95.7, 96.4(2,7), 96.6–96.8, 99.11, 101.8, 103.1, 104.1; **721**—ch 28
Review boards, taxation, *see Taxation below*
Revitalize Iowa's sound economy (RISE) **761**—ch 163
RISE, *see Revitalize Iowa's Sound Economy (RISE) above*
Roads
See also HIGHWAYS
Access rights, agreement **761**—112.11(6)
Bridges, *see Bridges, Construction/Replacement above*
Construction/preservation **261**—53.5; **761**—ch 163, 173.1, chs 178, 180
Detour approval **761**—151.1(2)
Farm-to-market **761**—chs 101, 102, 170, 172, 174, 178
Maintenance, boundary change **263**—8.3(15)
Scenic byways **761**—ch 132
Secondary, fund distribution **761**—ch 102
Signs, memorial highways, historic/scenic trails **761**—131.10(2)
Traffic safety fund **661**—20.3(6); **761**—ch 164

Sewage **701**—18.5(3), 18.39, 26.72
Sewer/water projects **641**—24.7(6); **761**—ch 180, *see also Grants above*
Sheriffs, *see SHERIFFS*
Snowmobile trails, *see TRAILS*
Social services programs, *see HUMAN SERVICES DEPARTMENT*
Soil/water conservation **27**—1.2, ch 6, 10.71, 22.21(3), 22.40(3,4); **571**—ch 31, *see also SOIL CONSERVATION DIVISION*
Solid waste disposal, *see Waste below*
Streams, protected **567**—72.50–72.52
Supervisors board
Annexation **263**—8.3, ch 11; **721**—21.30(2,3)
Block grants, human services **441**—153.3
Brain injury waiver services **441**—83.82(2)*a*(4), 83.90
Budgets **547**—4.2, ch 5
Care facilities **481**—57.13(1)*l*, 62.16(6), 63.13(1)*l*, 65.18(5)
Committee, attraction/tourism (CAT) **261**—ch 211
Conference boards **701**—71.19(2)
Elections **701**—105.1, 108.2(5); **721**—21.600, 21.601, 21.602(2)*c,d*, 21.800, 21.802, 21.810(3), 21.820, 21.830(3), 22.100, ch 27
Emergency management commission **605**—7.3
Enterprise zones **261**—59.3(1)*b*, 59.3(5)*a*(2,3)
Feeding operations, confinement, permits **567**—65.10
Gambling, excursion boats/structures **721**—21.820
Health department, withdrawal **641**—78.5
Hotel/motel taxation **701**—103.1(4), 105.1
Interim assistance, human services **441**—ch 57
IPERS (Iowa public employees' retirement system), benefits **495**—5.2(11)
Islands, identification **263**—11.2
Juveniles, shelter/detention homes **441**—chs 105, 167
Medical decision-making boards **641**—85.1–85.3, 85.10

