

(3) Other means considered by the board to represent true costs savings or enhanced generation of revenue.

[Statutory Authority: Chapter 41.60 RCW. 99-24-092, § 383-07-115, filed 11/30/99, effective 1/1/00; 92-09-048, § 383-07-115, filed 4/10/92, effective 5/11/92.]

WAC 383-07-120 Distribution of awards. Awards shall be distributed to employees and supervisors of the team identified as team members in the final report as follows:

(1) If the board determines in its judgment that a team qualifies for an award, the board shall authorize payment of the award to the team a percentage of net savings as negotiated between the team and agency management. The percentage of actual net savings and/or revenue generated shall not exceed twenty-five percent of the total net savings and/or revenue to be shared among team members.

(2) The team award shall be divided and distributed in equal shares to members of the team, except those who have worked within the team for less than the TIP project period or less than full time during the project period shall receive a pro rata share based upon the fraction of the TIP project period worked.

(3) No individual share of the team award shall exceed ten thousand dollars per person, which is the maximum award allowed in RCW 41.60.041(2) and WAC 383-07-125(2).

(4) Funds for paying awards shall be drawn from the agency in which the team is located. Awards for generating increased revenue to a state fund or account may be paid from the benefitted fund or account. Awards may be paid to teams for process changes which generate new or additional money for the general fund or any other funds of the state. The director of the office of financial management shall distribute moneys appropriated for this purpose with the concurrence of the productivity board. Transfers shall be made from other funds of the state to the general fund in amounts equal to award payments made by the general fund, for innovations generating new or additional money for those funds. Awards may only be given for savings derived and/or revenue generated for the state.

(5) Teams not demonstrating cost efficiencies may receive special recognition of merit in the form and manner determined by the board.

[Statutory Authority: Chapter 41.60 RCW. 99-24-092, § 383-07-120, filed 11/30/99, effective 1/1/00; 92-09-048, § 383-07-120, filed 4/10/92, effective 5/11/92; 89-19-006, § 383-07-120, filed 9/7/89, effective 10/8/89; 88-15-033 (Order 88-1), § 383-07-120, filed 7/14/88.]

WAC 383-07-125 Payment award scale. The following payment award scale shall be developed by the productivity board. TIP awards shall be based on the following:

(1) Team awards are based on a percentage of the savings and/or revenue determined by the team and agency management during the application process. The total team award shall not exceed twenty-five percent of the actual net savings and/or net revenue generated to the state for the TIP project period. The team award shall be divided among the team members.

(2) No award may be granted in excess of ten thousand dollars.

(3) No cash awards shall be given for team projects that do not produce actual cost savings or generate revenue to the state.

[Statutory Authority: Chapter 41.60 RCW. 99-24-092, § 383-07-125, filed 11/30/99, effective 1/1/00.]

WAC 383-07-130 Award authorization and payment procedures. Following approval of a teamwork incentive award by the productivity board, the program manager shall submit a notice to the agency authorizing payment of awards in accordance with RCW 41.60.120 and WAC 383-07-125.

(1) The award authorization notice shall include:

(a) The total amount of savings and/or revenue;

(b) The team award based upon the percentage specified by WAC 383-07-125; and

(c) A list of employees and the amount of each individual's award share.

(2) The award authorization notice shall be sent to the agency's TIP liaison for processing payments of awards and fees. A copy of the authorization shall be forwarded to the team supervisor.

(3) The award authorization notice shall be sent as soon as possible following board action.

(4) The agency shall arrange for payment of awards in a timely manner.

[Statutory Authority: Chapter 41.60 RCW. 99-24-092, § 383-07-130, filed 11/30/99, effective 1/1/00; 92-09-048, § 383-07-130, filed 4/10/92, effective 5/11/92; 89-19-006, § 383-07-130, filed 9/7/89, effective 10/8/89; 88-15-033 (Order 88-1), § 383-07-130, filed 7/14/88.]

Title 388 WAC

SOCIAL AND HEALTH SERVICES, DEPARTMENT OF (PUBLIC ASSISTANCE)

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Chapter 388-01 WAC

DSHS ORGANIZATION/DISCLOSURE OF PUBLIC
RECORDS

WAC

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WAC 388-01-010 What are the purposes of this chapter? The purposes of this chapter are to:

- (1) Describe the organization of the department of social and health services (DSHS);
- (2) Ensure that DSHS complies with laws governing the disclosure (release) of public records; and
- (3) Explain how an individual or organization can obtain public records.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-010, filed 7/19/99, effective 8/19/99.]

WAC 388-01-020 What is DSHS and how is DSHS organized? (1) DSHS was created to unite related statewide social and health service programs within a single agency. DSHS programs are designed to protect the general public, as well as persons who are unable to fully care for themselves or meet their basic needs.

- (2) It is organized into seven administrations plus the secretary's and deputy secretary's offices:
 - (a) Aging and adult services,
 - (b) Children's services,
 - (c) Economic services,
 - (d) Health and rehabilitative services,
 - (e) Juvenile rehabilitation,
 - (f) Management services, and
 - (g) Medical assistance.

(3) To request an organizational chart, contact: DSHS, Office of the Secretary, P.O. Box 45010, Olympia, WA 98504-5010, or telephone number (360) 902-7800.

(4) DSHS has offices in the community to serve clients. Local DSHS offices have various names, such as community services office (CSO), regional offices, home and community services (HCS), division of child support (DCS), children's services, division of developmental disabilities (DDD) field service offices, and facilities.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-020, filed 7/19/99, effective 8/19/99.]

WAC 388-01-030 What department records are considered public? (1) Public records are those records that are not confidential or otherwise exempt from release to the public. DSHS prepares and keeps public records that relate to the programs it administers.

(2) Different types of public records may include: documents, audio and video recordings, pictures, electronic disks, and magnetic tapes.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-030, filed 7/19/99, effective 8/19/99.]

WAC 388-01-040 What public records are available for release? (1) Public records kept by DSHS are available for release unless the law specifically excludes (or exempts) them.

(2) For a list of public records that are excluded from public disclosure by law, see RCW 42.17.310 through RCW 42.17.31911, and other disclosure laws specific to DSHS programs.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-040, filed 7/19/99, effective 8/19/99.]

WAC 388-01-050 Who should be contacted to request a public record? An individual should contact the public disclosure coordinators at DSHS offices to request a public record. Public disclosure coordinators are located at local community service offices (CSO), regional offices, home and community services (HCS), division of child support (DCS), children's services, DDD field services offices, DSHS facilities, and within each DSHS administration.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-050, filed 7/19/99, effective 8/19/99.]

WAC 388-01-060 How can an individual request a public record? (1) An individual can request a public record orally or in writing. DSHS encourages that all public record requests be in writing on a "request for disclosure of DSHS records" form, DSHS 17-041(X). Individuals may request this form from DSHS, Forms and Records Management Services, P.O. Box 45805, Olympia, WA 98504-5805, (360) 664-6120, or e-mail at DSHSFormsRecordsMgmt@dshs.wa.gov.

(2) If the form is not used, the written public record request should include the following information:

(a) The requester's name, organization, mailing address, telephone number, fax number, and e-mail address;

(b) The date of the request;

(c) A detailed description of the public record being requested;

(d) The address where copies of the record are to be mailed, or if the requester wants to examine the record at DSHS; and

(e) The signature of the requester.

(3) An individual can fill out a record request at a DSHS office, or send it by regular mail, electronic mail, or fax to the public disclosure coordinator at the appropriate DSHS office.

(4) DSHS may ask an individual requesting a public record for personal identification when the law makes a record disclosable to a specific person.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-060, filed 7/19/99, effective 8/19/99.]

WAC 388-01-070 When can a public record be examined? (1) Individuals can examine public records during DSHS office hours. The office hours are 8:00 a.m. to noon and 1:00 p.m. to 5:00 p.m., Monday through Friday, except for legal holidays. Contact the public disclosure coordinator in the appropriate office to arrange a time to examine the public record.

(2) In order to preserve the record or prevent interference in the performance of departmental duties, DSHS reserves the right to restrict an individual's ability to examine or copy public records. This does not prevent DSHS from providing copies of the public record by mail.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-070, filed 7/19/99, effective 8/19/99.]

WAC 388-01-080 Does DSHS charge for examining or copying public records? (1) There is no fee for examining public records.

(2) DSHS charges one or more of the following fees for copies of public records:

(a) Up to fifteen cents per page for black and white photocopies of a record;

(b) The actual cost of manuals, blueprints, and other non-printed materials such as audio or video tapes; and

(c) The cost of postage, when items are mailed (see RCW 42.17.260).

(3) Government agencies, or DSHS clients involved in an administrative hearing procedure, may receive public records reasonably related to the hearing free of charge.

(4) DSHS may waive copying and postage fees if:

(a) Providing a copy of the record assists in managing a program; or

(b) The expense of billing exceeds the copying and postage costs.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-080, filed 7/19/99, effective 8/19/99.]

WAC 388-01-090 When and how must DSHS respond to a public record request? Within five business days after receiving the public record request, DSHS must review the public record and must:

(1) Provide the public record; or

(2) Acknowledge receipt of the request, and give the DSHS date for response; or

(3) Deny the request in writing, noting the reason(s) for denial.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-090, filed 7/19/99, effective 8/19/99.]

WAC 388-01-100 When might DSHS need to extend the time to respond to a public record request? (1) DSHS might need to extend the time to respond to a public record request to:

- (a) Locate and gather the information requested;
- (b) Notify an individual or organization affected by the request; and/or
- (c) Determine whether the information requested is exempt and whether all or part of the public record requested can be released; and/or
- (d) Contact the individual requesting the public record to clarify the intent, scope or specifics of the request. If the individual requesting the public record fails to clarify the request, DSHS does not have to respond to the request.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-100, filed 7/19/99, effective 8/19/99.]

WAC 388-01-110 What if an individual thinks DSHS is unreasonably delaying the release of a public record? If an individual requesting a public record thinks DSHS is unreasonably delaying the release of a public record, the individual may:

- (1) Petition the public disclosure coordinator to release the public record before the date indicated on DSHS response (see WAC 388-01-090); or
- (2) File a lawsuit in superior court to require DSHS to release the public record.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-110, filed 7/19/99, effective 8/19/99.]

WAC 388-01-120 What if the public record that is requested contains information that is exempt from public disclosure? (1) If the requested public record contains information that is exempt from public disclosure, DSHS may:

- (a) Release the nonexempt portion, explaining what exemption applies to the deleted portion of the record; or
 - (b) Deny release of the entire record, sending a written explanation citing the exemption that applies to the denial.
- (2) DSHS may release information to law enforcement officers and United States immigration officials to the extent authorized by RCW 74.04.062.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-120, filed 7/19/99, effective 8/19/99.]

WAC 388-01-130 What are an individual's options if DSHS denies a public record request? If DSHS denies a public record request, an individual may do any of the following:

- (1) Petition for a review of the denied request from the denying public disclosure coordinator or a director approved designee. Contact DSHS to obtain a petition form (DSHS 17-062(X)) at: DSHS Forms and Records Management Services, P.O. Box 45805, Olympia, WA 98504-5805, (360) 664-6120, or e-mail DSHSFormsRecordsMgmt@dshs.wa.gov. DSHS has two business days after receiving the

petition to respond. If DSHS upholds the denial, the decision is considered final; or

- (2) Ask the office of the attorney general to review the public record request.

(a) Send a copy of the denied public record request and the DSHS written denial to:

Office of Attorney General
Public Records Review
P.O. Box 40100
Olympia WA 98504-0100

(b) The office of the attorney general will review the request and DSHS denial. The office of attorney general issues a written opinion as to whether the requested public record is excluded from disclosure.

(3) File a lawsuit for release of a public record in superior court in the county where the public record is located.

(a) DSHS must establish that its denial of a public record is legal.

(b) If the DSHS denial is reversed, the court may require DSHS to pay costs and attorney fees. DSHS may be fined five dollars to one hundred dollars a day for each day they denied the public record.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-130, filed 7/19/99, effective 8/19/99.]

WAC 388-01-140 If a public record contains personal information that identifies an individual or organization, other than the subject of the record, is that individual or organization notified? (1) If a public record contains personal information that identifies an individual or organization other than the subject of the requested public record, DSHS may notify that individual or organization.

(2) DSHS may send a written notice to the individual or organization if releasing the personal information could damage the individual or organization, or government operations, or is not in the best interest of the public. The notice should include:

- (a) The record being requested;
- (b) The date DSHS intends to release the record; and
- (c) How the individual or organization can prevent release of the record (see RCW 42.17.330).

