

Chapter 182-508 WAC

ADULT MEDICAL AND CHEMICAL DEPENDENCY

WAC

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WAC 182-508-0001 Medical assistance coverage for adults not covered under family medical programs. (1) An adult who does not meet the institutional status requirements as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is con-

sidered for categorically needy (CN) coverage under this chapter. Individuals excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section an individual is eligible for CN coverage when the individual:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 182-503-0505; and

(b) Has CN countable income and resources that do not exceed the income and resource standards in WAC 182-512-0010; and

(c) Is sixty-five years of age or older, or meets the blind and/or disability criteria of the federal SSI program.

(2) An adult not meeting the conditions of subsection (1)(b) of this section is eligible for CN medical coverage if the individual:

(a) Is a current beneficiary of Title II of the Social Security Act (SSA) benefits who:

(i) Was a concurrent beneficiary of Title II and supplemental security income (SSI) benefits;

(ii) Is ineligible for SSI benefits and/or state supplemental payments (SSP); and

(iii) Would be eligible for SSI benefits if certain cost-of-living (COLA) increases are deducted from the client's current Title II benefit amount:

(A) All Title II COLA increases under P.L. 94-566, section 503 received by the individual since their termination from SSI/SSP; and

(B) All Title II COLA increases received during the time period in (d)(iii)(A) of this subsection by the individual's spouse or other financially responsible family member living in the same household.

(b) Is an SSI beneficiary, no longer receiving a cash benefit due to employment, who meets the provisions of section 1619(b) of Title XVI of the SSA;

(c) Is a currently disabled individual receiving widow's or widower's benefits under section 202 (e) or (f) of the SSA if the disabled individual:

(i) Was entitled to a monthly insurance benefit under Title II of the SSA for December 1983;

(ii) Was entitled to and received a widow's or widower's benefit based on a disability under section 202 (e) or (f) of the SSA for January 1984;

(iii) Became ineligible for SSI/SSP in the first month in which the increase provided under section 134 of P.L. 98-21 was paid to the individual;

(iv) Has been continuously entitled to a widow's or widower's benefit under section 202 (e) or (f) of the SSA;

(v) Would be eligible for SSI/SSP benefits if the amount of that increase, and any subsequent COLA increases provided under section 215(i) of the SSA, were disregarded;

(vi) Is fifty through fifty-nine years of age; and

(vii) Filed an application for medicaid coverage before July 1, 1988.

(d) Was receiving, as of January 1, 1991, Title II disabled widow or widower benefits under section 202 (e) or (f) of the SSA if the individual:

(i) Is not eligible for the hospital insurance benefits under medicare Part A;

(ii) Received SSI/SSP payments in the month before receiving such Title II benefits;

(iii) Became ineligible for SSI/SSP due to receipt of or increase in such Title II benefits; and

(iv) Would be eligible for SSI/SSP if the amount of such Title II benefits or increase in such Title II benefits under section 202 (e) or (f) of the SSA, and any subsequent COLA increases provided under section 215(i) of the act were disregarded.

(e) Is a disabled or blind individual receiving Title II Disabled Adult Childhood (DAC) benefits under section 202(d) of the SSA if the individual:

(i) Is at least eighteen years old;

(ii) Lost SSI/SSP benefits on or after July 1, 1988, due to receipt of or increase in DAC benefits; and

(iii) Would be eligible for SSI/SSP if the amount of the DAC benefits or increase under section 202(d) of the DAC and any subsequent COLA increases provided under section 215(i) of the SSA were disregarded.

(f) Is an individual who:

(i) In August 1972, received:

(A) Old age assistance (OAA);

(B) Aid to blind (AB);

(C) Aid to families with dependent children (AFDC); or

(D) Aid to the permanently and totally disabled (APTD);

and

(ii) Was entitled to or received retirement, survivors, and disability insurance (RSDI) benefits; or

(iii) Is eligible for OAA, AB, AFDC, SSI, or APTD solely because of the twenty percent increase in Social Security benefits under P.L. 92-336.

(3) An adult who does not meet the institutional status requirement as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for medically needy (MN) coverage under this chapter. Individuals excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section an individual is eligible for MN coverage when the individual:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 182-503-0505; and

(b) Has MN countable income that does not exceed the income standards in WAC 182-512-0010, or meets the excess income spenddown requirements in WAC 388-519-0110; and

(c) Meets the countable resource standards in WAC 182-519-0050; and

(d) Is sixty-five years of age or older or meets the blind and/or disability criteria of the federal SSI program.

(4) MN coverage is available for an aged, blind, or disabled ineligible spouse of an SSI recipient. See WAC 388-519-0100 for additional information.

(5) An adult may be eligible for the alien emergency medical program as described in WAC 182-507-0110.

(6) An adult is eligible for the aged, blind, or disabled program when the individual:

(a) Meets the requirements of the aged, blind, or disabled program in WAC 388-400-0060 and 388-478-0033; or

(b) Meets the SSI-related disability standards but cannot get the SSI cash grant due to immigration status or sponsor deeming issues. An adult may be eligible for aged, blind, or disabled cash benefits and CN medical coverage due to different sponsor deeming requirements.

(7) An adult is eligible for the medical care services (MCS) program when the individual:

(a) Meets the requirements under WAC 182-508-0005; or

(b) Meets the aged, blind, or disabled requirements of WAC 388-400-0060 and is a qualified alien as defined in WAC 388-424-0001 who is subject to the five-year bar as described in WAC 388-424-0006(3); or a nonqualified alien as defined in WAC 388-424-0001; or

(c) Meets the requirements of the ADATSA program as described in WAC 182-508-0320 and 182-508-0375.

(8) An adult receiving MCS who resides in a county designated as a mandatory managed care plan county must enroll in a plan, pursuant to WAC 182-538-063.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0001, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0005 Eligibility for medical care services. (1) An individual is eligible for medical care services (MCS) benefits to the extent of available funds if the individual:

(a) Completes an interview with the agency or its designee;

(b) Is incapacitated as required under WAC 182-508-0010 through 182-508-0120;

(c) Is at least eighteen years old or, if under eighteen, a member of a married couple;

(d) Is in financial need according to MCS' income and resource rules in chapter 182-509 WAC. The agency or the agency's designee determines who is in the individual's assistance unit according to WAC 182-506-0020;

(e) Meets the medical care services citizenship/alien status requirements under WAC 182-503-0532;

(f) Provides a Social Security number as required under WAC 388-476-0005;

(g) Resides in the state of Washington as required under WAC 182-503-0520;

(h) Reports changes of circumstances as required under WAC 182-504-0100; and

(i) Completes a midcertification review and provides proof of any changes as required under WAC 182-504-0040.