Medical examiners **641**—127.11
Mental health/retardation services **441**—25.51(3), 25.62, 25.74, ch 34, 83.61(2)*g*(4), 83.67(6), 83.70, *see also Mental Health/Retardation Services above*
Pipeline construction **199**—9.7
REAP funds **571**—33.30(8)
Residential facilities admissions, contracts **201**—43.1(1)
Resource centers, admissions **441**—28.3(1)
Road detour approval **761**—151.1(2)*a*
Secondary road fund distribution committee **761**—ch 102
Soil/water resource conservation plan **27**—22.21(3), 22.40(4)
Taxation
Assessment equalization, protest **701**—71.14
Cigarettes/tobacco, permits/licenses, denial/revocation **701**—81.12(1), 81.13(4), 83.13–83.16
Exemptions, *see Property this subheading below*
Hotel/motel, *see Taxation below*
Local option, *see Taxation below*
Property
Classification, housing development **701**—71.1(8)
Exemptions **701**—78.8, 80.2, 80.5, 80.6, 80.8, 80.9
Refunds **701**—75.7
Tax credit **701**—80.10, 80.11(2)
Valuation, wind energy conversion **701**—80.13
Telephone service, E911 (enhanced) **605**—10.3; **721**—21.810
Transit systems **701**—64.3"4," 64.15
Voting, *see Elections this subheading above*
Waste, hazardous, facilities **567**—150.4
Wells, *see Wells below*
Wind/renewable energy production facilities, approval **199**—15.20(1)
Workforce investment, chief elected official board **877**—7.5
Supplemental security income (SSI), interim assistance **441**—ch 57
Swimming pools/spas **641**—ch 15
Taxation
See also Supervisors Board above
Athletics, gross receipts **701**—18.39
Exemption **261**—58.4(2), 59.6(3)*b*; **481**—100.11; **701**—16.26(2)*c*, 17.1(5)*t*, 17.1(6)*e*(19), 17.28, 18.17, 18.20(2)*c*, 18.38, 18.39, 19.12, 26.42(7), 64.3"4," 80.2, 80.4(7), 80.5, 80.6, 80.9
Franchise tax distribution **701**—58.7
Hotel/motel **701**—103.1(4), 103.14, 103.15, 104.7, ch 105
Incentives, distressed areas **261**—ch 59
Local option, sales/services **281**—ch 96; **481**—100.11; **701**—42.11, chs 105, 107–109; **721**—21.800–21.802
Property **261**—58.4(2), 59.6(3)*b*; **571**—33.30(6); **701**—chs 71, 73–75, 78, 79, 80.2, 80.4(7), 80.5, 80.6, 80.7(8), 80.8–80.10, 80.11(2,3), 80.13, 108.9, *see also Review Boards this subheading below; Treasurer below; ASSESSORS*
Recorder **591**—11.5(2)*g,i*; **701**—71.10(2), 79.1–79.3, 79.5(5)
Relief agencies **701**—17.5, 18.6
Review boards **701**—71.2, 71.17, 71.18, 71.20, 78.2, *see also Conference Boards above*
Sales/services **701**—18.5(3), 18.39, 26.71(3), 26.72, *see also Local Option, Sales/Services this subheading above*
Underground storage tanks
Deed claims **591**—11.2(9)
Liens **591**—11.5(2)*f,g,i*
Telecommunications **261**—chs 41, 61; **751**—7.4(6–8), 7.6"11," 7.7(1)*k,q*

Telephone service, E911 (enhanced) **605**—ch 10; **721**—21.810
Tobacco settlement funds **441**—ch 25 Div. VI
Traffic safety **661**—ch 20; **761**—ch 164
Trails, *see TRAILS*
Treasurer
Contributions, anatomical gifts **761**—400.26
Motor vehicles
See also MOTOR VEHICLES
Registration, *generally* **761**—chs 400, 401
Reports **761**—400.64
Taxation **701**—17.6, 34.2, 34.4–34.6, 34.9, 34.19
Property, taxation
Assessments
Generally **701**—71.1(2), 71.2(2)
Computers/industrial machinery **701**—80.7(8)
Omission **701**—71.25(2)*c*
Audits **701**—73.27(5), 73.30, 74.7
Credit **701**—ch 73, 80.1(4), 80.10
Mobile/modular/manufactured homes **701**—74.4, 74.6–74.8
Payment, partial **701**—74.8(1), 75.2
Refunds **701**—75.7
Tax sale **701**—75.6
Utilities, gas/electric **701**—70.4, 70.6, 70.12
Real property conversion **761**—400.40
REAP account **571**—33.30(8)
Rent, reimbursement, elderly **701**—ch 73
Telephone service, E911 (enhanced) **605**—10.11
Underground storage tanks (USTs)
See also Taxation above
Cleanup claims **591**—11.2(6,9,11)
Utility facilities
Electric power generating **199**—24.6, 24.7
Road crossings, approval **761**—115.8(1)*b*
Veterans affairs
Assistance, interim, reimbursement **441**—ch 57
Benefits, application **801**—14.5
Graves registration **801**—1.7
Officers, training **801**—1.15
Vital statistics information, *see Registrars above*
Volunteer services **441**—ch 12
Waste
See also Sewage above
Hazardous, facilities **567**—150.3(4)*d*(9), 150.4, ch 211
Oil, recycling **567**—119.7(2)
Solid **567**—chs 101, 105, 209, 211; **701**—18.5(3), 18.39, 26.71(3)
Yard **567**—ch 105
Wastewater **567**—63.4, 64.3(4)*b*, *see also Loans above*
Wells
Construction permits **567**—ch 38
Grants, sampling/closure **641**—ch 24
Plugging **567**—39.9; **641**—ch 24
Site, groundwater assessment **567**—135.10(4)*i*