(3) DSHS may also send a written notice to the record requester notifying them that:

(a) The individual or organization whose personal information is contained in the requested public record has been notified;

(b) DSHS expects a response from the individual or organization regarding disclosure of their personal information by a specified date; and

(c) Disclosure may be denied.

(4) DSHS releases the record by the specified date if no one objects or the contacted party does not respond by the specified date.

(5) DSHS must notify the office of the attorney general when an individual or organization, other than the subject of a record, files a lawsuit to prevent release of the record.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-140, filed 7/19/99, effective 8/19/99.]

WAC 388-01-150 Can an individual's record be requested by his or her representative? (1) An individual's attorney, legal guardian, or lay representative can request the individual's record with a signed written release.

(2) The written release must include:

- (a) The identity of the individual(s) or organization(s) authorized to receive the records;
- (b) An identification of the record(s), or part of the record, that the individual wants released; and
- (c) The date the release expires.

(3) DSHS may ask for identification verifying the representatives's relationship to the individual.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-150, filed 7/19/99, effective 8/19/99.]

WAC 388-01-160 Is DSHS required to create public records for requesters? (1) DSHS is only required to provide access to existing, identifiable public records in its possession at the time of the request (see RCW 42.17.270).

(2) DSHS is not required to collect information to create a public record that does not exist at the time of the public record request.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-160, filed 7/19/99, effective 8/19/99.]

WAC 388-01-170 Can DSHS release public records to its offices and to outside agencies? (1) For the purposes of this chapter, outside agencies include, but are not limited to, group homes, mental health centers, drug and alcohol agencies, and other state agencies.

(2) DSHS may release public records to its offices and to outside agencies when the information relates to the administration of DSHS programs unless exempt by 45 C.F.R. 205.50 or other law.

(3) If an outside agency requests a public record for reasons other than information that relates to the administration of DSHS programs, the outside agency must have the individual's written authorization.

(4) Outside agencies receiving information are subject to applicable disclosure confidentiality laws.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-170, filed 7/19/99, effective 8/19/99.]

WAC 388-01-180 Who should be contacted to review an interpretive or policy statement index, or to get a copy of the documents? DSHS issues administrative policy statements that apply to the whole department. Administrations may issue policies and interpretive statements that relate to their own programs. See RCW 34.05.010.

(1) To receive a copy of a DSHS administrative policy, send a written request to: Office of Legal Affairs, Rules and Policies Assistance Unit, P.O. Box 45850, Olympia, Washington 98504-5850.

(2) To receive a copy or review a specific administration's policies or interpretive statements, send a written request to the administration.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-180, filed 7/19/99, effective 8/19/99.]

WAC 388-01-190 How can an individual get an index of DSHS significant decisions? (1) The DSHS board of appeals reviews and selects orders and creates an index of significant decisions that substantially affect DSHS performance (see RCW 42.17.260).

(2) The index:

- (a) Is divided into program categories;
- (b) Contains a copy or synopsis of the order; and
- (c) Is updated, as needed.

(3) An individual can inspect or request a copy of the index by contacting the board of appeals located at:

Board of Appeals
 Blake Office Park
 4500 - 10th Avenue Southeast
 Lacey, WA 98503-5803
 (360) 664-6100

Mailing address:
 Board of Appeals
 P.O. Box 45803
 Olympia, WA 98503-5803

(4) An individual may ask the board of appeals to index an order as a significant decision by sending a written request with a copy of the order to the mailing address.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-190, filed 7/19/99, effective 8/19/99.]

WAC 388-01-200 How are petitions for declaratory orders filed? (1) First, read the information on declaratory orders in RCW 34.05.240 and WAC 10-08-250, 10-08-251, and 10-08-252.

(2) Next, file the petition with the Rules and Policies Assistance Unit; DSHS; P.O. Box 45850; Olympia, WA 98504-5850.

[Statutory Authority: RCW 42.17.250 and 34.05.220. 99-15-065, § 388-01-200, filed 7/19/99, effective 8/19/99.]

Chapter 388-04 WAC

PROTECTION OF HUMAN RESEARCH SUBJECTS

(Formerly chapter 388-10 WAC)

WAC

388-04-010	Purpose.
388-04-020	Definitions.
388-04-030	Statement of policy.
388-04-040	Implementation.
388-04-050	General applicability.
388-04-060	Documentation of research proposals and review dispositions.
388-04-070	Human research review guidelines.

WAC 388-04-010 Purpose. The purpose of this chapter shall be to establish rules implementing the department's policy for the protection of departmental wards, clients, and employees who serve as human subjects in research and related activities. These rules do not supersede or limit the applicability of other state and federal laws and regulations. For example, see Title 45, Part 46 of the Code of Federal Regulations.

[99-15-021, recodified as § 388-04-010, filed 7/12/99, effective 7/12/99. Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-010, filed 8/12/81.]

WAC 388-04-020 Definitions. (1) "Research" means a systematic investigation designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute "research" for purposes of these rules, whether or not they are supported or conducted under this label.

(2) "Related activities" means demonstration, service, development, and other projects that contain a research component.

(3) "Human subject" means a person about whom an investigator (whether professional or student) conducting research obtains data (a) through intervention or interaction with the person, (b) through observation of the person's behavior, or (c) from personal records and other private information sources.

[99-15-021, recodified as § 388-04-020, filed 7/12/99, effective 7/12/99. Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-020, filed 8/12/81.]

WAC 388-04-030 Statement of policy. (1) No service unit or administrative unit within the department's jurisdiction shall allow, or shall participate in, the conduct of research and related activities unless the plans or protocols for such activities have been reviewed and approved by the department of social and health services human research review board or have been specifically exempted from this review requirement by published departmental guidelines.

(2) It is the intent of the department's human subjects protection policy that review of research and related activities by the review board determine that the rights and welfare of clients, wards, and employees are adequately protected; that risks to individuals are minimized, are not unreasonable and are outweighed by the potential benefits to them or by the knowledge to be gained; and that the proposed project design and methods are adequate and appropriate in the light of stated project purposes.

[99-15-021, recodified as § 388-04-030, filed 7/12/99, effective 7/12/99. Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-030, filed 8/12/81.]

WAC 388-04-040 Implementation. (1) The department shall maintain a human research review board which shall have primary responsibility for the ethical and technical review of the use of human subjects in research and related projects conducted within the department's jurisdiction. Unfavorable review dispositions by this review board, including disapproval of proposed research, research restrictions, or special approval conditions, cannot, by federal regulation (45 CFR 46.112) be removed except by the review board. Favorable review decisions by the board shall be subject to review and concurrence by appropriate departmental officials.

(2) To assure continued protection of human subjects in on-going research at the activity site, departmental service units involved in a significant number of research and related activities shall establish their own research oversight committees. These local committees shall function as extensions of the human research review board. They shall be responsi-

ble for providing ethical and procedural oversight in accordance with the review board's directions.

(3) Review of proposals requiring professional competencies beyond those represented on the human research review board shall require prior and written review consultation with at least four research experts who are competent to judge the scientific merit, benefits, and risks of the proposed research.

[99-15-021, recodified as § 388-04-040, filed 7/12/99, effective 7/12/99. Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-040, filed 8/12/81.]

WAC 388-04-050 General applicability. The department's human research review rules shall apply to all organizational units of the department. They shall apply to all research and related activities that involve departmental clients, wards, or employees as human subjects or that require disclosure of their personal records, regardless of funding source, and regardless of whether the research is conducted by a departmental employee or by a nondepartmental investigator. The rules shall apply to all research and related activities subcontracted by the department under state and federal grants and contracts to nondepartmental organizations and individuals, regardless of whether the research or related activity involves departmental clients or a nondepartmental subject population.

[99-15-021, recodified as § 388-04-050, filed 7/12/99, effective 7/12/99. Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-050, filed 8/12/81.]

WAC 388-04-060 Documentation of research proposals and review dispositions. (1) All research and related activity proposals subject to review under WAC 388-10-050 shall be submitted in writing and such proposals shall conform to the format and content guidelines published by the department.

(2) The director of the departmental unit responsible for human research review policy administration shall document in writing all review dispositions affecting research and related activity proposals submitted to the department. In the case of unfavorable dispositions, such documentation shall contain a statement of the reasons for the negative disposition.

[99-15-021, recodified as § 388-04-060, filed 7/12/99, effective 7/12/99. Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-060, filed 8/12/81.]

WAC 388-04-070 Human research review guidelines. (1) The department shall develop and publish a comprehensive set of procedural guidelines for the protection of human research subjects within its jurisdiction. These guidelines shall be at least as restrictive as the minimum requirements set forth in Title 45, Part 46 of the Code of Federal Regulations, but may be more restrictive if necessary to satisfy the protective purposes of the department's human subjects protection policy.

(2) The published guidelines shall speak at least to the following topics:

- (a) Applicability;
- (b) Responsibility for policy and rule implementation;

- (c) Basic definitions;
- (d) Proposal format and content;
- (e) Review and certification requirements;
- (f) Activities exempt from review requirements;
- (g) Approval and disapproval authority; appeals;
- (h) Qualification requirements for investigators;
- (i) Review board composition and functions;
- (j) Review of ongoing research projects;
- (k) Informed consent requirements;
- (l) Disclosure of personal records for research purposes;
- (m) Publication conditions;
- (n) Provisions for adapting guidelines to the changing requirements of state and federal laws and regulations.

[99-15-021, recodified as § 388-04-070, filed 7/12/99, effective 7/12/99. Statutory Authority: RCW 43.20A.550, 81-17-022 (Order 1687), § 388-10-070, filed 8/12/81.]

**Chapter 388-07 WAC
ABBREVIATIONS**

WAC
388-07-005 Repealed.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

388-07-005 Acronyms. [Statutory Authority: RCW 74.08.090, 89-12-078 (Order 2807), § 388-07-005, filed 6/7/89; 81-01-013 (Order 1572), § 388-07-005, filed 12/8/80; Order 1044, § 388-07-005, filed 8/14/75; Order 615, § 388-07-005, filed 10/7/71; Order 523, § 388-07-005, filed 3/31/71, effective 5/1/71.] Repealed by 99-24-054, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 74.08.090.

WAC 388-07-005 Repealed. See Disposition Table at beginning of this chapter.

**Chapter 388-08 WAC
PRACTICE AND PROCEDURE—FAIR HEARING**

WAC
388-08-410 Application of chapter 388-08 WAC.
388-08-413 Application for an adjudicative proceeding.
388-08-437 Filing and service of papers.
388-08-440 Vacating an order of dismissal for reason of default or withdrawal.
388-08-464 Petition for review—Response to petition—Disqualification of review judge.
388-08-470 Reconsideration.
388-08-515 Notice to limited-English-speaking parties.
388-08-555 Separate hearing regarding disclosure of investigative and intelligence files.
388-08-575 Judicial review of final adjudicative order.

WAC 388-08-410 Application of chapter 388-08 WAC. (1) Scope. This chapter applies to adjudicative proceedings begun on or after July 1, 1989, in programs administered by the department of social and health services (DSHS). The definition of the word "begun" is receipt of the application for an adjudication proceeding as provided in WAC 388-08-413(3). Proceedings begun before July 1, 1989, are governed by the procedural rules in effect on June 30, 1989. Legal authority for adopting this chapter is RCW 34.05.220 (1)(a).

(2) Conflict of rules. If a provision in this chapter conflicts with a provision in the chapter containing the program's substantive rules, the provision in the chapter containing the program's substantive rules governs.

(3) Presiding officer. The presiding officer shall be either an administrative law judge (ALJ) from the office of administrative hearings or a review judge from the DSHS board of appeals. References to ALJ in this chapter apply to a review judge when a review judge is the presiding officer.

(4) Reviewing officer. The reviewing officer shall be the secretary or a review judge from the DSHS board of appeals.

(5) Physical and mailing addresses:

(a) ALJ administrative and field office addresses are listed under WAC 10-04-020. The mailing address for applications for adjudicative proceedings or requests for hearing in DSHS programs before the office of administrative hearings is: Office of Administrative Hearings, P.O. Box 2465, Olympia WA 98507-2465 or the address of the assigned field office.

(b) The DSHS board of appeals is located in the Blake Office Park, 4500 - 10th Avenue Southeast, Lacey, Washington and the mailing address is Board of Appeals, P.O. Box 45803, Olympia, WA 98504-5803.