(2) An individual is not eligible for MCS benefits if the individual:

(a) Is eligible for temporary assistance for needy families (TANF) benefits.

(b) Refuses or fails to meet a TANF rule without good cause.

(c) Refuses to or fails to cooperate in obtaining federal aid assistance without good cause.

(d) Refuses or fails to participate in drug or alcohol treatment as required in WAC 182-508-0220.

(e) Is eligible for supplemental security income (SSI) benefits.

(f) Is an ineligible spouse of an SSI recipient.

(g) Refuses or fails to follow a Social Security Administration (SSA) program rule or application requirement without good cause and SSA denied or terminated the individual's benefits.

(h) Is fleeing to avoid prosecution of, or to avoid custody or confinement for conviction of, a felony, or an attempt to commit a felony as described in WAC 182-503-0560.

(i) Is eligible for a categorically needy (CN) medicaid program.

(j) Refuses or fails to cooperate with CN medicaid program rules or requirements.

(3) An individual who resides in a public institution and meets all other requirements may be eligible for MCS depending on the type of institution. A "public institution" is an institution that is supported by public funds, and a governmental unit either is responsible for it or exercises administrative control over it.

(a) An individual may be eligible for MCS if the individual is:

(i) A patient in a public medical institution; or

(ii) A patient in a public mental institution and is sixty-five years of age or older.

(b) An individual is not eligible for MCS when the individual is in the custody of or confined in a public institution such as a state penitentiary or county jail, including placement:

(i) In a work release program; or

(ii) Outside of the institution including home detention.

(4) If an enrollment cap exists under WAC 182-508-0150, a waiting list of persons may be established.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0005, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0010 Incapacity requirements for medical care services (MCS). Eligibility for the medical care services (MCS) program is based on an individual being incapacitated from working. For an individual to receive MCS program benefits, the agency or the agency's designee must determine the individual is incapacitated.

"Incapacitated" means that an individual cannot be gainfully employed as a result of a physical or mental impairment that is expected to continue for at least ninety days from the date the individual applies.

"Mental impairment" means a diagnosable mental disorder. The agency or the agency's designee excludes any diagnosis of or related to alcohol or drug abuse or addiction.

"Physical impairment" means a diagnosable physical illness.

(1) The agency or the agency's designee determines the individual is incapacitated if the individual is:

(a) Disabled based on Social Security Administration (SSA) disability criteria;

(b) Eligible for services from the division of developmental disabilities (DDD);

(9/13/12)

(c) Diagnosed as having mental retardation based on a full scale score of seventy or lower on the Wechsler adult intelligence scale (WAIS);

(d) At least sixty-four years and seven months old;

(e) Eligible for long-term care services from aging and disability services administration; or

(f) Approved through the progressive evaluation process (PEP).

(2) The agency or the agency's designee considers an individual to be incapacitated for ninety days after:

(a) The individual is released from inpatient treatment for a mental impairment if:

(i) The release from inpatient treatment was not against medical advice; and

(ii) The individual was discharged into outpatient treatment.

(b) The individual is released from a medical institution where the individual received long-term care services from the aging and disability services administration.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0010, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0015 Determining if an individual is incapacitated. When an individual applies for medical care services (MCS) program benefits, the individual must provide medical evidence to the agency or the agency's designee that shows the individual is unable to work.

If an individual is gainfully employed at the time of application for MCS, the agency or the agency's designee denies incapacity. "Gainful employment" means an individual is performing, in a regular and predictable manner, an activity usually done for pay or profit and earning more than the substantial gainful activity standard as defined by the Social Security Administration.

(1) The agency or the agency's designee doesn't consider work to be gainful employment when the individual is working:

(a) Under special conditions that go beyond the employer providing reasonable accommodation, such as in a sheltered workshop the agency or the agency's designee has approved; or

(b) Occasionally or part-time because the individual's impairment limits the hours the individual is able to work compared to unimpaired workers in the same job.

(2) The agency or the agency's designee determines if the individual is incapacitated when the individual:

(a) Applies for medical benefits;

(b) Becomes employed;

(c) Obtains work skills by completing a training program; or

(d) The agency or the agency's designee receives new information that indicates the individual may be employable.

(3) Unless the individual meets the other incapacity criteria in WAC 182-508-0010, the agency or the agency's designee decides incapacity by applying the progressive evaluation process (PEP) to the medical evidence that the individual provides that meets WAC 182-508-0030. The PEP is the sequence of eight steps described in WAC 182-508-0035 through 182-508-0110.

(4) If the individual has a physical or mental impairment and the individual is impaired by alcohol or drug addiction

and does not meet the other incapacity criteria in WAC 182-508-0010, the agency or the agency's designee decides if the individual is eligible for MCS by applying the PEP described in WAC 182-508-0035 through 182-508-0110. The individual isn't eligible for MCS benefits if the individual is incapacitated primarily because of alcoholism or drug addiction.

(5) In determining incapacity, the agency or the agency's designee considers only the individual's ability to perform basic work-related activities. "Basic work-related activities" are activities that anyone would be required to perform in a work setting. They consist of: Sitting, standing, walking, lifting, carrying, handling; and other physical functions (including manipulative or postural functions such as pushing, pulling, reaching, handling, stooping, or crouching), seeing, hearing, communicating, remembering, understanding and following instructions, responding appropriately to supervisors and co-workers, tolerating the pressures of a work setting, maintaining appropriate behavior, and adapting to changes in a routine work setting.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0015, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0020 Acceptable medical evidence.

The agency or the agency's designee accepts medical evidence from these sources:

(1) For a physical impairment, a health professional licensed in Washington state or where the examination was performed:

(a) A physician, which for medical care services (MCS) program purposes, includes:

- (i) Medical doctor (M.D.);
- (ii) Doctor of osteopathy (D.O.);
- (iii) Doctor of optometry (O.D.) to evaluate visual acuity impairments;

(iv) Doctor of podiatry (D.P.) for foot disorders; and

(v) Doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) for tooth abscesses or temporomandibular joint (TMJ) disorders.

(b) An advanced registered nurse practitioner (ARNP) for physical impairments that are within the ARNP's area of certification to treat;

(c) The chief of medical administration of the Veterans' Administration, or their designee, as authorized in federal law; or

(d) A physician assistant when the report is cosigned by the supervising physician.