Wildlife
Conservation officer, salvage **571**—ch 80
Habitats **571**—chs 22, 23, 25

Work incentive demonstration program (WIN), *see Employment Programs: PROMISE JOBS above*

COUNTY FINANCE
See COUNTIES: Finance Committee

COUPONS
See TAXATION subheadings Cigarettes/Tobacco; Sales And Use

COURTS
Abuse, *see District below; Juvenile below*
Adoptions **441**—200.7, 200.10
Appeals
Civil rights **161**—4.8
Criminal **61**—1.3(3)*c*
Estate tax disputes **701**—87.5
HIV offenders **641**—11.72(7)
Indigents **493**—12.2(1), 12.3(2), 12.4(4), 12.5, 12.6(1–3), 12.7(3)
License revocation, *see specific professions subheading Licenses*
Public health, *see PUBLIC HEALTH DEPARTMENT*

Bailiffs, IPERS benefits **495**—5.2(2)
Bonds, financial guaranty insurance **191**—22.1(2)*d*
Child support/care
Hearings, administrative levies **441**—98.97(3)
Orders **441**—98.22–98.24, 98.33, 98.35, 98.43–98.45, ch 99, 110.12(5), 150.3(6)*b*, ch 151, 200.7, 200.10; **481**—8.1(6); **491**—6.11(3)

Civil rights hearings, costs **161**—4.7
Corrections, residential facilities admissions **201**—43.1(1)
Diseases, health department intervention **641**—1.9(7,9,10)
District
Abuse, adult **441**—176.6(3,8–10), 176.10(8)
Appellate defender **481**—1.10
Boundary changes, appeals **263**—10.4
Counsel, court-appointed **493**—ch 10
Debts
Asset transfers, Medicaid **441**—89.9; **481**—75.10
Child support, hearings, administrative levies **441**—98.97(3)
Offset **11**—40.10–40.16

Employer contributions, unemployment, nonpayment **871**—23.56(3), 23.67(2)
Engineering examiners disputes **193C**—4.26(3)
Guardians, care facilities **481**—57.13(1)*l*, 62.16(6), 63.13(1)*l*
Health department, cases **641**—75.8(10,11), 201.28
Hunter violations **571**—15.6(2)
Probation **61**—8.1
Propane education and research council enforcement **599**—1.7

Indigents **281**—21.32 "2"; **481**—ch 9; **493**—chs 10–12
IPERS benefits
Domestic relations orders **495**—16.2
Income withholding orders **495**—16.1

Judiciary, retention **721**—1.12

Jury service, merit employees **11**—63.12
Juvenile
Care/treatment services
Generally **441**—ch 151 Div. I, 153.17
Community-supervised **441**—151.4(1)*b*, 151.32
Graduated sanction **441**—151.1, 151.2(2–4), 151.3, 151.4(1)*b*,*c*, 151.6, 151.30–151.35
Monitoring/outreach/tracking **441**—151.4(1)*b*, 151.33
Reimbursement **441**—151.3, 151.4, ch 151 Div. II, 151.30(5), 151.31(5), 151.32(5), 151.33(5)
School-based **441**—151.4(1)*c*, 151.31
Training, life skills **441**—151.4(1)*b*, 151.30
Child abuse **441**—175.25(3,5,8), 175.27, 175.32
Counsel **493**—10.5(2)*c*, 10.5(7), *see also Indigent Defense Claims this subheading below*
Eldora training school **441**—103.9(4), 103.12(2), 103.14(2), 103.17(2), 103.18(2)
Foster care **441**—150.3(6)*b*, 156.9, 202.17
Indigent defense claims **481**—9.1, 9.4"1"; **493**—12.1(1), 12.2(1)*a*, 12.2(11), 12.3(1), 12.4(1), 12.5(2,3), 12.6(2,3)
Mental hospital admissions **441**—28.2(2,3)
State home
Depositions **441**—101.3(6)
Placements **281**—63.6(2)
Magistrates, IPERS benefits **495**—5.2(4)
Military **611**—ch 1
Motor vehicle violations **761**—640.4(4), 640.5
Prisoners, access **201**—50.20, 51.17
Sexual assault, HIV cases **641**—11.72, 11.74(5,6)
Taxation
See also TAXATION
Estate inheritance
Appeals **701**—87.5
Costs, deduction **701**—86.6(1)*i*
Federal laws, interpretation **701**—89.8(2)
Probate property **701**—89.8(5)
Water usage allocation/restrictions **567**—52.10