[Statutory Authority: RCW 34.05.220 and 34.05.413, 99-16-023, § 388-08-410, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 34.05.220 (1)(a), 90-04-076 (Order 2999), § 388-08-410, filed 2/5/90, effective 3/1/90.]

WAC 388-08-413 Application for an adjudicative proceeding. (1) Who may apply. Any person or authorized representative may file an oral or written application for an adjudicative proceeding.

(2) Form of application. The application need not be in any particular form but should specify the decision being appealed and the reasons the appellant is dissatisfied with the decision.

(3) Application.

(a) An oral application shall be made to a responsible department or office of administrative hearings employee.

(b) A written application should be filed at the office of administrative hearings at the address in WAC 388-08-410 (5)(a). However, the application can be filed with any responsible department or office of administrative hearings employee.

[Statutory Authority: RCW 34.05.220 and 34.05.413, 99-16-023, § 388-08-413, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 34.05.220 (1)(a), 90-04-076 (Order 2999), § 388-08-413, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 34.04.020, 84-05-040 (Order 2076), § 388-08-413, filed 2/17/84; 79-09-054 (Order 1426), § 388-08-413, filed 8/24/79.]

WAC 388-08-437 Filing and service of papers. (1) Service required when filing. A party filing a pleading, brief, or other paper, except an application for an adjudicative proceeding, with the board of appeals or the office of administrative hearings shall serve a copy of the paper upon:

(a) Every other party; or

(b) If the other party is represented or has an agent, the other party's representative or agent.

(2) Filing and service made by. Unless otherwise provided by law, filing and service shall be made by:

(a) Personal service;

- (b) First class, registered, or certified mail;
 - (c) Telegraph;
 - (d) Electronic telefacsimile transmission and same-day mailing of copies; or
 - (e) Commercial parcel delivery company.
- (3) Filing complete. Filing with the board of appeals shall be complete upon actual receipt during office hours at the board of appeals. Filing with the office of administrative hearings shall be complete upon actual receipt during office hours at any field or administrative office.
- (4) Service complete. Service shall be complete when:
- (a) Personal service is made;
 - (b) Mail is properly stamped and addressed and is deposited in the United States mail;
 - (c) A properly addressed telegram is deposited with a telegraph company with charges prepaid;
 - (d) An electronic telefacsimile transmission produces proof of transmission; or
 - (e) A commercial parcel is delivered to the parcel delivery company with charges prepaid.
- (5) Proof of service. Where proof of service is required by statute or rule, filing the papers with the board of appeals or the office of administrative hearings, together with one of the following, shall constitute proof of service:
- (a) An acknowledgement of service;
 - (b) A certificate of service including the date the papers were served upon all parties and the signature of the serving party indicating service was completed under subsection (4) of this section.

[Statutory Authority: RCW 34.05.220 and 34.05.413. 99-16-023, § 388-08-437, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-08-437, filed 2/5/90, effective 3/1/90.]

WAC 388-08-440 Vacating an order of dismissal for reason of default or withdrawal. (1) Right to request. The parties shall have the right to file a written request to vacate an order of dismissal for reason of default or withdrawal.

(2) Contents. The request shall state the grounds relied upon.

(3) Time limits.

(a) The period to file a request is twenty-one days from the date the administrative law judge (ALJ) serves the order of dismissal.

(b) The ALJ shall waive the twenty-one day limit for filing a request when a person:

(i) Files a request within thirty days of the date the order becomes final; and

(ii) Demonstrates good cause for failure to file a timely request. Good cause means one of the grounds enumerated in Court Rule 60 and includes:

(A) A person's mistake, inadvertence, or excusable neglect preventing the person from timely filing a request; or

(B) An unavoidable casualty or misfortune preventing the person from timely filing a request.

(4) Filing. The person shall file the request at the board of appeals or the office of administrative hearings.

(5) Grounds to vacate an order of dismissal. When, in the reasoned opinion of the ALJ, good cause to grant the relief is shown, the ALJ shall vacate the order of dismissal and reinstate the application.

[Statutory Authority: RCW 34.05.220 and 34.05.413. 99-16-023, § 388-08-440, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-08-440, filed 2/5/90, effective 3/1/90.]

WAC 388-08-464 Petition for review—Response to petition—Disqualification of review judge. (1) Initial orders that may become final orders.

(a) If a petition for review is not filed within twenty-one days from service of the initial order, the initial order shall, subject to the provisions of this section, become the final order.

(b) An initial order shall not become the final order after a food stamp administrative disqualification hearing. Each party shall have the right to file a petition for review of the administrative law judge's order. Whether a petition for review is or is not filed, the review judge shall enter the final order on behalf of the secretary.

(2) Who may petition. Each party has the right to file a petition for review of an order entered by an administrative law judge.

(3) Petition contents. The petition for review shall:

(a) Specify the portions of the order to which exception is taken; and

(b) Refer to the evidence of record relied upon to support the petition.

(4) Petition time limits.

(a) The period to timely file a petition for review is twenty-one days from the date the initial decision was served.

(b) A review judge shall extend the twenty-one-day period to file a petition for review upon request of a party when:

(i) The request is made during the twenty-one-day period; and

(ii) Good cause for the extension is shown.

(c) The review judge shall waive the twenty-one-day limit for filing a petition for review when a person:

(i) Files a petition for review within thirty days of the date the initial order becomes final; and

(ii) Demonstrates good cause for failure to file a timely petition. Good cause means one of the grounds enumerated in Court Rule 60 and includes:

(A) A petitioner's mistake, inadvertence, or excusable neglect preventing the petitioner from timely filing a petition; or

(B) An unavoidable casualty or misfortune preventing the petitioner from timely filing a petition for review.

(5) Petition filing and service. The petition for review shall be in writing and filed with the board of appeals at the address in WAC 388-08-410 (5)(b). The petitioning party is encouraged to serve a copy of the petition upon the other party or the other party's representative at the time the petition is filed. The board of appeals shall serve a copy on the other party or representative.

(6) Notice of petition. When a petition for review is filed, the board of appeals shall send a copy of the petition to the nonpetitioning party and, if represented, to the representative with a notice of the right to file a response.

(7) Response time limit, filing, service.

(a) The nonpetitioning party shall file any response with the board of appeals within seven days of the date of service

of a copy of the petition on the nonpetitioning party or representative.

(b) The nonpetitioning party shall serve a copy of the response on the petitioner and any other party or, if represented, on the representative at the time the response is filed.

(c) A review judge may extend the period to file a response upon request of a party showing good cause.

(d) A review judge may, in the review judge's discretion, accept a late filed response and consider the response when ruling on a petition for review.

(8) Disqualification. The board of appeals shall disclose the name of the review judge assigned to rule on a petition to any party or representative making inquiry. An individual petitioning to disqualify a review judge under RCW 34.05.425 shall file the petition with the review judge assigned to the proceeding.

[Statutory Authority: RCW 34.05.220 and 34.05.413. 99-16-023, § 388-08-464, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-08-464, filed 2/5/90, effective 3/1/90.]

WAC 388-08-470 Reconsideration. Within ten days of service of a review order, any party may file a petition for reconsideration. A review judge shall extend the period to file a petition upon request of a party made during the ten-day filing period when good cause for the extension is shown. The petition shall state the specific grounds upon which relief is requested. A petition for reconsideration shall be filed at the board of appeals at the address in WAC 388-08-410 (5)(b).

[Statutory Authority: RCW 34.05.220 and 34.05.413. 99-16-023, § 388-08-470, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-08-470, filed 2/5/90, effective 3/1/90.]

WAC 388-08-515 Notice to limited-English-speaking parties. This section applies when the board of appeals or the office of administrative hearings is notified or otherwise made aware that a limited-English-speaking person is a party in an adjudicative proceeding. All notices concerning the proceedings, including notices of hearing, continuance, and dismissal shall:

- (1) Be written in the primary language of the party; or
- (2) Include a notice in the primary language of the party describing:

- (a) The significance of the notice; and
- (b) How the party may receive assistance in understanding the notice and, if necessary, responding to the notice.

[Statutory Authority: RCW 34.05.220 and 34.05.413. 99-16-023, § 388-08-515, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-08-515, filed 2/5/90, effective 3/1/90.]

WAC 388-08-555 Separate hearing regarding disclosure of investigative and intelligence files. (1) Applicability and request to the division of fraud investigation (DFI). When the appellant seeks disclosure of a record maintained by the DFI subject to the exemption under WAC 388-01-040, the following process shall determine whether, on a case-by-case basis, disclosure shall be ordered:

(a) The appellant or the appellant's representative shall file a written request with the office of administrative hearings, no later than fourteen days before the hearing;

(b) The request shall identify the record sought;

(c) The request shall state the reasons why the appellant believes disclosure is necessary;

(d) The request shall identify the local community service office or the DFI field office where the appellant wishes to review the record;

(e) The office of administrative hearings shall forward a request copy to the DFI at its headquarters office in Olympia; and

(f) Upon the appellant's showing of good cause, the ALJ may shorten the fourteen-day notice period.

(2) DFI action.

(a) Within ten days of receipt of a properly filed request, the DFI shall determine whether the record sought is within an exemption to disclosure.

(b) Any exempt record shall be:

(i) Sealed in an envelope clearly designated as an exempt or confidential record of the DFI;

(ii) Placed in the DFI file;

(c) The DFI shall then notify the appellant or representative, in writing, of the:

(i) DFI's action; and

(ii) Appellant's or representative's right to a disclosure hearing.

(iii) If any information is placed in a sealed envelope and excluded from disclosure, the notice shall state the specific exemption relied upon for this action. The notice shall provide the appellant a ten-day opportunity to inspect the DFI file by the person, or the person's representative, at the community service office or DFI field office designated by the appellant. In no event shall the investigative file leave the physical control of the designated DFI records custodian, provided the appellant may copy all documents not sealed in an envelope designated as exempt or confidential.

(d) If no amended disclosure request under subsection (3) of this section is filed, the issue of disclosure shall be regarded as moot.

(3) ALJ action. If the appellant wants further disclosure, the appellant shall file an amended disclosure request with the ALJ. The ALJ shall schedule a separate, *in camera* hearing to determine whether, and to what extent, to allow the disclosure of an exempted record.

(a) The department shall have the burden of proving, by a preponderance of the credible evidence, whether the necessity to protect an exempt record or confidential information clearly outweighs the disclosure interests.

(b) Either party may offer witnesses to testify on the disclosure issue. When the appellant calls witnesses from the state, investigative, law enforcement, or penology agencies as adverse witnesses, the appellant may ask leading questions.

(c) Attendance shall be limited to the parties, the parties' representatives, the ALJ, and any witnesses to be called provided, upon the request of either party or upon the ALJ's own motion, the ALJ may exclude nontestifying witnesses from the hearing.

(d) In determining whether to disclose information to the appellant, the ALJ shall review the information, but shall not disclose the information to the appellant.

(e) The ALJ shall enter an initial order.

(i) If the information sought is pertinent to any ongoing criminal investigation, disclosure shall only be ordered by a superior court of this state.

(ii) The ALJ shall order nondisclosure of specific information consistent with law after making findings of fact showing:

(A) The information sought to be disclosed is inadmissible and immaterial to establishing a defense; or

(B) Specific investigative or intelligence information, which cannot be deleted from any specific records sought, is clearly necessary to protect any vital governmental function, ongoing criminal investigation, or an individual's right of privacy; or

(C) After weighing the public interest in protecting the flow of information against the individual's right to prepare the individual's defense, the evidence demonstrates it is not necessary to disclose particular intelligence or investigative information.

(iii) An order for disclosure shall state the times and methods for record inspection. In no event shall such order compel the release of an original record but, rather, where release is ordered, copies shall be provided. Copying a record shall be governed by WAC 388-01-080.

(f) Each party has the right to file a petition for review of the initial order under WAC 388-08-464. There shall be no disclosure under an initial order until exhausting all review proceedings.

(4) Assignment of new ALJ. When the ALJ conducts the *in camera* review under subsection (3) of this section and determines information should not be disclosed to the appellant, the chief ALJ or the chief ALJ's designee shall assign another ALJ to preside over the adjudicative proceeding.

[Statutory Authority: RCW 34.05.220 and 34.05.413. 99-16-023, § 388-08-555, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-08-555, filed 2/5/90, effective 3/1/90.]