(2) For a mental impairment, professionals licensed in Washington state or where the examination was performed:

(a) A psychiatrist;

(b) A psychologist;

(c) An advanced registered nurse practitioner certified in psychiatric nursing; or

(d) At the agency's or the agency's designee's discretion:

(i) A person identified as a mental health professional within the regional support network mental health treatment system provided the person's training and qualifications at a minimum include having a master's degree and two years of mental health treatment experience; or

(ii) The physician who is currently treating the individual for a mental impairment.

(3) **"Supplemental medical evidence"** means information from a health professional not listed in subsection (1) or (2) of this section and who can provide supporting medical evidence for impairments identified by any of the professionals listed in subsection (1) or (2) of this section. The agency includes as supplemental medical evidence sources:

(a) A health professional who has conducted tests on or provides ongoing treatment to the individual, such as a physical therapist, chiropractor, nurse, physician assistant;

(b) Workers at state institutions and agencies who are not health professionals and are providing or have provided medical or health-related services to the individual; or

(c) Chemical dependency professionals (CDPs) when requesting information on the effects of alcohol or drug abuse.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0020, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0030 Required medical evidence. An individual must provide medical evidence of an impairment(s) and how the impairment(s) affects the ability to perform regular and continuous work activity. Medical evidence must be in writing and be clear, objective and complete.

(1) Objective evidence for physical impairments means:

(a) Laboratory test results;

(b) Pathology reports;

(c) Radiology findings including results of X rays and computer imaging scans;

(d) Clinical finding including, but not limited to, ranges of joint motion, blood pressure, temperature or pulse; and documentation of a physical examination; or

(e) Hospital history and physical reports and admission and discharge summaries; or

(f) Other medical history and physical reports related to the individual's current impairments.

(2) Objective evidence for mental impairments means:

(a) Clinical interview observations, including objective mental status exam results and interpretation.

(b) Explanation of how examination findings meet the clinical and diagnostic criteria of the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

(c) Hospital, outpatient and other treatment records related to the individual's current impairments.

(d) Testing results, if any, including:

(i) Description and interpretation of tests of memory, concentration, cognition or intelligence; or

(ii) Interpretation of medical tests to identify or exclude a connection between the mental impairment and physical illness.

(3) Medical evidence sufficient for an incapacity determination must be from a medical professional described in WAC 182-508-0020 and must include:

(a) A diagnosis for the impairment, or impairments, based on an examination performed within twelve months of application;

(b) A clear description of how the impairment relates to the individual's ability to perform the work-related activities listed in WAC 182-508-0015(5); and

(c) Documentation of how the impairment, or impairments, is currently limiting the individual's ability to work

based on an examination performed within the ninety days of the date of application or the forty-five days before the month of incapacity review.

(4) When making an incapacity decision, the agency or the agency's designee considers documentation in addition to objective evidence to support the acceptable medical source or treating provider's opinion that the individual is unable to perform substantial gainful employment, such as proof of hospitalization.

(5) The agency or the agency's designee doesn't use symptoms related to substance abuse or a diagnosis of addiction or chemical dependency when determining incapacity when the only impairment supported by objective medical evidence is drug or alcohol addiction.

(6) The agency or the agency's designee considers diagnoses that are independent of addiction or chemical dependency when determining incapacity.

(7) The agency or the agency's designee determines the individual has a diagnosis that is independent of addiction or chemical dependency if the impairment will persist at least sixty days after the individual stops using drugs or alcohol.

(8) If the individual can't obtain medical evidence sufficient for the agency or its designee to determine if the individual is likely to be disabled without cost to the individual, and the individual meets other eligibility conditions in WAC 182-508-0005, the agency pays the costs to obtain objective evidence based on the agency's published payment limits and fee schedules.

(9) The agency or the agency's designee can't use a statement from a medical professional to determine that the individual is incapacitated unless the statement is supported by objective medical evidence.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0030, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0035 How severity ratings of impairment are assigned. (1) **"Severity rating"** means a rating of the extent of the individual's incapacity, and how severely it impacts the individual's ability to perform the basic work activities. Severity ratings are assigned in Steps II through IV of the PEP. The following chart provides a description of levels of limitations on work activities and the severity ratings that would be assigned to each.

Effect on Work Activities	Degree of Impairment	Numerical Value
(a) There is no effect on performance of one or more basic work-related activities.	None	1
(b) There is no significant limit on performance of one or more basic work-related activities.	Mild	2
(c) There are significant limits on performance of one or more basic work-related activity.	Moderate	3

(9/13/12)

Effect on Work Activities	Degree of Impairment	Numerical Value
(d) There are very significant limits on the individual's performance of one or more basic work-related activities.	Marked	4
(e) The individual is unable to perform at least one basic work-related activity.	Severe	5

(2) The agency or the agency's designee uses the description of how the individual's condition impairs their ability to perform work activities given by the medical evidence provider to establish severity ratings when the impairments are supported by, and consistent with, the objective medical evidence.

(3) A contracted doctor reviews the individual's medical evidence and the ratings assigned to the individual's impairment when there is at least a moderate severity rating and the individual's impairment has lasted, or is expected to last, twelve months or more with available treatment.

(4) The contracted doctor reviews the individual's medical evidence, severity ratings, and functional assessment to determine whether:

(a) The medical evidence is objective and sufficient to support the findings of the provider;

(b) The description of impairments is supported by the medical evidence; and

(c) The severity rating and assessment of functional limitations assigned by the agency or the agency's designee are consistent with the medical evidence.

(5) If the medical evidence provider's description of the individual's impairments is not consistent with the objective medical evidence, the agency or the agency's designee takes the following action:

(a) Assigns a severity rating and functional limitations consistent with the objective medical evidence;

(b) Clearly describes why the agency rejected the medical provider's opinion; and

(c) Identifies the medical evidence used to make the determination.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0035, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0040 PEP Step I—Review of medical evidence required for eligibility determination. When the agency or the agency's designee receives the individual's medical evidence, the agency or the agency's designee reviews it to see if it is sufficient to decide whether the individual's circumstances meet incapacity requirements.

(1) The agency or the agency's designee requires medical information to determine incapacity. The information must:

(a) Contain sufficient information as described under WAC 182-508-0030;

(b) Be written by an authorized medical professional described in WAC 182-508-0020;

(c) Document the existence of a potentially incapacitating condition; and

(d) Indicate an impairment is expected to last ninety days or more from the application date.

(2) If the information received isn't clear, the agency or the agency's designee may require more information before the agency or the agency's designee decides the individual's ability to be gainfully employed. As examples, the agency or the agency's designee may require the individual to get more medical tests or be examined by a medical specialist.