CREDIT
See also LOANS
Alcoholic beverage sales **185**—4.20(5), 16.7, 16.13(5)
Cards **161**—ch 6; **197**—ch 7; **701**—59.28(2)*h*,*i*, 63.14; **781**—chs 5, 8
Consumer credit code **61**—1.3(2)*b*, chs 10–12, 14–16, 19, 20, 22; **191**—23.23(2)*l*, *see also ATTORNEY GENERAL*
Continuing education, *see specific profession*
Credit union deposits, letter of credit **781**—14.4, 14.5
Disclosure **781**—ch 5
Discrimination **161**—ch 6
Farm mediation **61**—ch 17
Housing, low-income **265**—ch 12
Insurance
Consumer transactions **61**—chs 14, 20; **191**—10.7(1), ch 28
Letters of credit **191**—57.4(2), 73.5

Premiums **191**—5.20
Reinsurance, ceding insurers **191**—5.31, 5.33, 17.3, 17.4

Line, lenders/creditors **61**—ch 16
Production credit association
Loans **261**—ch 69
Taxation **701**—58.7(1)

Solid waste disposal, financial assurance, letter of credit **567**—103.3(6)*c*, 104.26(5)*d*, 105.14(5)*d*, 106.18(5)*d*, 112.31(6)*c*, 113.14(6)*c*, 114.31(6)*c*, 115.31(6)*c*, 118.16(6)*d*, 120.13(4)*d*, 121.8(4)*d*, 122.28(5)*d*, 123.12(6)*d*
Taxation claim, *see TAXATION*
Warehouse operators/grain dealers, *see GRAIN; WAREHOUSES: Agricultural Products*

CREDIT UNIONS
Accounts **61**—26.4, 26.7; **189**—chs 8, 18; **701**—86.1(6)
Administration **189**—ch 1
Advertising **189**—5.4(2), 24.6
Attorney general representation **61**—1.3(2)*c*
Board, review **181**—1.4(3); **189**—1.3(2), ch 14
Branch offices **189**—chs 6, 15
Brokerage services, *see Securities, Brokerage Services below*
Bylaws, amendment **189**—ch 12
Charter
Applications **189**—2.6, 2.12, 2.13
Bonds **189**—2.5
Commencement, business **189**—2.9
Conversion **189**—ch 3
Definitions **189**—2.1, 3.1
Employee groups **189**—2.11
Incorporation **189**—2.8
Organization **189**—2.4, 2.8(1)
Standards **189**—2.7, 2.10

Child support, administrative levy **441**—98.93, 98.94, 98.96
Commerce department supervision **181**—1.4(3)
Corporate central establishments **189**—ch 10
Credit cards, disclosure **781**—ch 5
Debit cards, *see Funds: Electronic Transfer below*
Debts
Administrative levies **701**—ch 154
Cancellation products **189**—ch 5
Debt management company, licensure **187**—2.9(4)

Definitions **189**—1.1, 2.1, 14.1, 15.1, 17.2, 18.1, 23.1, 24.2, 25.1
Depositories
Agreements **781**—14.4, 14.7
Collateral **781**—14.6, 14.7
Custodians **781**—14.7
Default **781**—14.10
Definitions **781**—14.2
Forms **781**—14.3
Letter of credit **781**—14.4, 14.5
Sale/merger **781**—14.9
Termination **781**—14.8