WAC 388-08-575 Judicial review of final adjudicative order. (1) Right to judicial review; exclusive remedy. An appellant or intervener aggrieved, as described under RCW 34.05.530, by the final decision or order in a department of social and health services (DSHS) adjudicative proceeding may appeal the decision or order to court. Judicial review shall only be obtained under chapter 34.05 RCW. Judicial review may not be obtained through any other procedure.

(a) Chapter 34.05 RCW contains the pertinent provisions of the law.

(b) RCW 74.08.080(3) contains additional provisions about public assistance proceedings.

(2) Instituting judicial review; filing and serving the petition. As described in RCW 34.05.542(2), within thirty days after the department mails the final decision, the petitioner shall file the petition for judicial review with the court and serve a copy of the petition on DSHS, the office of the attorney general, and all parties of record.

(a) A petition shall be filed in the Superior Court at the petitioner's option for:

(i) Thurston County;

(ii) The county of the petitioner's residence or principal place of business; or

(iii) Any county where property affected by the decision is located.

(b) Delivery of a copy of the petition for judicial review on DSHS under RCW 34.05.542(4) may be made by serving a copy of the petition on the secretary or on the board of appeals by personal service or mail that provides proof of receipt. If there is an attorney of record for DSHS, service on the agency may be made by mailing a copy of the petition, postage prepaid, to the attorney of record.

(c) Service of a copy of the petition for judicial review on the office of the attorney general may be made by mailing a copy of the petition, postage prepaid, to the attorney of record or to the Office of the Attorney General, P.O. Box 40124, Olympia, WA 98504-0124.

(d) Service of a copy of the petition for judicial review on other parties of record may be made by mailing a copy of the petition to the other parties, properly addressed and postage prepaid.

[Statutory Authority: RCW 34.05.220 and 34.05.413. 99-16-023, § 388-08-575, filed 7/26/99, effective 8/26/99. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-08-575, filed 2/5/90, effective 3/1/90.]

Chapter 388-10 WAC

PROTECTION OF HUMAN RESEARCH SUBJECTS

WAC

388-10-010 through 388-10-070 Decodified.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-10-010	Purpose. [Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-010, filed 8/12/81.] Decodified by 99-15-021, filed 7/12/99, effective 7/12/99.
388-10-020	Definitions. [Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-020, filed 8/12/81.] Decodified by 99-15-021, filed 7/12/99, effective 7/12/99.
388-10-030	Statement of policy. [Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-030, filed 8/12/81.] Decodified by 99-15-021, filed 7/12/99, effective 7/12/99.
388-10-040	Implementation. [Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-040, filed 8/12/81.] Decodified by 99-15-021, filed 7/12/99, effective 7/12/99.
388-10-050	General applicability. [Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-050, filed 8/12/81.] Decodified by 99-15-021, filed 7/12/99, effective 7/12/99.
388-10-060	Documentation of research proposals and review dispositions. [Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-060, filed 8/12/81.] Decodified by 99-15-021, filed 7/12/99, effective 7/12/99.
388-10-070	Human research review guidelines. [Statutory Authority: RCW 43.20A.550. 81-17-022 (Order 1687), § 388-10-070, filed 8/12/81.] Decodified by 99-15-021, filed 7/12/99, effective 7/12/99.

Reviser's note: Later promulgation, see chapter 388-04 WAC.

WAC 388-10-010 through 388-10-070 Decodified.
See Disposition Table at beginning of this chapter.

Chapter 388-14 WAC
SUPPORT ENFORCEMENT

WAC

388-14-420	Once a support enforcement case is opened, under what circumstances can it be closed?
388-14-421	Under what circumstances may DCS deny a request to close a support enforcement case?
388-14-422	Who is mailed notice of DCS' intent to close a case?
388-14-423	What if I don't agree with the case closure notice?
388-14-424	What happens to payments that come in after a case is closed?
388-14-490	All Washington employers must report new hires to the Washington state support registry.

WAC 388-14-420 Once a support enforcement case is opened, under what circumstances can it be closed? Once the division of child support (DCS) starts providing support enforcement services under RCW 26.23.045 and chapter 74.20 RCW, the case must remain open, unless DCS determines that:

(1) There is no current support order, and the support debt owed by the noncustodial parent (NCP) is less than five hundred dollars, or cannot be enforced under Washington law;

(2) The NCP or putative (alleged) father is dead with no assets, income or estate available for collection;

(3) The NCP has no assets or income available for collection and is not able to provide support during the child's minority because of being:

(a) Institutionalized in a psychiatric facility;

(b) Incarcerated without possibility of parole; or

(c) Medically verified as totally and permanently disabled with no evidence of ability to provide support.

(4) The applicant, agency or recipient of nonassistance services submits a written request for closure, and there is no current assignment of medical or support rights;

(5) DCS has enough information to use an automated locate system, and has not been able to locate the NCP after three years of diligent efforts;

(6) DCS does not have enough information to use an automated locate system, and has not been able to locate the NCP after one year of diligent efforts;

(7) DCS is unable to contact the applicant, agency or recipient of services for at least sixty days;

(8) DCS documents failure to cooperate by the physical custodian or the initiating jurisdiction, and that cooperation is essential for the next step in enforcement;

(9) DCS cannot obtain a paternity order because:

(a) The putative father is dead;

(b) Genetic testing has excluded all putative fathers;

(c) The child is at least eighteen years old;

(d) DCS, a court of competent jurisdiction or an administrative hearing determines that establishing paternity would not be in the best interests of the child in a case involving incest, rape, or pending adoption; or

(e) The biological father is unknown and cannot be identified after diligent efforts, including at least one interview by DCS or its representative with the recipient of support enforcement services.

(10) DCS, a court of competent jurisdiction or an administrative hearing determines that the recipient of services has

wrongfully deprived the noncustodial parent of physical custody of the child as provided in WAC 388-11-065(3);

(11) DCS, the department of social and health services, a court of competent jurisdiction or an administrative hearing determines that action to establish or enforce a support obligation cannot occur without a risk of harm to the child or the physical custodian;

(12) DCS has provided locate-only services in response to a request for state parent locator services (SPLS);

(13) The NCP is a citizen and resident of a foreign country, and:

(a) NCP has no assets which can be reached by DCS; and

(b) The country where NCP resides does not provide reciprocity in child support matters.

(14) The child is incarcerated or confined to a juvenile rehabilitation facility for a period of ninety days or more; or

(15) Any other circumstances exist which would allow closure under 45 CFR 303.11 or any other federal statute or regulation.

[Statutory Authority: RCW 26.23.035, 34.05.220 and 74.20A.310. 99-20-012, § 388-14-420, filed 9/24/99, effective 10/25/99. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.310 and 26.23.035. 97-13-092, § 388-14-420, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090, 45 CFR 303.11 and 45 CFR 303.100. 93-05-020 (Order 3512), § 388-14-420, filed 2/10/93, effective 3/13/93. Statutory Authority: RCW 74.08.090. 90-16-041 (Order 3043), § 388-14-420, filed 7/24/90, effective 8/24/90; 88-07-012 (Order 2606), § 388-14-420, filed 3/4/88.]

WAC 388-14-421 Under what circumstances may DCS deny a request to close a support enforcement case?

(1) The division of child support (DCS) may deny a request to close a support enforcement case when:

(a) There is a current assignment of support or medical rights on behalf of the children in the case;

(b) There is accrued debt under a support order which has been assigned to the state;

(c) Support or medical rights on behalf of the children have previously been assigned to the state;

(d) The person who requests closure is not the recipient of support enforcement services; or

(e) A superior court order requires payments to the Washington state support registry (WSSR).

(2) If there is no current assignment of support or medical rights, DCS may close the portion of the case which is owed to the physical custodian, but if there is accrued debt under a support order which has been assigned to the state, DCS keeps that portion of the case open.

(3) If a superior court order specifies that the noncustodial parent (NCP) must make payments to the WSSR, but the physical custodian does not want support enforcement services, DCS keeps the case open as a payment services only (PSO) case, which means that:

(a) DCS provides payment processing and records maintenance, and

(b) DCS does not provide enforcement services.

[Statutory Authority: RCW 26.23.035, 34.05.220 and 74.20A.310. 99-20-012, § 388-14-421, filed 9/24/99, effective 10/25/99.]

WAC 388-14-422 Who is mailed notice of DCS' intent to close a case? (1) Sixty days before closing a case

the division of child support (DCS) sends a notice of intent to close, advising the parties why DCS is closing the case.

(a) DCS does not send a notice when closing a case under WAC 388-14-420 (11) or (12).

(b) DCS does not provide sixty days' prior notice when closing a case under WAC 388-14-420(4).

(2) DCS mails a notice by regular mail to the last known address of the physical custodian and the noncustodial parent.

(3) In an interstate case, DCS mails the notice to the physical custodian by regular mail in care of the other state's child support agency.

(4) If DCS is closing an interstate case because of noncooperation by the initiating jurisdiction, DCS also mails the notice to the other state's child support agency.

[Statutory Authority: RCW 26.23.035, 34.05.220 and 74.20A.310. 99-20-012, § 388-14-422, filed 9/24/99, effective 10/25/99.]

WAC 388-14-423 What if I don't agree with the case closure notice? (1) Only the person who applied for support enforcement services, also known as the recipient of services, may request a hearing to challenge closure of a case.

(2) If the recipient of services requests a hearing, the other party may participate in the hearing.

(3) The closure of a child support case does not stop the physical custodian or noncustodial parent from filing an application for support enforcement services in the future, but the reason for closure may affect whether the division of child support will open a new case.

[Statutory Authority: RCW 26.23.035, 34.05.220 and 74.20A.310. 99-20-012, § 388-14-423, filed 9/24/99, effective 10/25/99.]

WAC 388-14-424 What happens to payments that come in after a case is closed? After support enforcement services are terminated, DCS returns support money to the noncustodial parent except if the case remains open as a payment services only (PSO) case as described in WAC 388-14-421(4).

[Statutory Authority: RCW 26.23.035, 34.05.220 and 74.20A.310. 99-20-012, § 388-14-424, filed 9/24/99, effective 10/25/99.]

WAC 388-14-490 All Washington employers must report new hires to the Washington state support registry. (1) RCW 26.23.040 requires all employers doing business in the state of Washington to comply with the employer reporting requirements regarding new hires.

(2) The minimum information that must be reported is the employee's name, date of birth, social security number and date of hire.

(3) An employer who submits a copy of the employee's completed W-4 form complies with the filing requirements of RCW 26.23.040(3).

(4) An employer may choose to voluntarily report the other statutory elements.

[Statutory Authority: RCW 26.23.040. 99-20-011, § 388-14-490, filed 9/24/99, effective 10/25/99; 92-13-026 (Order 3403), § 388-14-490, filed 6/9/92, effective 7/10/92.]

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Chapter 388-15 WAC

SOCIAL SERVICES FOR FAMILIES, CHILDREN AND ADULTS

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-15-170	Definitions. [Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-170, filed 10/22/98, effective 11/22/98. Statutory Authority: RCW 74.12.340 and 45 CFR Part 98.41 Child Care and Development Block Grant. 93-10-021 (Order 3535), § 388-15-170, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.12.340 and 45 CFR 98.20, 98.30, 98.43 and 98.45; and 45 CFR 257.21, 257.30, 257.31 and 257.41. 92-11-062 (Order 3393), § 388-15-170, filed 5/19/92, effective 6/19/92. Statutory Authority: RCW 74.08.090. 88-24-023 (Order 2732), § 388-15-170, filed 12/2/88; 86-12-051 (Order 2387), § 388-15-170, filed 6/3/86; 86-03-078 (Order 2333), § 388-15-170, filed 1/22/86; 83-02-028 (Order 1931), § 388-15-170, filed 12/29/82. Statutory Authority: RCW 43.20A.550. 82-14-048 (Order 1839), § 388-15-170, filed 6/30/82. Statutory Authority: RCW 74.08.090. 82-01-051 (Order 1735), § 388-15-170, filed 12/16/81; 81-10-034 (Order 1650), § 388-15-170, filed 4/29/81; 80-15-010 (Order 1552), § 388-15-170, filed 10/6/80. Statutory Authority: RCW 43.20A.550. 78-04-004 (Order 1276), § 388-15-170, filed 3/2/78; Order 1238, § 388-15-170, filed 8/31/77; Order 1204, § 388-15-170, filed 4/1/77; Order 1147, § 388-15-170, filed 8/26/76; Order 1124, § 388-15-170, filed 6/9/76; Order 1120, § 388-15-170, filed 5/13/76; Order 1088, § 388-15-170, filed 1/19/76.] Decodified by 99-15-076, filed 7/20/99, effective 7/20/99. Recodified as 388-165-110.
388-15-171	Subsidized child care for teen parents. [Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-171,

filed 10/22/98, effective 11/22/98.] Decodified by 99-15-076, filed 7/20/99, effective 7/20/99. Recodified as 388-165-120.