(3) The agency or the agency's designee denies incapacity if:

(a) There is only one impairment and the severity rating is less than three;

(b) A reported impairment isn't expected to last ninety days or more from the date of application;

(c) The only impairment supported by objective medical evidence is drug or alcohol addiction; or

(d) The agency or the agency's designee doesn't have clear and objective medical evidence to approve incapacity.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0040, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0050 PEP Step II—Determining the severity of mental impairments. If the individual is diagnosed with a mental impairment by a professional described in WAC 182-508-0020, the agency or the agency's designee uses information from the provider to determine how the impairment limits work-related activities.

(1) The agency or the agency's designee reviews the following psychological evidence to determine the severity of the individual's mental impairment:

(a) Psychosocial and treatment history records;

(b) Clinical findings of specific abnormalities of behavior, mood, thought, orientation, or perception;

(c) Results of psychological tests; and

(d) Symptoms observed by the examining practitioner that show how the individual's impairment affects their ability to perform basic work-related activities.

(2) The agency or the agency's designee excludes diagnosis and related symptoms of alcohol or substance abuse or addiction when the only impairment supported by objective medical evidence is drug or alcohol addiction.

(3) If the individual is diagnosed with mental retardation, the diagnosis must be based on the Wechsler adult intelligence scale (WAIS). The following test results determine the severity rating:

Intelligence Quotient (IQ) Score	Severity Rating
85 or above	1
71 to 84	3
70 or lower	5

(4) If the individual is diagnosed with a mental impairment with physical causes, the agency or the agency's designee assigns a severity rating based on the most severe of the following four areas of impairment:

(a) Short term memory impairment;

(b) Perceptual or thinking disturbances;

(c) Disorientation to time and place; or

(d) Labile, shallow, or coarse affect.

(5) The agency or the agency's designee bases the severity of an impairment diagnosed as a mood, anxiety, thought, memory, personality, or cognitive disorder on a clinical assessment of the intensity and frequency of symptoms that:

(a) Affect the individual's ability to perform basic work-related activities; and

(b) Are consistent with a diagnosis of a mental impairment as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

(6) The agency or the agency's designee bases the severity rating for a functional mental impairment on accumulated severity ratings for the symptoms in subsection (5)(a) of this section as follows:

Symptom Ratings or Condition	Severity Rating
(a) The clinical findings and objective evidence are consistent with a significant limitation on performing one or more basic work activities.	Moderate (3)
(b) The individual is diagnosed with a functional disorder with psychotic features;	Marked (4)
(c) The individual has had two or more hospitalizations for psychiatric reasons in the past two years;	
(d) The individual has had more than six months of continuous psychiatric inpatient or residential treatment in the past two years;	
(e) The clinical findings and objective evidence are consistent with very significant limitations on ability to perform one or more basic work activities.	Severe (5)
(f) The clinical findings and objective evidence are consistent with an inability to perform one or more basic work activities.	

(7) If the individual is diagnosed with any combination of mental retardation, mental impairment with physical causes, or functional mental impairment, the agency or the agency's designee assigns a severity rating as follows:

Condition	Severity Rating
(a) Two or more disorders with moderate severity (3) ratings; or	Marked (4)
(b) One or more disorders rated moderate severity (3), and one rated marked severity (4).	
(c) Two or more disorders rated marked severity (4).	Severe (5)

(8) The agency or the agency's designee denies incapacity when the individual hasn't been diagnosed with a significant physical impairment and the individual's overall mental severity rating is one or two;

(9) The agency or the agency's designee approves incapacity when the individual has an overall mental severity rating of severe (5).

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0050, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0060 PEP Step III—Determining the severity of physical impairments. The agency or the agency's designee must decide if the individual's physical impairment is serious enough to limit the individual's ability to be gainfully employed. "Severity of a physical impairment" means the degree that an impairment restricts the individual from performing basic work-related activities (see WAC 182-508-0015). Severity ratings range from one to five, with five being the most severe. The agency or the agency's designee will assign severity ratings according to the table in WAC 182-508-0035.

(1) The agency or the agency's designee assigns to each physical impairment a severity rating that is supported by medical evidence.

(2) If the individual's physical impairment is rated two, and there is no mental impairment or a mental impairment that is rated one, the agency or the agency's designee denies incapacity.

(3) If the individual's physical impairment is consistent with a severity rating of five, the agency or the agency's designee approves incapacity.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0060, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0070 PEP Step IV—Determining the severity of multiple impairments. (1) If an individual has more than one impairment, the agency or the agency's designee decides the overall severity rating by deciding if the individual's impairments have a combined effect on their ability to be gainfully employed.

(2) When an individual has two or more diagnosed impairments that limit work activities, the agency or the agency's designee assigns an overall severity rating as follows:

Client Condition	Severity Rating
(a) All impairments are mild and there is no cumulative effect on basic work activities.	Mild 2
(b) All impairments are mild and there is a significant cumulative effect on one or more basic work activities.	Moderate 3
(c) Two or more impairments are of moderate severity and there is a very significant cumulative effect on basic work activities.	Marked 4
(d) Two or more impairments are of marked severity.	Severe 5

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(3) The agency or the agency's designee denies incapacity when the overall severity rating is two.

(4) The agency or the agency's designee approves incapacity at this step when the overall severity rating is five.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0070, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0080 PEP Step V—Determining level of function of mentally impaired individuals in a work environment. If an individual has a mental impairment, the agency or the agency's designee evaluates the individual's cognitive and social functioning in a work setting. "Functioning" means an individual's ability to perform typical tasks that would be required in a routine job setting and the individual's ability to interact effectively while working.

(1) The agency or the agency's designee evaluates cognitive and social functioning by assessing the individual's ability to:

(a) Understand, remember, and persist in tasks by following very short and simple instructions.

(b) Understand, remember, and persist in tasks by following detailed instructions.

(c) Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances without special supervision.

(d) Learn new tasks.

(e) Perform routine tasks without special supervision.

(f) Adapt to changes in a routine work setting.

(g) Make simple work-related decisions.

(h) Be aware of normal hazards and take appropriate precautions.

(i) Ask simple questions or request assistance.

(j) Communicate and perform effectively in a work setting.

(k) Complete a normal workday and workweek without interruptions from psychologically based symptoms.

(l) Set realistic goals and plan independently.

(m) Maintain appropriate behavior in a work setting.