Division
Address **181**—1.6(7)
Adjudicative proceedings, emergency **189**—22.31
Appeals **189**—2.13, 22.25–22.27, 23.10
Contested cases **189**—2.13, ch 22, 23.5(2)
Declaratory orders **189**—ch 21
Hearings, *see Contested Cases this subheading above*
Organization **181**—1.4(3); **189**—ch 1
Purchasing **541**—ch 10, *see also ADMINISTRATIVE SERVICES DEPARTMENT (DAS)*
Records, *generally*, public/fair information **189**—ch 25
Rule making **189**—chs 4, 20, 23
Superintendent **181**—1.5; **189**—2.13, 3.1, 3.5, 3.7, 3.9, ch 13

Elections
Bylaws **189**—ch 12, 16.1
Directors, board, ballots **189**—chs 16, 19
Funds, committee deposits, *see Funds below*

Electronic transfers, *see Funds below*
Employee groups **189**—2.11
Foreign **189**—ch 15
Forms **189**—1.4; **781**—14.3
Funds
See also Investments below; Loans below
Election campaign deposits **351**—4.5
Electronic transfer **189**—ch 24
Public, *see Depositories above*

Individual development accounts (IDAs) **441**—ch 10
Insolvency **189**—ch 11
Insurance **189**—2.9, 8.2; **781**—14.10
Investigations/examinations **189**—ch 14
Investments **189**—ch 17; **441**—10.2(4); **781**—ch 4
Loans
Disclosure **189**—5.7–5.10; **191**—5.50–5.55
Foreign credit unions **189**—15.3(2,14)
Housing, military service members **265**—ch 27
Line of credit **61**—ch 16
Linked investments for tomorrow (LIFT) **781**—ch 4
Losses
Generally **189**—ch 18
Adjustments, allowance account **189**—18.4–18.6
Definitions **189**—18.1
Financial statements **189**—18.3
Reserve, legal **189**—18.2, 18.6(5)
Waiver **189**—18.6(6)

Real estate **189**—ch 9
Student **283**—ch 10

Low-income **189**—ch 7
Retirement facilities **191**—ch 24
Safe deposit boxes **701**—26.8(4), 86.1(6)
Securities, brokerage services **191**—50.21, 50.22

Taxation
Credits **123**—chs 2–4
Estimation **701**—ch 61
Motor vehicle repossessions **701**—34.17

Terminals, satellite **189**—ch 24
Voting **189**—chs 12, 16, 19

CREMATION
See also FUNERALS
Crematories **641**—ch 86; **645**—101.7, 101.13
Definitions **645**—100.1, 103.1
Disease **645**—100.6(1)*b*, 100.6(4)
Permits **641**—127.6; **645**—100.1
Remains, disposition **641**—101.6(3); **645**—100.10(6)*a*

CRIME
See also ABUSE; PEACE OFFICERS; POLICE; PUBLIC DEFENDER; PUBLIC SAFETY
Administrative services department (DAS)
Discipline, state employees **11**—60.2
Job applicants **11**—54.2(6)*h*, 54.3(3)

Adoptions, denial **441**—200.11, 200.13
Alcohol/drug testing devices **661**—7.8, 150.3(2), ch 157
Appeals **61**—1.3(3)*c*; **205**—ch 15; **481**—71.7, 73.9
Autopsies **641**—127.3(1)*a*, *see also DEATH: Medical Examiner's Duties*
Capitol complex offenders **11**—100.2(1)*d*, 100.2(2)*e*, 100.2(3)
Children, *see Victims below*
Correctional facilities **201**—chs 20, 37, 38, 40–47, 50, 51, *see also CORRECTIONS DEPARTMENT*
Criminal justice
Bureau **61**—1.3(3)
Information systems **661**—chs 8, 11
Juvenile justice planning **428**—chs 1–3, 6–9; **541**—1.4, 1.6(2)