388-15-174 Subsidized child care for seasonal workers. [Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-174, filed 10/22/98, effective 11/22/98.] Decodified by 99-19-087, filed 9/17/99, effective 9/17/99.

388-15-175 Child care for child protective services (CPS) and child welfare services (CWS). [Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-175, filed 10/22/98, effective 11/22/98.] Decodified by 99-15-076, filed 7/20/99, effective 7/20/99. Recodified as 388-165-140.

388-15-176 In-home/relative child care. [Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-176, filed 10/22/98, effective 11/22/98.] Decodified by 99-15-076, filed 7/20/99, effective 7/20/99. Recodified as 388-165-235.

WAC 388-15-170 Decodified. See Disposition Table at beginning of this chapter.

WAC 388-15-171 Decodified. See Disposition Table at beginning of this chapter.

WAC 388-15-174 Decodified. See Disposition Table at beginning of this chapter.

WAC 388-15-175 Decodified. See Disposition Table at beginning of this chapter.

WAC 388-15-176 Decodified. See Disposition Table at beginning of this chapter.

WAC 388-15-196 Individual providers and home care agency providers. The intent of WAC 388-15-196 through 388-15-19680 is to describe the:

(1) Qualifications of an individual provider (IP), defined in WAC 388-15-202 (25) and (26);

(2) Qualifications of a home care agency provider, defined in WAC 388-15-202(2);

(3) Conditions under which the department will pay an individual provider; and

(4) Conditions under which the department may deny a contract to an individual provider or terminate payment to an individual provider or a home care agency provider.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-196, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-196, filed 8/27/98, effective 9/27/98. Statutory Authority: RCW 74.04.050, 74.08.090, 74.39A.005, 74.39A.007, 74.39A.050 and 74.39A.070. 97-16-106, § 388-15-196, filed 8/6/97, effective 9/6/97. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-196, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-196, filed 9/28/95, effective 10/29/95.]

WAC 388-15-19600 How do I apply to be an individual provider of an adult client? A person who wants to be an individual provider must contact the client's social worker or case manager.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19600, filed 1/14/99, effective 2/14/99.

Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19600, filed 8/27/98, effective 9/27/98.]

WAC 388-15-19610 What requirements must an adult client's individual provider or a home care agency provider meet? An individual provider or a home care agency provider of an adult must:

(1) Meet the requirements of chapter 246-336 WAC, if employed by a home care agency;

(2) Meet the following requirements, if employed by the client as an individual provider:

(a) Be eighteen years of age or older;

(b) Not be the spouse of the client receiving services, unless the client is on the chore personal care program or the parent of a child age seventeen or younger;

(c) Have no conviction for a disqualifying crime, as listed in RCW 43.43.830 and 43.43.842;

(d) Have no findings of fact or conclusions of law or orders of guilt for abuse, neglect, exploitation or abandonment of a minor or vulnerable adult, as defined in RCW 74.39A.050(8);

(e) Have not had a license or a contract for the care of children or vulnerable adults denied, suspended, or revoked, or terminated; for noncompliance with state and federal regulations;

(f) Have read and understand the client's service plan, translated or interpreted, as necessary, for the client and/or IP; and

(g) Provide the services, as outlined in the client's service plan within the scope of practice in WAC 388-15-203.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19610, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19610, filed 8/27/98, effective 9/27/98.]

WAC 388-15-19620 How do I get paid as an individual provider? In order to be paid by the department, an individual provider must:

(1) Be hired by a client/legal guardian;

(2) Provide the social worker/case manager/designee with a Social Security card and picture identification;

(3) Complete and submit to the social worker/case manager/designee the department's criminal conviction background inquiry application;

(4) Sign a home and community-based service provider contract/agreement to provide services to a COPEs or Medicaid personal care client, or other department contract or agreement; and

(5) Meet the conditions in WAC 388-15-19610(2).

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19620, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19620, filed 8/27/98, effective 9/27/98.]

WAC 388-15-19630 Under what conditions will the department deny payment to an individual provider or a home care agency provider? The department will deny pay-

ment when an individual provider or a home care agency provider:

- (1) Does not meet the conditions of the contract;
- (2) Has been terminated by the department for cause;
- (3) Does not successfully complete the training requirements within the time limits in WAC 388-15-19650 through 388-15-19680;

(4) Demonstrates an unwillingness or inability to provide care following mandatory training or other training provided by the client's social worker/case manager or through the nurse expertise service; or

(5) Does not meet the conditions as stated in WAC 388-15-19610 and 388-15-19620.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19630, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19630, filed 8/27/98, effective 9/27/98.]

WAC 388-15-19640 Does the individual provider or the home care agency provider have responsibilities in addition to the service plan? In addition to providing services as outlined on the client's service plan, the individual provider or the home care agency provider must:

(1) Accommodate client's individual preferences and differences in providing care;

(2) Contact the client's representative and case manager when there are changes which affect the personal care and other tasks listed on the service plan;

(3) Observe the client for change(s) in health, and respond to emergencies;

(4) Notify the case manager immediately when the client enters a hospital, an adult family home, an adult residential care facility, an enhanced adult residential care facility, an assisted living facility, or a nursing facility; and

(5) Notify the case manager immediately if the client dies.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19640, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19640, filed 8/27/98, effective 9/27/98.]

WAC 388-15-19650 What are the educational requirements for an individual provider or a home care agency provider? To meet the educational requirements, an individual provider or a home care agency provider must:

(1) Possess a certificate of successfully completing department-designated fundamentals of caregiving training within one hundred and twenty days after beginning employment;

(2) Complete a minimum of ten hours of continuing education credits each calendar year following the year in which the fundamentals of caregiving training is taken. One hour of completed instruction equals one hour of credit on topics that pertain to services provided in an in-home setting including, but not limited to:

- (a) Client's rights;
- (b) Personal care (such as transfers or skin care);
- (c) Dementia;
- (d) Mental illness;

(e) Depression;

(f) Medication assistance;

(g) Communication skills;

(h) Alternatives to restraints;

(i) Activities for clients; and

(3) Provide the department with proof of completion of continuing education credits.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19650, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19650, filed 8/27/98, effective 9/27/98.]

WAC 388-15-19660 Do all individual providers or home care agency providers have to take the fundamentals of caregiving training? An IP or a home care agency provider can do the following instead of taking the fundamentals of caregiving:

(1) Pass the department's challenge test for the required class. This test can be taken once only. An IP contacts the AAA designated trainer to request the test; or

(2) Complete the department designated modified fundamentals of caregiving training and be a:

(a) Registered or licensed practical nurse;

(b) Physical or occupational therapist;

(c) Certified nursing assistant; or

(d) Medicare-certified home health aide; or

(3) Complete the division of developmental disabilities' (DDD) staff training required by chapter 275-26 WAC and continue to work for a DDD-contracted agency.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19660, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19660, filed 8/27/98, effective 9/27/98.]

WAC 388-15-19670 Are there special rules about training for parents who are the individual providers of division of developmental disabilities (DDD) adult children? Natural, step, or adoptive parents of adult DDD children:

(1) Must possess a certificate of successfully completing a six-hour DDD-approved training or a specially designed department-approved training within one hundred eighty days after beginning employment;

(2) Are exempt from continuing education requirements; and

(3) Are exempt from the fundamentals of caregiving training if they provide care only for their own adult DDD child.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19670, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19670, filed 8/27/98, effective 9/27/98.]

WAC 388-15-19680 Are there special rules about training for parents who are the individual providers of non-DDD adult children? Natural, step, or adoptive parents of adult non-DDD children must:

(1) Possess a certificate of successfully completing the fundamentals of caregiving training within one hundred eighty days after beginning employment; or

(2) Pass the department's challenge test; and

(3) Complete and provide proof of ten hours of continuing education credits as required under WAC 388-15-19650 (2) and (3).

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19680, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19680, filed 8/27/98, effective 9/27/98.]

WAC 388-15-650 Purpose. To assist individuals to remain in the community in the least restrictive environment while enabling families and other caregivers to continue providing needed support. WAC 388-15-650 through 388-15-662 is to regulate adult day health facilities that receive Medicaid or state general funding for client care. Adult day health programs that do not receive any Medicaid or state general funds are exempt from these requirements.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-650, filed 5/27/99, effective 6/27/99.]

WAC 388-15-651 Definitions. "Adult day care" (level I). Adult day care provides supervised daytime programs where frail and disabled adults can participate in social, educational, and recreational activities. Services at this level are the basic "core services" that must be provided in all adult day care and adult day health programs. Level I is appropriate for clients who have chronic medical conditions that do not require the services of a skilled health professional on a routine basis. A registered nurse and social worker provide consultation regarding the individual's participation in the program and assessment of the client's overall well-being and need for additional services. Level I offers respite to caregivers by providing a safe alternative to home care.

"Adult day health" (level II). Adult day health is a structured program that provides licensed rehabilitative and skilled nursing services in an environment that also offers social work services and socialization for frail and disabled adults. Level II services provide rehabilitative, nursing, and professional level of psychological/counseling services with a focus on prevention, teaching, and health monitoring. Each participant has a specialized plan of care designed to structure his or her participation and to address particular needs.

"Certification." The process by which an area agency on aging as authorized by the department certifies an adult day health center to be eligible for Medicaid (Title XIX) reimbursement for direct, level II services provided to eligible individuals. The program must directly provide the services and meet requirements set by the department including fiscal requirements for contracting with the department. Adult day health centers that do not accept Medicaid or state-funded clients are not certified through this process.

"Core services." A common set of services that is provided by all programs. Services must include: client screening, individual assessment, plan of care; basic health monitoring with consultation from a registered nurse; social services, therapeutic activities, at least one nutritional meal per

day, including modified diet if needed; coordination and/or provision of transportation; and emergency care for participants.

"Intake evaluation." The screening process conducted by the adult day health program must be completed in order to gain an initial assessment of the appropriateness of the adult day health program for the client. During the intake process, clients for whom the program is not appropriate, are referred to other community agencies.

"Plan of care." The written plan that is developed with the participation of the client, and/or the client's authorized representative, is monitored by the individual responsible from the multidisciplinary team for each participant's plan. The plan of care details the services to be provided through identifying services needed with goals, objectives, and duration of the services.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-651, filed 5/27/99, effective 6/27/99.]

WAC 388-15-652 Adult day care (COPES level I). (1) Determining eligibility for COPES level I adult day care.

(a) Home and community services staff (HCS) or area agency on aging (AAA) case managers determine eligibility, by determining the needs of the client cannot be appropriately met in a less structured setting and in accordance with the criteria listed in subsection (2) of this section.

(b) The need for services must be documented in the plan of care, assessed, and re-authorized at regular, specified intervals.

(c) A physician does not need to authorize adult day care services as is required for level II adult day health.

(2) A person who is eligible for COPES and needing supervision or activities of daily living who can benefit from level I services to remain in their own home may receive level I services if it is an approved part of the clients service plan developed by HCS staff, AAA staff or authorized subcontractors.

Eligibility criteria for adult day care COPES level I. Clients are eligible when they are:

(a) Eligible for COPES as defined in WAC 388-15-620; and

(b) Ineligible for, and/or are eligible for, but do not have access to, level II adult day health; and

(c) Determined to be in need of one or more of the following services:

(i) Provision of personal care as defined in WAC 388-15-202(38);

(ii) Basic health monitoring with consultation from a registered nurse;

(iii) Therapeutic activities; or

(iv) Supervision or protection.

(3) Identifying providers. The AAA directly designates adult day care level I providers through a COPES contract.

(4) Rates and sources of payment for adult day care level I.

(a) Transportation is not reimbursed under this rate. Arrangements for transportation for eligible Medicaid recipients are made with the local Medicaid transportation brokers or with individual client COPES funds.