(2) The agency or the agency's designee approves incapacity when it has objective medical evidence, including a mental status exam (MSE) per WAC 182-508-0050, that demonstrates the individual is:

(a) At least moderately impaired in their ability to understand, remember, and persist in tasks following simple instructions, and at least moderately limited in their ability to:

(i) Learn new tasks;

(ii) Be aware of normal hazards and take appropriate precautions; and

(iii) Perform routine tasks without undue supervision; or

(b) At least moderately impaired in the ability to understand, remember, and persist in tasks following complex instructions; and at least markedly limited in the ability to:

(i) Learn new tasks;

(ii) Be aware of normal hazards and take appropriate precautions; and

(iii) Perform routine tasks without undue supervision.

(3) The agency or the agency's designee approves incapacity when the individual is moderately (rated three) impaired in their ability to:

(a) Communicate and perform effectively in a work setting; and

(b) Markedly (rated four) impaired in their ability to maintain appropriate behavior in a work setting.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0080, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0090 PEP Step VI—Determining level of function of physically impaired individuals in a work environment. In Step VI of the PEP, the agency or the agency's designee reviews the medical evidence provided and determines how an individual's physical impairment prevents that individual from working. This determination is then used in Steps VII and VIII of the PEP to determine the individual's ability to perform either work they have done in the past or other work.

(1) **"Exertion level"** means having strength, flexibility, and mobility to lift, carry, stand or walk as needed to fulfill job duties in the following work levels. For this section, "occasionally" means less than one third of the time and "frequently" means one third to two thirds of the time.

The following table is used to determine an individual's exertion level. Included in this table is a strength factor, which is an individual's ability to perform physical activities, as defined in Appendix C of the *Dictionary of Occupational Titles* (DOT), Revised Edition, published by the U.S. Department of Labor as posted on the Occupational Information Network (O.*NET).

If an individual is able to:	Then the individual is assigned this exertion level
(a) Lift ten pounds maximum and frequently lift or carry light-weight articles. Walking or standing only for brief periods.	Sedentary
(b) Lift twenty pounds maximum and frequently lift or carry objects weighing up to ten pounds. Walk six out of eight hours per day or stand during a significant portion of the work-day. Sitting and using pushing or pulling arm or leg movements most of the day.	Light
(c) Lift fifty pounds maximum and frequently lift or carry up to twenty-five pounds.	Medium
(d) Lift one hundred pounds maximum and frequently lift or carry up to fifty pounds.	Heavy

(2) **"Exertionally related limitation"** means a restriction in mobility, agility or flexibility in the following twelve activities: Balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping. If an individual has exertionally related limitations, then the agency or the agency's designee considers them in determining the individual's ability to work.

(3) **"Functional physical capacity"** means the degree of strength, agility, flexibility, and mobility an individual can apply to work-related activities. The agency or the agency's

designee considers the effect of the physical impairment on the ability to perform work-related activities when the physical impairment is assigned an overall severity rating of three or four. The agency or the agency's designee determines functional physical capacity based on the individual's exertional, exertionally related and nonexertional limitations. All limitations must be substantiated by the medical evidence and directly related to the diagnosed impairment(s).

(4) **"Nonexertional physical limitation"** means a restriction on work activities that does not affect strength, mobility, agility, or flexibility. Examples are:

(a) Environmental restrictions which could include, among other things, an individual's inability to work in an area where they would be exposed to chemicals; and

(b) Workplace restrictions, such as impaired hearing or speech, which would limit the types of work environments an individual could work in.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0090, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0100 PEP Step VII—Evaluating a client's capacity to perform relevant past work. If the individual's overall severity rating is moderate (three) or marked (four) at this stage of the PEP and the agency or the agency's designee has not approved or denied the individual's application, then the agency or the agency's designee will decide if the individual can do the same or similar work as they have done in the past. The agency or the agency's designee looks at the individual's current physical and/or mental limitations from cognitive, social, and vocational factors to make this decision. Vocational factors are education, relevant work history, and age.

(1) The agency or the agency's designee evaluates education in terms of formal schooling or other training that would enable the individual to meet job requirements. Education is classified as:

If the individual:	Then the individual's education level is
(a) Can't read or write a simple communication, such as two sentences or a list of items.	Illiterate
(b) Has no formal schooling or vocational training beyond the eleventh grade; or	Limited education
(c) Has participated in special education in basic academic classes of reading, writing, or mathematics in high school.	
(d) Has received a high school diploma or general equivalency degree (GED); or	High school and above level of education
(e) Has received skills training and was awarded a certificate, degree or license.	

(2) The agency or the agency's designee evaluates the individual's work experience to determine if they have relevant past work. "Relevant past work" means work that:

(a) Is defined as gainful employment per WAC 182-508-0015;

(b) Has been performed in the past five years; and

(c) The individual performed long enough to acquire the knowledge and skills to continue performing the job. The individual must meet the specific vocational preparation level as defined in Appendix C of the *Dictionary of Occupational Titles*.

(3) For each relevant past work situation that the individual had, the agency or the agency's designee determines:

(a) The exertion or skill requirements of the job; and

(b) Current cognitive, social, or nonexertion factors that significantly limit the individual's ability to perform past work.

(4) After considering vocational factors, the agency or the agency's designee denies incapacity when the individual has:

(a) The physical and mental ability to perform past work, and there is no significant cognitive, social or exertion limitation that would prevent the individual from performing past work; or

(b) Recently acquired specific work skills through completion of schooling or training, for jobs within the individual's current physical or mental capacities.

(5) The agency or the agency's designee approves incapacity when the individual is fifty-five years of age or older and doesn't have the physical or mental ability to perform past work.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0100, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0110 PEP Step VIII—Evaluating a client's capacity to perform other work. If the individual decides they cannot do work that they've done before, then the agency or the agency's designee decides if the individual can do any other work.