Definitions **201**—38.2; **661**—83.2
DNA
Database **661**—ch 156
Profiling **61**—ch 8; **661**—150.3(5)

Employees, state, *see Administrative Services Department (DAS) above*
Fraud
See also specific profession subheading Board: Discipline
Educators, license **282**—14.109
Emergency medical care personnel **641**—131.7(2)*d,r,t*
Financial assistance recipients **481**—chs 71–74
Funerals, preneed sales/services **191**—105.6(1–3), 106.2
Gaming, employees/licensees, *see RACING AND GAMING*
IPERS **495**—11.7(5)
Real estate
Appraisers **193F**—16.2(5)
Salespersons **193E**—4.1(7)

Securities, *see SECURITIES subheadings Fraud; Investment Advisers*
Small business, targeted **481**—25.10
Tax evasion **701**—10.71(3,7), 10.101(2)
Unemployment compensation **871**—24.2(1)*c*(2), 24.2(1)*g*(4), 24.23(39), ch 25

Furloughs **201**—20.12
Human immunodeficiency virus (HIV)
Information **661**—8.103
Tests **641**—11.70–11.74
Transmission, offenders **661**—83.2(1)*i*

Indigents, *see Legal Assistance, Indigents below*
Intelligence systems **661**—ch 81
Investigations **481**—chs 71–74; **661**—1.2(6), ch 11, 83.1, 83.3–83.5, chs 121, 150, *see also Records: Check/Evaluation, Licensees/Employees below; BUREAU OF CRIMINAL IDENTIFICATION; RACING AND GAMING: Employees/Licensees*
Juvenile, *see JUVENILES*
Kidnapping **201**—38.2; **661**—83.2(1)*g*, 83.2(4)*b*
Laboratories **61**—8.5; **641**—126.3(2); **657**—10.4; **661**—7.8(2), 95.1–95.9, chs 150, 156, 157.4, 157.5
Law enforcement administrators telecommunications advisory committee (LEATAC) **661**—ch 15
Legal assistance, indigents **481**—1.10, ch 9; **493**—chs 10–12
License/registration, revocation/denial
See also specific profession
Electricians/electrical contractors **661**—502.4(5)
Food establishments **481**—30.2, 31.11, 34.5
Gaming, employees/licensees **491**—6.5(1,3), *see also specific race under RACING AND GAMING*
Hotels/motels **481**—37.10
Motor vehicle **761**—ch 615, 640.4–640.6
Real estate, salespersons/appraisers **193E**—4.1(7); **193F**—16.2(5)

Missing person information **661**—8.102, ch 89
Moral turpitude, weapons certification **501**—10.4
Parole **61**—ch 8; **205**—chs 6–8, 10, 11, 13–15; **441**—9.10(16), *see also CORRECTIONS DEPARTMENT: Community-Based Programs; Institutions, Adult; PAROLE*
Physicians, felony **653**—23.1(9)
Prevention, juvenile **428**—ch 3
Rape
See also Victims: Sexual Abuse below
Examinations/reimbursements **61**—9.80
Funds, administration **61**—9.8
HIV tests **641**—11.70–11.74

Records
Access/redissemination **191**—1.3(11)*e*(3), 54.13(4); **199**—1.9(5)*a*(5)"3"; **661**—8.104, 8.105, ch 11, 81.2(1–5,8–10), 81.3, 81.5, 83.4
Check/evaluation, licensees/employees
Administrative services department (DAS) **11**—54.3(3)
Bankers/brokers **187**—18.1, 18.2(4), 18.4(2,3,7,8)
Child care, *see CHILDREN: Abuse*
Consumer choices option program **441**—77.30(14)*e*, 78.34(13)*e*, 78.37(16)*c*, 78.38(9)*c*, 78.41(15)*c*, 78.43(15)*c*, 78.46(6)*c*
Criminal justice agencies **661**—8.104(3)
Educators **282**—17.1; **661**—11.21(4)
Elder group homes **321**—26.7
Funeral, preneed sales **191**—100.4(4), 103.2(5)*c*
Gambling **491**—6.2(1)*j*, 6.2(2), 11.13(3)*a*; **531**—1.5(2), 1.29; **641**—162.20(7), *see also BIDS AND BIDDING: Lottery Authority; RACING AND GAMING: Employees/Licensees: Investigation/Inspection*
Health care facilities, *see HEALTH CARE FACILITIES: Personnel*
Home health agencies **481**—50.9
Hospice **481**—50.9