(b) Services are reimbursed on an hourly basis up to four hours per day. Any service provided over four hours per day shall be reimbursed at the daily rate. Effective July 1, 1999 the rates are as follows:

Counties	COPEs Level I	
	Daily rate	Hourly rate
King	\$34.51	\$8.62
Benton, Clark, Franklin, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima	\$30.70	\$7.68
All other counties	\$29.10	\$7.27

(c) Service plan for adult day care level I. The level I service is a part of the COPEs service plan for the client. This plan is developed by HCS, AAA (or authorized subcontractor) staff. A client/participant may receive both level I and level II services on different days. If, according to an adult day health center plan of care, a client/participant may need a level II service three days per week, but only wishes and would benefit from socialization or activities of daily living (ADL) assistance two additional days, both services may be authorized to complement the week.

[Statutory Authority: RCW 74.39A.007 and 74.08.090, 99-12-072, § 388-15-652, filed 5/27/99, effective 6/27/99.]

WAC 388-15-653 Adult day health (level II). (1) Determining eligibility for level II.

(a) Certified providers assess the prospective client's need for day health. The assessment must include all services that the client has been authorized to receive. A state-approved assessment tool must be used. The two approved tools are:

(i) The OARS multidimensional functional assessment; and

(ii) The comprehensive assessment (CA) provided by AASA. The CA must not contain the AASA/DSHS logo.

(b) The adult day health provider must document the client's need for skilled nursing care or rehabilitative therapy and the frequency of the planned care provision.

(c) Day health providers must verify each client's Medicaid (Title XIX) and/or COPEs eligibility.

(d) The provider must obtain a current medical report from the client's physician. The report must have been completed and dated by the client's physician within the last three months. The facility must inform the physician that he or she is documenting the need for skilled nursing or professional rehabilitative therapy services. The facility staff must obtain, from the attending physician, the following additional medical information:

(i) Frequency with which the client must be seen by the physician (client must agree to visits as ordered by the physician);

(ii) Orders for physical, speech, and hearing or other rehabilitative therapy; and

(iii) The physician's signature shall indicate that the client has a medical need for adult day health services and orders the development of a plan of care, and the provision of adult day health services.

(e) The multidisciplinary team, in preparing the plan of care, shall include input from the attending physician of any client funded by Medicaid.

(f) The plan of care shall be forwarded to the attending physician within one week of completion.

(g) Medicaid clients shall have their plan of care reassessed at least once every three months by the multidisciplinary team, which is to include the clients attending physician.

(h) Progress notes on Medicaid clients must be recorded weekly.

(i) Changes in the Medicaid clients plan of care are to be filed in their case record and a copy forwarded to the clients physician.

(2) Eligibility criteria for adult day health level II.

(a) Applicants are considered eligible for level II when they are:

(i) Active Title XIX recipients in the following categories:

Medical ID Code	Medical program eligibility
CNP	Categorically needy program
CNP-QMB	Categorically needy qualified medical beneficiaries
GAU/W	General assistance unemployable alcohol and drug addiction treatment and support act

or

(ii) Enrolled COPEs clients receiving at least one COPEs service (not including level II day health).

(b) In addition to subsection (1)(a) of this section, eligible clients must also be in need of one or more of the following and not have access to:

(i) Skilled nursing services: Skilled nursing services are services provided by a registered nurse (RN), or a licensed practical nurse (LPN). Reminding or coaching a client is not a skilled service. Skilled nursing services may include, but is not limited to, one or more of the following:

(A) Observation and assessment: This service may be medically necessary for a client who is in an unstable condition.

(B) Teaching and training activities: Teaching and training activities enable the client to become independent. Examples of teaching a client are:

(I) Self-administration of an injection,

(II) Prefill insulin syringes,

(III) Irrigate a catheter,

(IV) Care for a colostomy or ileostomy,

(V) Dressing changes and aseptic techniques,

(VI) Management of activities of daily living,

(VII) Understand an illness, medications, its symptoms and how to cope.

(C) Intervention: Services provided directly by the licensed nurse may include, but are not limited to:

(I) Insert or irrigate a catheter,

(II) Administer medications or medical gases,

(III) The administration and management of infusion therapy services.

(ii) Rehabilitative therapies: Therapy services must be medically necessary for preventing further deterioration or

restoring a function affected by the client's illness, disability, or injury. These services must be provided by or under the supervision of the therapist.

(A) Physical therapy: Physical therapy must be provided according to applicable state practice laws and regulations. Physical therapy may include but not be limited to:

(I) Assessing the participant's mobility level, strength, range of motion, endurance, balance, ability to transfer.

(II) Provide treatment to relieve pain and/or develop, restore, or maintain functioning.

(III) Establish a maintenance program and provide written and verbal instructions to program staff and the family/caregiver to assist the participant with implementation.

(B) Occupational therapy: Occupational therapy services must be provided according to applicable state practice laws and regulations. Occupational therapy may include, but are not limited to:

(I) Administer basic evaluation to determine baseline level of functioning, ability to transfer, range of motion, balance, strength and coordination, activities of daily living and cognitive-perceptual functioning.

(II) Teach and train participant and/or staff in the use of therapeutic, creative, and self-care activities to improve or maintain the participant's capacity for self-care and independence, and increase the range of motion, strength and coordination.

(C) Speech pathology and audiology: Speech pathology and audiology services must be provided according to applicable state practice laws and regulations. Services may include, but are not limited to:

(I) Establish a treatment program to improve communication ability and correct disorders.

(II) Provide speech therapy procedures that include auditory comprehension tasks, visual and/or reading comprehension tasks, language intelligibility tasks, or training involving the use of alternative communication devices.

(III) Swallowing assessment and treatment.

(c) The client must receive services from one of the licensed professionals listed above. If, at the time of reassessment, it is determined that the participant requires fewer or more days of attendance, based on documentation of care delivered, the plan of care will be adjusted.

(3) Identifying providers. Level II providers for billing purposes are designated through a contract with the DSHS medical assistance administration (MAA). In order to be eligible to contract with MAA, they must be certified by the AAA. The AAA is required to conduct an annual review for continuing certification for each provider.

(4) Rates for level II and sources of payment.

(a) Transportation is not reimbursed under level II adult day health rate. Arrangements for transportation are made with the local Medicaid transportation brokers.

(b) Effective July 1, 1999 the rates are as follows:

Counties	Rate
	Level II
King	\$44.92
Benton, Clark, Franklin, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima	\$40.73
All other counties	\$38.49

(c) There is a one time only intake evaluation that is reimbursed at eighty-four dollars and fifty-six cents.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-653, filed 5/27/99, effective 6/27/99.]

WAC 388-15-654 Plan of care. The plan of care:

(1) Is developed by the multidisciplinary team of the adult day health program. In determining days of attendance for each participant, the program will assess the individual for the frequency of need for any of the above listed services. In addition, the plan should determine the frequency for active psycho-social therapy, which includes assessment for and treatment of mental illness, which must be provided by an appropriate therapist as defined in RCW or state regulations.

(2) For level II determine the frequency of attendance based on frequency of need for skilled nursing or rehabilitation therapy.

(3) Must be authorized by the participant's physician. The physician must be informed that he or she is documenting the participant's need for services described in the plan of care.

(4) Must include at a minimum the following:

(a) Identified needs in each service area;

(b) Time-limited measurable goals and objectives of the care for the person served;

(c) Type and scope of interventions to be provided in order to reach predicted outcomes;

(d) Discharge/transition plan for the person, including specific criteria for discharge/transition.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-654, filed 5/27/99, effective 6/27/99.]

WAC 388-15-655 Title XIX adult day health certification and monitoring. (1) Administration.

(a) Role of the AAA.

(i) The AAA, as authorized by the department, is responsible for the administration of the certification process for determining eligibility of an adult day health program to receive Medicaid (Title XIX) funds. The AAA will make the initial certification and annual review (recertification) of applicants. A letter of certification will be given to applicants meeting all requirements, administrative and fiscal, for contracting with the department. The AAA shall notify the department in writing of all certifications.

(ii) When an applicant applying for initial certification does not meet all the certification requirements, certification will be denied. A notice from the AAA setting forth the reason for denial will be mailed to the applicant within thirty days after completion of the site visit.

(iii) The department may take action such as, but not limited to, stop placement, corrective action or revocation of certification at any time the adult day health center is found not to be in compliance with client eligibility requirements, or not meeting the administrative or fiscal requirements. The AAA shall notify the program in writing of the reasons for revocation. Revocation will become effective sixty days after notice is mailed to the facility. Revocation may be suspended if the program submits an approved corrective action plan within thirty days after the mailing date of the revocation

notice. The AAA will determine the date by which the corrective action must be completed.

(2) Minimum requirements for certification.

(a) Mission statement, articles of incorporation and bylaws.

(b) Names and addresses of the board of directors (including minutes of the last three meetings) if the applicant is a nonprofit organization. Names and addresses of all owners if the applicant is a proprietary.

(c) Organizational chart.

(d) Total program operating budget including all revenue sources and client fees generated.

(e) Program policies and operating procedures manual (all programs must operate at least three days a week and provide a structured program for participants at least four hours a day.

(f) Personnel policies and job descriptions of each paid staff position and volunteer positions.

(g) Definitions, policies and procedures about suspected abuse, neglect, or exploitation and mandatory reporting to adult protective services.

(h) Financial statement or the latest audit report of the organization by a certified public accountant (CPA).

(i) A floor plan of the facility indicating usage of space with interior measurements.

(j) Building inspection report, fire department inspection report, local health department inspection report, and food handler permit if food is prepared in the facility.

(k) Updated TB test for each staff member.

(l) All forms used in client's case records/files.

(m) Program/activities calendar for the month prior to application.

[Statutory Authority: RCW 74.39A.007 and 74.08.090, 99-12-072, § 388-15-655, filed 5/27/99, effective 6/27/99.]

WAC 388-15-656 Administration and organization.

(1) Governing board.

(a) Unless the program is independently owned or functions through a governmental unit, a formal governing body shall have full legal authority and fiduciary responsibility for the operation of the program, adopting bylaws, and rules that address:

(i) Purposes of the program;

(ii) Governing body's composition and size, and members' and committee chairs' terms of office;

(iii) Frequency of meetings.

(b) The organization shall develop a written plan, reviewed on a regular basis, that addresses:

(i) The core values and mission of the organization, that promote seeing the persons served as the focus of the adult day health program;

(ii) That supports leadership that identifies and demonstrates ethical behavior in business, marketing, communication, and the provision of services; and

(iii) Information dissemination from a variety of sources to plan and improve performance and to educate, inform and demonstrate to all stakeholders the value of adult day health services.

(2) The advisory committee.

(a) Every adult day health program shall have a body that serves as an advisory committee. When an adult day health program is a subdivision or subunit of a multifunction organization, a committee or subcommittee of the governing body of the multifunction organization may serve as the advisory committee of the program.

(b) For a single purpose agency the governing body may fulfill the functions of the advisory committee.

(c) The advisory committee shall meet at least twice a year, but preferably quarterly, and shall have an opportunity, at least annually, to review and make recommendations on program policies. The advisory committee should be representative of the community and include family members of current or past participants and nonvoting staff representatives.

(3) A written plan of operation.

The administrator shall be responsible for the development of a current, written plan of operation with approval of the governing body. The plan of operation shall be reviewed, and if necessary, revised annually. The plan may include:

(a) Short- and long-range program goals;

(b) Definition of the target population, including number, age and needs of participants;

(c) Geographical definition of the service area;

(d) Hours and days of operation;

(e) Description of basic services and any optional services;

(f) Policies and procedures for service delivery;

(g) Policies and procedures for admission and discharge;

(h) Policies and procedures for assessment and reassessment, and the development of a plan of care with participants and/or family/caregiver by an interdisciplinary team;

(i) Staffing pattern;

(j) A plan for utilizing community resources;

(k) Policies and procedures for recruitment, orientation, training, evaluation, and professional development of staff and volunteers;

(l) General record policies;

(m) Statement of participant rights;

(n) Mandated reporting procedures;

(o) Marketing plan;

(p) Strategic planning;

(q) Accident, illness, and emergency procedures;

(r) Grievance procedures;

(s) Procedures for reporting suspected abuse;

(t) Payment mechanisms, funding sources and rates; or

(u) Operational budget.

(4) A written emergency plan. A written plan for handling emergencies shall be developed, and posted at each program site and on all program owned vehicles. Staff shall be trained to ensure smooth implementation of the emergency plan. If a single participant is present, at least one staff member on site shall be trained in cardiopulmonary resuscitation (CPR) and first aid.

(5) Lines of supervision and responsibility.

(a) To ensure continuity of direction and supervision, there shall be a clear division of responsibility between the governing body and the adult day health program administrator.