(1) The agency or the agency's designee approves incapacity if the individual has a physical impairment and meets the vocational factors below:

Highest Work Level Assigned by the Practitioner	Age	Education Level	Other Vocational Factors
Sedentary	Any age	Any level	Does not apply
Light	50 and older	Any level	Does not apply
Light	35 and older	Illiterate or LEP	Does not apply
Light	18 and older	Limited Education	Does not have any past work
Medium	50 and older	Limited Education	Does not have any past work

(2) The agency or the agency's designee approves incapacity when the individual has a moderate (three) or marked (four) mental health impairment and the agency or the agency's designee has objective medical evidence, including

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a mental status exam (MSE) per WAC 182-508-0050, that demonstrates social or cognitive factors described in WAC 182-508-0080, interfere with working as follows:

Social and Cognitive Limitation	Age
(a) Moderately impaired (rated three) in the individual's ability to: (i) Communicate and perform effectively in a work setting; and (ii) Maintain appropriate behavior in a work setting.	50 years and older
(b) The individual is severely impaired in their ability to: (i) Understand, remember, and persist in tasks following detailed instructions; (ii) Set realistic goals and plan independently; or (iii) Learn new tasks.	45 years and older
(c) The individual is severely impaired in their ability to: (i) Understand, remember, and persist in tasks by following very short and simple instructions; (ii) Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances without special supervision; (iii) Perform routine tasks without special supervision; (iv) Adapt to changes in a routine work setting; (v) Make simple work-related decisions; (vi) Be aware of normal hazards and take appropriate precautions; (vii) Ask simple questions or request assistance; (viii) Communicate and perform effectively in a work setting; (ix) Complete a normal workday and work week without interruption from psychologically based symptoms; or (x) Maintain appropriate behavior in a work setting.	Any age

(3) The agency or the agency's designee approves incapacity when the individual has both mental and physical impairments with at least a moderate overall severity and the agency or the agency's designee has objective medical evidence, including a mental status exam (MSE) per WAC 182-508-0050, that demonstrate social or cognitive factors, as described in WAC 182-508-0080 that interfere with work as follows:

Age	Education	Other Restrictions
Any age	Any level	(a) The individual is moderately impaired in their ability to communicate and perform effectively in a work setting.
50 or older	Limited education or less	(b) Restricted to medium work or less.
Any age	Limited education or less	(c) Restricted to light work level or less.

(4) The agency or the agency's designee denies incapacity if the agency or the agency's designee decides the individual doesn't meet the criteria listed above.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0110, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0120 Deciding how long a client is incapacitated. The agency or the agency's designee decides how long an individual is incapacitated, up to the maximum period set by WAC 182-508-0160, using medical evidence on the expected length of time needed to heal or recover from the incapacitating disorder(s).

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0120, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0130 Medical care services—Limited coverage. (1) The agency covers only the medically necessary services within the applicable program limitations listed in WAC 182-501-0060.

(2) The agency does not cover medical services received outside the state of Washington unless the medical services are provided in a border city listed in WAC 182-501-0175.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0130, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0150 Enrollment cap for medical care services (MCS). (1) Enrollment in medical care services (MCS) coverage is subject to available funds.

(2) The agency may limit enrollment into MCS coverage by implementing an enrollment cap and waiting list.

(3) If an individual is denied MCS coverage due to an enrollment cap:

(a) The individual is added to the MCS waiting list based on the date the individual applied.

(b) Applicants with the oldest application date will be the first to receive an opportunity for enrollment when MCS coverage is available.

(4) An individual is exempted from the enrollment cap and wait list rules when:

(a) MCS was terminated due to agency error;

(b) The individual is in the thirty-day reconsideration period for incapacity reviews under WAC 182-508-0160(4); or

(c) The individual is being terminated from a CN medical program and was receiving and eligible for CN coverage prior to the date a wait list was implemented and the following conditions are met:

(i) The individual met financial and program eligibility criteria for MCS at the time their CN coverage ended; and

(ii) The individual met the incapacity criteria for MCS at the time their CN coverage ended.

(d) The individual applied for medical coverage and an eligibility decision was not completed prior to the enrollment cap effective date.

(5) If the individual is sent an offer for MCS enrollment, the individual must submit a completed application no later than the last day of the month following the month of enrollment offer. The individual must reapply within this time period and subsequently be determined eligible before MCS coverage can begin. The individual must reapply and requalify even if the individual was previously determined eligible for MCS.

(6) The individual is removed from the MCS wait list if the individual:

(a) Is not a Washington resident;

(b) Is deceased;

(c) Requests removal from the wait list;

(d) Fails to submit an application after an enrollment offer is sent as described in subsection (5) of this section;

(e) Reapplies as described in subsection (5) of this section, but does not qualify for MCS; or

(f) Is found eligible for categorically or medically needy coverage.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0150, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0160 When medical care services benefits end. (1) The maximum period of eligibility for medical care services (MCS) is twelve months before the agency or the agency's designee must review incapacity. The agency or the agency's designee uses current medical evidence and the expected length of time before the individual will be capable of gainful employment to decide when MCS benefits will end.

(2) The individual's benefits stop at the end of the individual's incapacity period unless the individual provides additional medical evidence that demonstrates during the current incapacity period that there was no material improvement in the individual's impairment. No material improvement means that the individual's impairment continues to meet the progressive evaluation process criteria in WAC 182-508-0015 through 182-508-0110, excluding the requirement that the individual's impairment(s) prevent employment for ninety days.

(3) The medical evidence must meet all of the criteria defined in WAC 182-508-0030.

(4) The agency or the agency's designee uses medical evidence received after the individual's incapacity period had ended when:

(a) The delay was not due to the individual's failure to cooperate; and

(b) The agency or the agency's designee receives the evidence within thirty days of the end of the individual's incapacity period; and

(c) The evidence meets the progressive evaluation process criteria in WAC 182-508-0015 through 182-508-0110.

(5) Even if the individual's condition has not improved, the individual isn't eligible for MCS when:

(a) The agency or the agency's designee receives current medical evidence that doesn't meet the progressive evaluation

tion process criteria in WAC 182-508-0035 through 182-508-0110; and

(b) The agency's or the agency designee's prior decision that the individual's incapacity met the requirements was incorrect because:

(i) The information the agency or the agency's designee had was incorrect or not enough to show incapacity; or

(ii) The agency or the agency's designee didn't apply the rules correctly to the information it had at that time.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0160, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0220 How alcohol or drug dependence affects an individual's eligibility for medical care services (MCS). (1) An individual who gets medical care services (MCS) must complete a chemical dependency assessment when the agency or the agency's designee has information that indicates the individual may be chemically dependent.

(2) An individual must accept an assessment referral and participate in drug or alcohol treatment if a certified chemical dependency counselor indicates a need for treatment, unless the individual meets one of the following good cause reasons:

(a) The agency or the agency's designee determines that the individual's physical or mental health impairment prevents them from participating in treatment.

(b) The outpatient chemical dependency treatment the individual needs isn't available in the county they live in.

(c) The individual needs inpatient chemical dependency treatment at a location that they can't reasonably access.