CRIME (cont'd)
Records
Check/evaluation, licensees/employees

Juvenile detention/shelter homes **441**—105.3(3)*g*,*i*,*j*, 105.5(5)
NICS (national instant criminal history background check system) **661**—91.1
Noncriminal justice agencies **661**—11.14, 11.21
Nurses, *see NURSES: Background Checks*
Pharmacies **657**—8.13
Physicians **653**—8.4(1)*a*,*f*, 8.4(2)*a*, 8.4(3)*a*, 8.4(4)*a*, 8.4(7), 9.5(1)*a*,*b*, 9.5(2)*p*, 9.6(3), 9.7(1), 9.7(2)*c*, 9.13(2)*a*(9), 9.13(2)*b*, 10.3(3)*a*, 10.3(3)*b*(11), 10.4(3)*a*, 10.4(3)*b*(10), 10.5(3)
Substance abuse programs **641**—155.21(9)*i*, 155.25(11)
Weapons permit applicants (NICS) **661**—91.1, 91.4(6), 91.5(2)

Confidential **205**—6.4(2); **421**—2.14(5); **661**—8.103, 11.3, 83.3(7), 83.4(4), 83.4(8)
DNA **661**—150.3(5), 156.9
Evidence **661**—150.4, 150.6
Fees **661**—11.15
Fingerprints **491**—6.2(1)*f*; **661**—11.19, *see also Check/Evaluation, Licensees/Employees: Physicians this subheading above; NURSES: Background Checks*
HIV tests **641**—11.74(7); **661**—8.103
Laboratory **661**—156.9
Open **661**—83.4, 89.105
Release, *see Access/Redissemination this subheading above*
Repository **661**—1.2(6), ch 11
Review **661**—11.4, 11.5, 81.4
Sex offenders **201**—38.4(8), *see also Sex Offenders: Registry below*

Restitution, *see CORRECTIONS DEPARTMENT subheadings Community-Based Programs; Institutions, Adult*
Schools
Educators, license **282**—11.35(2), 17.1, 25.3(1)
Student victims, transfers **281**—ch 11

Sex offenders
Appeals **201**—38.3(4,5)
Assessment **201**—38.3, 38.4(3,6); **661**—83.4(9)
Definitions **661**—83.2
DNA database **661**—ch 156
Educators **282**—11.35(2), 25.3(1)
HIV tests **641**—11.70–11.74
Institutionalized, visitor restrictions **201**—20.3(4)*c*,*d*, 20.3(6)*d*
Management/treatment **201**—ch 38
Registry **441**—103.31–103.33, 107.4(5), 108.8(1)*c*(13), 108.9(4)*d*, 109.6(6), 110.7(3), 113.13, 157.3(1)*b*, 170.4(3)*h*, 200.4(1)*b*; **661**—ch 83

Unemployment compensation fraud, *see Fraud above*
Victims
See also Sex Offenders above; ABUSE; ATTORNEY GENERAL: Victim Assistance Program
Children **201**—20.3(4)*d*; **205**—7.1, 13.2; **281**—ch 11; **661**—83.2(1,4)
Compensation **61**—9.25–9.36, 9.86, 9.87; **641**—11.73; **701**—40.71
Grants **61**—9.50–9.65
Registration/notification **201**—20.15; **205**—ch 7, 14.6(2)
Restitution, *see CORRECTIONS DEPARTMENT subheadings Community-Based Programs; Institutions, Adult*
Sexual abuse **61**—9.29(7,9), 9.30(4), 9.35(1)*f*, 9.80–9.87; **641**—11.70–11.74; **661**—83.2; **701**—43.4(4)

Wildlife area trespass **571**—52.1(2)