(b) An administrator shall be appointed and given full authority and responsibility to plan, staff, direct, and implement the program. The administrator shall also have the responsibility for establishing collaborative relations with other community organizations to ensure necessary support services to participants and their families/caregivers.

(c) The administrator or the individual(s) designated by the administrator shall be on site to manage the program's day-to-day operations during hours of operation. If the administrator is responsible for more than one site, or has duties not related to adult day health administration or provision of services, a program director shall be designated for each additional site and shall report to the administrator.

(d) An organizational chart shall be developed to illustrate the lines of authority and communication channels, and shall be provided to all staff.

(6) Administrative policies and procedures.

(a) Every adult day health program shall demonstrate fiscal responsibility by utilizing generally accepted principles of accounting in all its financial transactions. Fiscal policies, procedures, and records shall be developed to enable the administrator to meet the fiscal reporting needs of the governing body.

(b) Every adult day health program shall develop a plan to address the future financial needs of the program. The plan shall include projected program growth, capital purchases, projected revenue, projected expenses, and plans for fund raising.

(7) Quality improvement.

(a) Every adult day health program shall develop a quality improvement plan, with specific measurable objectives, designed to meet requirements of any licensing, funding sources, and professional standards.

(b) Policies and procedures for monitoring program quality and determining further action shall be developed by the administrator with the advice of the multidisciplinary staff team and the advisory committee with the approval of the governing body.

(8) Personnel policies and practices.

(a) There shall be a written job description for each staff position that specifies:

- (i) Qualifications for the job;
- (ii) Delineation of tasks; and
- (iii) Lines of supervision and authority.

(b) Each employee shall receive, review, and sign a copy of the job description at the time of employment. Volunteers who function as staff also shall be provided written descriptions of responsibilities.

(c) Provision shall be made for orientation of new employees and volunteers. All staff and volunteers shall receive regular in-service training and staff development that meet their individual training needs. This shall be documented.

(d) Probationary evaluations and annual performance evaluations, in accordance with job descriptions, shall be conducted and shall conform to the policy of the funding or parent organization. Staff members shall review the written evaluation, that shall be signed by both the employee and supervisor. Copies shall be kept in locked personnel files.

(e) Each employee shall receive and/or review a copy of the program's personnel policies at the time of employment.

(f) Each employee shall have an individual file containing: Employee's qualifications, verification of training completed, signed job description and all performance evaluations. In addition, personnel files shall contain a copy of a current license or certificate, if applicable to the staff position, and certification of CPR and first aid training, if applicable.

(g) Whenever volunteers function in the capacity of staff, all applicable personnel policies pertain.

(h) The program shall conform to federal and state labor laws, must be in compliance with equal opportunity guidelines, and must adhere to federal and state employment regulations.

(9) Participant policies. Policies shall define the target population, admission criteria, discharge criteria, medication policy, participant rights, fee schedule, confidentiality, grievance procedures, and staff/participant ratios. Policies shall conform to the following:

(a) Nondiscrimination policy. No individual shall be excluded from participation in or be denied the benefits of or be otherwise subjected to discrimination in the adult day health program on the grounds of age, race, color, sex, religion, or national origin, creed, marital status, Vietnam era or disabled veteran's status, sensory, physical, or mental handicap.

(b) Bill of rights. A participant bill of rights shall be developed, posted, distributed to, and explained to participants, families, staff, and volunteers in the language understood by the individual.

(c) Illness/injury procedure. There shall be written procedures to be followed in case a participant becomes ill or is injured. The procedures shall be posted in at least one visible location at all program sites and shall be thoroughly explained, to staff, volunteers and participants. The procedures shall describe arrangements for hospital inpatient and emergency room service and include directions on how to secure ambulance transportation.

(d) Medications. Participants who need to take medications while at the program, and who are sufficiently mentally alert, shall be encouraged and expected to bring, keep and take their own medications as prescribed. Some participants may need assistance with their medications, and a few may need to have their medications administered by program staff. In order for program staff to administer any prescribed medication, there must be a written authorization from the participant's physician stating that the medication is to be administered at the program site and identifying the licensed person responsible for administration.

(e) The program shall develop written mediation procedures that are explained to all staff and anyone else who has responsibility in this area. At a minimum, these procedures shall describe the following:

- (i) How medications will be stored;
- (ii) Under what conditions licensed program staff will administer medications;
- (iii) How medications brought to the program by a participant must be labeled;

(iv) How general medications such as aspirin or laxatives are to be used;

(v) How the use of medications will be entered in participants' case records.

(10) General record.

The adult day health program shall maintain a secure participant record system to ensure confidentiality. The record system shall include, but is not limited to:

(a) A permanent registry of all participants with dates of admission and discharge;

(b) A written policy on confidentiality and the protection of records that defines procedures governing their use and removal, and conditions for release of information contained in the records;

(c) A written policy on conditions that require authorization in writing by the participant or the legally responsible party for release of appropriate information not otherwise authorized by law;

(d) A written policy providing for the retention and storage of records for at least five years (or in accordance with state or local requirement) from the date of the last service to the participant;

(e) A written policy on the retention and storage of such records in the event the program discontinues operation, depending on the requirements of funding sources;

(f) A policy and procedure manual governing the record system and procedures for all agency staff;

(g) Maintenance of records on the agency's premises in secure storage area;

(h) Notes and reports in the participant's record that are typewritten or legibly written in ink, dated, and signed by the recording person with his/her title.

(11) Participant records. The following shall be maintained as a record for each participant. This shall include, but is not limited to, the following:

(a) Application and enrollment forms;

(b) Medical history and functional assessment (initial and ongoing);

(c) Plan of care (initial and reviews) and revisions;

(d) Fee determination form;

(e) Service contract;

(f) Signed authorizations for releases of medical information and photos, as appropriate;

(g) Signed authorizations for participant to receive emergency medical care if necessary;

(h) Correspondence;

(i) Attendance and service records;

(j) Transportation plans;

(k) Where appropriate:

(i) Medical information form;

(ii) Documentation of physicians' orders;

(iii) Physical examinations;

(iv) Treatment, therapy, and medication notes;

(l) Progress notes, chronological and timely;

(m) Where appropriate, discharge plan and summary;

(n) Current photograph of client;

(o) Emergency contacts;

(p) Signed statement that participant or legal representative has read the policies of the program with respect to the Patient Self-Determination Act of 1990.

(12) Administrative records. Administrative records shall include the following:

(a) Personnel records (including personnel training);

(b) Fiscal records;

(c) Statistical records;

(d) Government-related records (funding sources/regulatory);

(e) Contracts;

(f) Organizational records;

(g) Results of quality improvement plan which could include annual evaluation, utilization review, or care plan audit;

(h) Board and advisory group meeting minutes;

(i) Certificates of fire and health inspections;

(j) Incident reports;

(k) Emergency plan;

(l) Criteria for participant termination.

(13) Community relations. Adult day health programs shall provide information on adult day health to target populations and the general public. Participants and their families shall be made aware of community agencies for financial, social, recreational, educational and medical services. In addition, the program staff shall establish linkages with other community agencies and institutions to coordinate services and form service networks.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-656, filed 5/27/99, effective 6/27/99.]

WAC 388-15-657 Staffing. (1) Staff selection is dependent on participant needs, program design, and regulatory requirements. The program must have the proper balance of professionals and paraprofessionals or nonprofessionals to adequately meet the needs of participants. Services must be delivered by those with adequate professional training. One staff person can have multiple functions; for example, an administrator who is also responsible for providing nursing services or social services.

(2) All core services shall have an administrator/program director and an activity coordinator on staff. Health care and social services personnel may be on staff or consulting. Personnel delivering level II services may be on staff or on contract.

(3) Staffing levels in all adult day health programs will vary based upon the number of participants and the care provided. The staffing level shall be sufficient to:

(a) Serve the number and functioning levels of adult day health program participants;

(b) Meet program objectives;

(c) Provide access to other community resources.

(4) The staff-participant ratio shall be a minimum of one to six. Persons counted in the staff-participant ratio are those who provide direct service with participants. When there is more than one participant present there shall be at least two staff members on the premises, one of whom is directly supervising the participants.

(5) As the number of participants with functional impairments increases, the staff-participant ratio shall be adjusted accordingly. Programs serving a high percentage of participants who are severely impaired shall have a staff-participant

ratio of one to four. All programs shall have a written policy regarding staff-participant ratios.

(6) To ensure adequate care and safety of participants, there shall be provision for qualified substitute staff.

(7) Volunteers shall be included in the staff ratio only when they conform to the same standards and requirements as paid staff, meet the job qualification standards of the organization, and have designated responsibilities.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-657, filed 5/27/99, effective 6/27/99.]

WAC 388-15-658 Personnel requirements. (1) Administrator. The administrator:

(a) Is responsible for the development, coordination, supervision, fiscal control and evaluation of services provided through the adult day health program.

(b) Shall have a master's degree and one year supervisory experience in health or social services (full-time or equivalent) or a bachelor's degree and two years supervisory experience in a social or health service setting.

(2) Program director.

(a) For level I, adult day care services the program director shall have a bachelor's degree in health, social services or a related field, with one year supervisory experience (full-time or equivalent) in a social or health service setting, or a high school diploma and four years of experience in a health or social services field of which two years must be supervision.

(b) For level II, adult day health services, minimum requirements for the program director shall be a bachelor's degree in health, social services or a related field, with one year supervisory experience (full-time or equivalent) in a social or health service setting.

(3) Social worker.

(a) The social worker shall have a master's degree in social work or counseling and at least one year of professional work experience (full-time or the equivalent), or a bachelor's degree in social work or counseling and two years of experience in a human service field.

(b) Depending on the setting and licensing requirements, social work functions may be performed by other human service professionals, such as rehabilitation counselors, gerontologists, or mental health workers (although they may not call themselves social workers without appropriate credentials).

(4) Registered nurse (RN). The nurse shall be a registered nurse (RN) with valid state credentials and a minimum of one year applicable experience (full-time equivalent).

(5) Licensed practical nurse (LPN). The licensed practical nurse (LPN) shall have valid state credentials and a minimum of one year applicable experience (full-time equivalent).

(6) Activities coordinator. The activities coordinator shall have a bachelor's degree in recreational therapy or a related field and one year of experience (full-time equivalent) in social or health services or an associate degree in recreational therapy or a related field plus two years of appropriate experience.

(7) Certified occupational therapy assistant (COTA) or physical therapy assistant. The COTA or physical therapy

assistant shall be certified with valid state credentials and a minimum of one year applicable experience (full-time equivalent).

(8) Nursing assistant/certified (NAC). The nursing assistant shall be certified with valid state credentials and a minimum of one year applicable experience (full-time equivalent).

(9) Program assistant/aide/personal care aide. The program assistant or aide shall have one or more years of experience in working with adults in a health care or social service setting.

(10) Therapists. Physical therapists, occupational therapists, speech therapists, recreation therapists, mental health therapists or any other therapists, utilized shall have valid state credentials and one year of experience in a social or health setting.

(11) Consultants. Consultants shall be available to provide services as needed in order to supplement professional staff and enhance the program's quality.

(12) Secretary/bookkeeper. The secretary/bookkeeper shall have at least a high school diploma or equivalent and skills and training to carry out the duties of the position.

(13) Driver. The driver shall have a valid and appropriate state driver's license, a safe driving record, and training in first aid and CPR. The driver shall meet any state requirements for licensure or certification.

(14) Volunteers. The volunteers shall be individuals or groups who desire to work with adult day health participants and shall take part in program orientation and training. The duties of volunteers shall be mutually determined by volunteers and staff. Duties, to be performed under the supervision of a staff member, shall either supplement staff in established activities or provide additional services for which the volunteer has special talents.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-658, filed 5/27/99, effective 6/27/99.]

WAC 388-15-659 Facility. (1) Location.

(a) Selection of a location for a program facility shall be based on information about potential participants in its service area and be made in consultation with other agencies, organizations, and institutions serving older individuals and those with functional impairments, as well as considering the availability of a suitable location.

(b) Space.

(i) The facility shall comply with applicable state and local building regulations, zoning, fire, and health codes or ordinances. When possible, the facility shall be located on the street level. If the facility is not located at street level, it is essential to have a ramp and/or elevators. An evacuation plan for relocation of participants shall also be in place in the event of an emergency.