(3) If an individual refuses or fails to complete an assessment or treatment without good cause, the individual's MCS coverage will end following advance notification rules under WAC 388-458-0030.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0220, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0230 Eligibility standards for medical care services (MCS); aged, blind, or disabled (ABD); and Alcohol and Drug Addiction Treatment and Support Act (ADATSA). The eligibility standards for MCS, ABD medical, and ADATSA program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Eligibility Standard
1	\$339
2	\$428

The eligibility standards for MCS and ADATSA assistance units with shelter provided at no cost are:

Assistance Unit Size	Eligibility Standard
1	\$206
2	\$261

The eligibility standards for MCS assistance units in medical institutions and group living facilities are:

Facility Type	Assistance Unit Size	Eligibility Standard
Medical institutions (includes nursing homes and hospitals)	1	41.62

Facility Type	Assistance Unit Size	Eligibility Standard
Adult family homes	1	339.00
Boarding homes (includes assisted living, enhanced residential centers (EARC), and adult residential centers (ARC))	1	38.84
DDD group home	1	38.84
Mental health adult residential treatment facilities (ARTF)	1	38.84

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0230, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0300 What is the purpose of this chapter? This chapter explains chemical dependency treatment services available through public assistance.

[11-22-051, recodified as WAC 182-508-0300, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0005, filed 7/28/00, effective 9/1/00.]

WAC 182-508-0305 Detoxification—Covered services. (1) The agency or the agency's designee only pays for services that are:

(a) Provided to eligible individuals as described in subsection (5) of this section;

(b) Directly related to detoxification; and

(c) Performed by a certified detoxification center or by a general hospital that has a contract with the department of social and health services to provide detoxification services.

(2) The agency limits on paying for detoxification services are:

(a) Three days for an acute alcoholic condition; or

(b) Five days for acute drug addiction.

(3) The agency only pays for detoxification services when notified within ten working days of the date detoxification began and all eligibility factors are met.

(4) To apply for detoxification services, an individual must complete an application for benefits. An interview is not required when applying for medical assistance. However, additional documentation may be needed to prove or confirm the information provided in the application form.

(5) An individual is eligible for detoxification services if the individual receives benefits under one of the following programs:

(a) Temporary assistance for needy families (TANF);

(b) Aged, blind, or disabled cash assistance program (ABD);

(c) Supplemental security income (SSI);

(d) Medical care services program (MCS);

(e) Alcohol and Drug Addiction Treatment and Support Act (ADATSA); or

(f) A medical assistance program.

(6) An individual who is not eligible for one of the programs listed in subsection (5) of this section is eligible for the detoxification program if they meet the following criteria:

(a) Nonexempt countable income does not exceed the eligibility standards for MCS and ADATSA as described in WAC 182-508-0230; and

(b) Nonexempt countable resources do not exceed one thousand dollars.

(7) The following expenses are deducted from income when determining countable income:

(a) Mandatory expenses of employment;

(b) Support payments paid under a court order; and

(c) Payments to a wage earner specified by a court in bankruptcy proceedings, or previously contracted major household repairs, when failure to make such payments will result in garnishment of wages or loss of employment.

(8) The following resources are not counted when determining countable resources:

(a) A home;

(b) Household furnishings and personal clothing essential for daily living;

(c) Other personal property used to reduce need for assistance or for rehabilitation;

(d) A used and useful automobile; and

(e) All income and resources of a noninstitutionalized SSI beneficiary.

(9) The following resources are counted when determining countable resources:

(a) Cash and other liquid assets;

(b) Marketable securities; and

(c) Any other resource not specifically exempted that can be converted to cash.

(10) If an individual receives detoxification services, the individual will not incur a deductible as a factor of eligibility for the covered period of detoxification.

(11) Once an individual has been determined eligible for detoxification services, the individual is eligible from the date detoxification begins through the end of the month in which the detoxification is completed.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0305, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0310 ADATSA—Purpose. (1) The Alcohol and Drug Addiction Treatment and Support Act (ADATSA) is a legislative enactment providing state-funded treatment and support to chemically dependent indigent individuals.

(2) ADATSA provides eligible individuals with treatment if they are chemically dependent and would benefit from it.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0310, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0315 ADATSA—Covered services. If an individual qualifies for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) they may be eligible for:

(1) Alcohol/drug treatment services and support based on an individual assessment of alcohol/drug involvement and treatment needs in accordance with RCW 70.96A.100.

(2) Medical care services (MCS) as described under WAC 182-508-0005, 182-501-0060, and 182-501-0065.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0315, filed 9/13/12, effective 10/14/12.]

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WAC 182-508-0320 ADATSA—Eligible individuals.

(1) To be eligible for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) services, an individual must:

(a) Be eighteen years of age or older;

(b) Be a resident of Washington as defined in WAC 182-503-0520;

(c) Meet citizenship requirements as described in WAC 182-503-0532;

(d) Provide their Social Security number; and

(e) Meet the same income and resource criteria for the medical care services (MCS) program (unless subsection (3) of this section applies), or receive federal assistance under supplemental security income (SSI) or temporary assistance for needy families (TANF).

(2) An individual is not eligible for the ADATSA program if the individual is otherwise eligible for TANF or family medical and loses their eligibility for medical coverage due to:

(a) Noncooperation with the division of child support requirements; or

(b) Failure to cooperate with third-party liability (TPL) requirements to identify any potential third-party payors for medical coverage.

(3) An individual with nonexcluded countable income higher than the MCS eligibility standard described in WAC 182-508-0230 may qualify for inpatient only residential treatment if total countable income is below the projected monthly cost of care in the treatment center based on the state daily reimbursement rate.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0320, filed 9/13/12, effective 10/14/12.]

WAC 182-508-0325 When am I eligible for ADATSA treatment services? (1) You are eligible for ADATSA treatment services when you meet the:

(a) Financial eligibility criteria in WAC 388-800-0048; and

(b) Incapacity eligibility criteria in WAC 388-800-0055.

(2) If you are able to access, at no cost, state-approved chemical dependency treatment comparable to ADATSA treatment services, you may choose it rather than ADATSA.

[11-22-051, recodified as WAC 182-508-0325, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0050, filed 7/28/00, effective 9/1/00.]