CRIMINAL AND JUVENILE JUSTICE PLANNING DIVISION
Address **428**—1.2(3)
Administrator **428**—3.1, 3.9

Appeals **428**—3.8
Councils, advisory
Duties **428**—1.3, 1.4
Meetings **428**—1.5
Declaratory orders **428**—ch 6
Definitions **428**—1.1, 3.1
Duties **428**—1.2
Funds
Formula-based allocations **428**—3.5, 3.7(4)
Grants **428**—1.3, 1.4, 3.1, 3.3, 3.4, 3.7–3.16
Sole source contracts **428**—3.3, 3.6
Records **428**—ch 2, *see also HUMAN RIGHTS DEPARTMENT*
Rule making **428**—chs 7–9

CROPS
See also FERTILIZERS; GRAIN; HERBICIDES; IRRIGATION; PESTICIDES; PLANTS; SEEDS
Damage, deer, depredation permits **571**—106.11
Insurance **191**—20.8
Land, crop share/lease **571**—18.1; **701**—40.38(1)*c*"7," 40.38(2)
Manure application **567**—65.3(1,4), 65.17, ch 65 Tables 3,3a,4,4a p.170–173, *see also Wastes, Application below*
Marketing data **21**—1.3(4,8)
Organic **21**—47.3
Soil erosion control **27**—10.20, 10.60(6), 10.81, 10.82, 10.84; **199**—9.4(6); **567**—52.2(1)*c*; **571**—ch 71
Taxation
Credit, family farm **701**—80.11(1)
Estimation **701**—49.3(3)
Farming, definition **701**—40.21(2)*d*, 40.28(1), 53.11(2)*d*, 54.1(1,2), 59.8(2)*d*
Fiduciary income **701**—89.8(7)*g,j*
Fuel, farming operations **701**—64.14
Income, gross **701**—40.38(2)
Inheritance **701**—86.11(7)
Real estate assessment **701**—71.1(3), 71.12
Wastes, application **567**—67.8(2)*l,m*, 68.10(2)*c*(2)"3,9," 120.9(11), 121.4, 121.5, 121.6(1)*a*(1), 121.6(1)*l*(6,7), *see also Manure Application above*
Wildlife habitats
Agricultural lease program **571**—ch 21
Private land **571**—22.5(5)

CRT
See CATHODE RAY TUBES (CRT)

CULTURAL AFFAIRS DEPARTMENT
Address **221**—1.6
Appeals/hearings **221**—6.10, 8.9, 9.8; **223**—48.16, 49.5; **481**—1.6"11"
Arts division **221**—1.5(1), 1.6(2), *see also ARTS*
Community cultural grants (ICCG) program
Administration **221**—6.2
Amounts **221**—6.6
Appeals **221**—6.10
Applications **221**—6.2–6.7, 6.10
Audits **221**—6.9
Contracts **221**—6.8
Definitions **221**—6.3

Cultural/entertainment districts, certification **221**—ch 9
Cultural leadership partners (CLP) program
  Appeals **221**—8.9
  Applications **221**—8.4, 8.6, 8.7
  Audits **221**—8.8(4)
  Contracts **221**—8.8(1)
  Definitions **221**—8.2
  Eligibility **221**—8.3, 8.6
  Matching funds **221**—8.2
  Records/reports **221**—8.2, 8.8(3,5)
Cultural trust fund **261**—165.1, 165.4(4)
Declaratory orders **221**—ch 3
Definitions **221**—1.1, 2.1, 2.10(1), 6.3, 8.2
Gifts/endowments **223**—1.7
Historical division **221**—1.5(2), 1.6(3), *see also HISTORICAL DIVISION*
Historical society, *see HISTORICAL DIVISION*
Mementos, sales, *see HISTORICAL DIVISION: Society*
Museums
  Funds **221**—ch 8
  Property disposition **221**—ch 7
Organization **221**—ch 1
Procurement **541**—ch 10, *see also ADMINISTRATIVE SERVICES DEPARTMENT (DAS)*
Records, *generally*, public/fair information **221**—ch 2
Rule making **221**—ch 4
Welcome center, project review committee **261**—34.4(6)

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