WAC 182-508-0330 What clinical incapacity must I meet to be eligible for ADATSA treatment services? You are clinically eligible for ADATSA treatment services when you:

(1) Are diagnosed as having a mild, moderate, or severe dependency on a psychoactive substance class other than nicotine or caffeine, using the current criteria for Psychoactive Substance Dependence in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (DSM IV or its successor);

(2) Have not abstained from alcohol and drug use for the last ninety days, excluding days spent while incarcerated;

(3) Have not been gainfully employed in a job in the competitive labor market at any time during the last thirty days. For the purposes of this chapter, "gainfully employed"

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means performing in a regular and predictable manner an activity for pay or profit. Gainful employment does not include noncompetitive jobs such as work in a department-approved sheltered workshop or sporadic or part-time work, if the person, due to functional limitation, is unable to compete with unimpaired workers in the same job; and

(4) Are incapacitated, i.e., unable to work. Incapacity exists if you are one or more of the following:

(a) Currently pregnant or up to two months postpartum;

(b) Diagnosed as at least moderately psychoactive substance dependent and referred for treatment by child protective services;

(c) Diagnosed as severely psychoactive substance dependent and currently an intravenous drug user;

(d) Diagnosed as severely psychoactive substance dependent and has at least one prior admission to a department-approved alcohol/drug treatment or detoxification program;

(e) Diagnosed as severely psychoactive substance dependent and have had two or more arrests for offenses directly related to the chemical dependency; or

(f) Lost two or more jobs during the last six months as a direct result of chemical dependency.

[11-22-051, recodified as WAC 182-508-0330, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0055, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0055, filed 7/28/00, effective 9/1/00.]

WAC 182-508-0335 Will I still be eligible for ADATSA outpatient services if I abstain from using alcohol or drugs, become employed, or have a relapse? When you are successfully participating in ADATSA outpatient treatment services you are still considered incapacitated and eligible for ADATSA treatment through completion of the planned treatment, even if you:

(1) Become employed;

(2) Abstain from alcohol or drug use; or

(3) Relapse (resumption of your psychoactive substance abuse dependence).

[11-22-051, recodified as WAC 182-508-0335, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0057, filed 7/28/00, effective 9/1/00.]

WAC 182-508-0340 What is the role of the certified chemical dependency service provider in determining ADATSA eligibility? (1) A department-certified chemical dependency service provider determines your clinical incapacity based on alcoholism and/or drug addiction.

(2) The certified chemical dependency service provider provides a written current assessment needed to determine your eligibility.

(3) This assessment is the department's sole source of medical evidence required for the diagnosis and evaluation of your chemical dependency and its effects on employability.

[11-22-051, recodified as WAC 182-508-0340, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0060, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0060, filed 7/28/00, effective 9/1/00.]

(9/13/12)

WAC 182-508-0345 What are the responsibilities of the certified chemical dependency service provider in determining eligibility? (1) The role of the certified chemical dependency service provider is to:

(a) Provide your diagnostic evaluation and decide your initial treatment placement;

(b) Conduct a face-to-face diagnostic assessment, according to WAC 388-805-310, to determine if you:

(i) Are chemically dependent;

(ii) Meet incapacity standards for treatment under WAC 388-800-0055; and

(iii) Are willing, able, and eligible to undergo a course of ADATSA chemical dependency treatment, once determined incapacitated.

(c) Determines a course of treatment based on your individual assessment of alcohol/drug involvement and treatment needs in accordance with RCW 70.96A.100.

[11-22-051, recodified as WAC 182-508-0345, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0065, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0065, filed 7/28/00, effective 9/1/00.]

WAC 182-508-0350 What happens after I am found eligible for ADATSA services? Once your financial and clinical eligibility is established, the certified chemical dependency service provider:

(1) Develops your ADATSA treatment plan;

(2) Arranges your initial chemical dependency treatment placements taking into account the treatment priorities described under WAC 388-800-0100;

(3) Provides you with written notification of your right to return to the community service office (CSO) at any time while receiving ADATSA treatment;

(4) Provides you with written notification of your right to request a fair hearing to challenge any action affecting eligibility for ADATSA treatment; and

(5) Notifies the CSO promptly of your placement or eligibility status changes.

[11-22-051, recodified as WAC 182-508-0350, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0070, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0070, filed 7/28/00, effective 9/1/00.]

WAC 182-508-0355 What criteria does the certified chemical dependency service provider use to plan my treatment? When evaluating a treatment plan which will benefit you the most, the certified chemical dependency service provider considers clinical or medical factors utilizing the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC).

[11-22-051, recodified as WAC 182-508-0355, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0075, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0075, filed 7/28/00, effective 9/1/00.]

WAC 182-508-0360 Do I have to contribute to the cost of residential treatment? Once you have been determined financially eligible to receive ADATSA residential

treatment services the department does not require you to contribute toward the cost of care.

[11-22-051, recodified as WAC 182-508-0360, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0085, filed 7/28/00, effective 9/1/00.]

WAC 182-508-0365 What happens when I withdraw or am discharged from treatment? (1) You will be terminated from ADATSA treatment services if you leave treatment.

(2) If you are discharged from treatment for any other reason, you will be referred to the next appropriate level of treatment.

(3) If you are absent from any residential treatment services for less than seventy-two hours you may reenter that program without being considered as having dropped out. This is done at the discretion of the treatment service administrator and without requiring you to apply for readmittance through the certified chemical dependency service provider.

(4) Once you voluntarily leave treatment you must reapply and be referred again to the certified chemical dependency service provider to receive further ADATSA treatment services.

(5) If you are terminated from treatment you are not eligible for benefits beyond the month in which treatment services end. Rules regarding advance and adequate notice still apply, but you are not eligible for continued assistance pending a fair hearing.

[11-22-051, recodified as WAC 182-508-0365, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0090, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0090, filed 7/28/00, effective 9/1/00.]

WAC 182-508-0370 What are the groups that receive priority for ADATSA services? (1) When assigning treatment admissions, the ADATSA/Adult assessment certified chemical dependency service provider:

(a) Gives first priority to you if you are a pregnant woman or a parent with a child under eighteen years old in the home;

(b) Provides priority access for admission if you are:

(i) Referred by the department's children's protective services (CPS) program; and/or

(ii) An injecting drug user (IDU).

(2) If you are completing residential treatment you have priority access to outpatient treatment.

[11-22-051, recodified as WAC 182-508-0370, filed 10/31/11, effective 10/31/11. Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0100, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0100, filed 7/28/00, effective 9/1/00.]

WAC 182-508-0375 ADATSA—Eligibility for state-funded medical care services (MCS). An ADATSA-eligible individual is eligible for state-funded medical care services (MCS) when one of the following situations exists:

(1) The individual meets the requirements in WAC 182-508-0320 and be waiting to receive the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) services;

(2) The individual is participating in ADATSA residential or outpatient treatment; or

(3) The individual has chosen opiate dependency (methadone maintenance) chemical dependency treatment services instead of other ADATSA treatment, but only if these treatment services are from a state-approved, publicly funded opiate dependency/methadone maintenance program.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. 12-19-051, § 182-508-0375, filed 9/13/12, effective 10/14/12.]