(ii) Each adult day health program, when it is co-located in a facility housing other services, shall have its own separate identifiable space for main activity areas during operational hours. Certain space can be shared, such as the kitchen and therapy rooms.

(iii) The facility shall have sufficient space to accommodate the full range of program activities and services. The facility shall provide at least sixty square feet of program

space for multi-purpose use for each day health participant. In determining adequate square footage, only those activity areas commonly used by participants are to be included. Dining and kitchen areas are to be included only if these areas are used by participants for activities other than meals. Reception areas, storage areas, offices, restrooms, passage ways, treatment rooms, service areas, or specialized spaces used only for therapies are not to be included when calculating square footage.

(iv) The facility shall be adaptable to accommodate variations of activities (group and/or individual) and services. The program shall provide and maintain essential space necessary to provide services and to protect the privacy of the participants receiving services. There shall be sufficient private space to permit staff to work effectively and without interruption. There shall be sufficient space available for private discussions.

(v) There shall be adequate storage space for program and operating supplies.

(vi) The facility's restrooms shall be located as near the activity area as possible, preferably no more than forty feet away. The facility shall include at least one toilet for each ten participants. Programs that have a large number of participants that require more scheduled toileting or assistance with toileting shall have at least one toilet for each eight participants. The toilet shall be equipped for use by mobility-limited persons, easily accessible from all program areas, and one or two of the toilet areas should be designed to allow assistance from one or two staff.

(vii) Each bathroom shall contain an adequate supply of soap, toilet tissues and paper towels.

(ix) In addition to space for program activities, the facility shall have a rest area and designated areas to permit privacy and to isolate participants who become ill or disruptive, or may require rest. It shall be located away from activity areas and near a restroom and the nurse's office. There shall be at least one bed, couch or recliner for each ten participants which can be used for resting or the isolation of a participant who is ill or suspected of coming down with a communicable disease. If beds are used, the mattresses shall be protected and linen changed after each use by different participants.

(x) A loading zone with sufficient space for getting on and off a vehicle shall be available for the safe arrival and departure of participants. There should be sufficient parking available to accommodate family caregivers, visitors, and staff. Adequate lighting should be provided.

(2) Atmosphere and design.

(a) The design shall facilitate the participants' movement throughout the facility and encourage involvement in activities and services. The environment shall reinforce orientation and awareness of the surroundings by providing cues and information about specific rooms, locations, and functions that help the participant to get his/her orientation to time and space.

(b) A facility shall be architecturally designed in conformance with the requirements of sections 504 of the Rehabilitation Act of 1973 to accommodate individuals with a disability and meet any state and local barrier-free requirements and/or the Americans with Disabilities Act.

(c) Illumination levels in all areas shall be adequate, and careful attention shall be given to avoiding glare. Attention shall be paid to lighting in transitional areas such as outside to inside and different areas of the facility.

(d) Sound transmission shall be controlled. Excessive noise, such as fan noise, shall be avoided.

(e) Comfortable conditions shall be maintained within a comfortable temperature range. Excessive drafts shall be avoided uniformly throughout the facility.

(f) Sufficient furniture shall be available for the entire participant population present. Furnishings shall accommodate the needs of participants and be attractive, comfortable, sturdy and safe. Straight-backed chairs with arms shall be used during activities and meals.

(g) An adult day health facility shall be visible and recognizable as a part of the community. The entrance to the facility shall be clearly identified. It shall also be appealing and protective to participants and others.

(h) When necessary, arrangements shall be made with local authorities to provide safety zones for those arriving by motor vehicle and adequate traffic signals for people entering and exiting the facility.

(i) A telephone shall be available for participant use.

(3) Safety and sanitation.

(a) The facility and grounds shall be safe, clean, and accessible to all participants. It shall be designed, constructed, and maintained in compliance with all applicable local, state, and federal health and safety regulations.

(b) There shall be an area for labeled medication, secured and stored apart from participant activity areas. If medications need to be refrigerated, they should be in a locked box - if not in their own refrigerator.

(c) Safe and sanitary handling, storing, preparation, and serving of food shall be assured. If meals are prepared on the premises, kitchen appliances, food preparation area, and equipment must meet state and local requirements.

(d) Toxic substances, whether for activities or cleaning, shall be stored in an area not accessible to participants. They must be clearly marked, the contents identified, and stored in original containers.

(e) At least two well-identified exits shall be available. Nonslip surfaces or bacteria-resistant carpets shall be provided on stairs, ramps, and interior floors.

(f) Alarm/warning systems are necessary to ensure the safety of the participants in the facility in order to alert staff to potentially dangerous situations. It is recommended that call bells be installed or placed in the rest areas, restroom stalls, and showers.

(g) An evacuation plan shall be strategically posted in each facility.

(h) The facility shall be free of hazards, such as high steps, steep grades, and exposed electrical cords. Steps and curbs shall be painted and the edges of stairs marked appropriately to highlight them. All stairs, curb cuts, ramps, and bathrooms accessible to those with disabilities shall be equipped with properly anchored handrails.

(i) Procedures for fire safety as approved by the local fire authority shall be adopted and posted, including provisions for fire drills, inspection and maintenance of fire extinguishers, periodic inspection, and training by fire department per-

sonnel. The program shall conduct and document quarterly fire drills and keep reports of drills on file. Improvements shall be made based on the fire drill evaluation. Smoke detectors shall also be used.

(j) Emergency first-aid kits shall be visible and accessible to staff. Contents of the kits shall be replenished after use and reviewed as needed. A nurse or personnel trained in first aid and CPR shall be on hand whenever participants are present. Infection control procedures shall be followed by all staff. All staff shall be trained in and use Universal Precautions.

(k) There shall be sufficient maintenance and housekeeping personnel to assure that the facility is clean, sanitary, and safe at all times. Maintenance and housekeeping shall be carried out on a regular schedule and in conformity with generally accepted sanitation standards, without interfering with the program.

(l) If smoking is permitted, an adequately ventilated special area away from the main program area shall be provided and supervised.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-659, filed 5/27/99, effective 6/27/99.]

WAC 388-15-660 Coordination of services. The need for coordination of care shall be considered for each participant. If the person is a client of another agency and/or receiving services from the department, the plan of care shall be developed in conjunction with the services provided by the other agencies or the department.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-660, filed 5/27/99, effective 6/27/99.]

WAC 388-15-661 Clients in residential care or nursing facility care settings. Residential clients may receive adult day health level II services when the service is an approved part of the service plan developed by AASA staff. Clients receiving nursing facility care shall not be authorized adult day health services. Clients who reside in enhanced adult residential care, adult residential care, assisted living or adult family homes shall not be authorized COPES funded adult day care.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-661, filed 5/27/99, effective 6/27/99.]

WAC 388-15-662 Expenditures not to exceed. If program expenditures exceed the budget appropriations, the department shall have the authority to limit services by setting forth alternative ways of determining eligibility such as:

(1) Authorizing service to only those clients with the greatest care needs.

(2) Department staff shall assess and authorize all adult day health services.

(3) Limit the number of days a client may receive services.

(4) The department shall comply with established rules and procedures for client notification should action in this section become necessary.

[Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-662, filed 5/27/99, effective 6/27/99.]

Chapter 388-43 WAC

DEAF AND HARD OF HEARING SERVICES

WAC

388-43-001 through 388-43-130 Decodified.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-43-001	Scope. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-001, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-002	Regional centers. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-002, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-003	Services. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-003, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-005	Definitions. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-005, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-010	Eligibility requirements. [Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-010, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-010, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-020	Approval of application for initial device or request for replacement device. [Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-020, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-020, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-030	Denial of initial application or request for replacement device. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-030, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-040	Application renewal process. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-040, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-050	Notice of approval or denial. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-050, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-060	Review by department. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-060, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-070	Distribution. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-070, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-080	Training. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-080, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-090	Ownership and liability. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-090, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-110	Telecommunications relay service. [Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-110, filed 12/30/93, effective 1/30/94.] Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.
388-43-130	Uses for returned equipment. [Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-130, filed 1/11/95, effective 2/11/95.]

Decodified by 99-20-022, filed 9/28/99, effective 9/28/99.

Reviser's note: Later promulgation, see chapter 388-818 WAC.

WAC 388-43-001 through 388-43-130 Decodified.
See Disposition Table at beginning of this chapter.

Chapter 388-71 WAC SOCIAL SERVICES FOR ADULTS

WAC

388-71-0800	What is PACE?
388-71-0805	What services does PACE cover?
388-71-0810	Who provides these services?
388-71-0815	Where are these services provided?
388-71-0820	How do I qualify for Medicaid-funded PACE services?
388-71-0825	What are my appeal rights?
388-71-0830	Who pays the PACE provider?
388-71-0835	How do I enroll into the PACE program?
388-71-0840	How do I disenroll from the PACE program?
388-71-0845	What are my rights as a PACE participant?

WAC 388-71-0800 What is PACE? (1) PACE, which stands for the program of all-inclusive care for the elderly, is a managed care program that provides:

- (a) Comprehensive, coordinated acute medical and long-term care services for a frail elderly population; and
- (b) A home and community-based alternative to nursing facility care.

(2) PACE is a Medicare/Medicaid program, authorized under section 1934 of the Social Security Act and administered by the department. The laws allow the department to expand home and community-based care options for the frail elderly population.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0800, filed 9/13/99, effective 10/14/99.]

WAC 388-71-0805 What services does PACE cover?

Under their contract with the department, the PACE provider develops a care plan that integrates necessary long-term care and acute medical services.

(1) The care plan includes, but is not limited to any of the following long-term care services:

- (a) Case management, to access and monitor services;
- (b) Home and community based services:
 - (i) Personal (in-home) care;
 - (ii) Residential care (e.g., boarding home, adult family home).

(c) And, if necessary, nursing facility care.

(2) The care plan may also include, but is not limited to the following medical services:

- (a) Routine medical care;
- (b) Vision care;
- (c) Hospice care;
- (d) Speech, occupational, and physical therapy;
- (e) Oxygen therapy;
- (f) Audiology (including hearing aids);
- (g) Transportation;
- (h) Podiatry;
- (i) Durable medical equipment (e.g., wheelchair);
- (j) Dental care;
- (k) Pharmaceutical products;

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(l) Shots.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0805, filed 9/13/99, effective 10/14/99.]

WAC 388-71-0810 Who provides these services? (1) A PACE multidisciplinary team, with the help of the client, family, and caseworker, develops and delivers necessary long-term care and acute medical services. Members of the team may include:

- (a) Primary care physicians and nurses;
- (b) Therapists;
- (c) Home care workers;
- (d) Social workers;
- (e) Transportation coordinators.

(2) As needed, the PACE provider may subcontract with other qualified professionals to provide services.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0810, filed 9/13/99, effective 10/14/99.]

WAC 388-71-0815 Where are these services provided? Most of the covered services are offered at the PACE site, which is a licensed adult day health center. The PACE team may also provide care in homes, hospitals, and nursing homes.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0815, filed 9/13/99, effective 10/14/99.]

WAC 388-71-0820 How do I qualify for Medicaid-funded PACE services? To qualify for Medicaid-funded PACE services, you must apply for an assessment by contacting your local Home and Community Services office. A case worker will assess and determine whether you:

(1) Are age:

- (a) Fifty-five or older, and blind or disabled as defined in WAC 388-15-202, Long-term care services—Definitions; or
- (b) Sixty-five or older.

(2) Need nursing facility level of care as defined in WAC 388-97-235, titled Medical eligibility for nursing facility care. Note: If you are already enrolled, but no longer need nursing facility care, you might still be eligible for PACE services if the case manager reasonably expects you to need nursing facility care within the next six months;

(3) Live within the designated service area of the PACE provider, currently the central Seattle area; and

(4) Meet financial eligibility requirements. This means the department will assess your finances and determine if your income and resources fall within the limits set in WAC 388-513-1315, Eligibility determination—Institutional.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0820, filed 9/13/99, effective 10/14/99.]

WAC 388-71-0825 What are my appeal rights? If the department determines you are ineligible, but you disagree, you may appeal the department's decision. For more information on your appeal rights, refer to chapter 388-08 WAC, Practice and procedures—Fair hearing.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0825, filed 9/13/99, effective 10/14/99.]

WAC 388-71-0830 Who pays the PACE provider?

Depending on your income and resources, you may be required to pay for part of the PACE services. The department's financial worker will determine what amount, if any, you must contribute if you decide to enroll. The department pays the PACE provider the remaining amount.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0830, filed 9/13/99, effective 10/14/99.]

WAC 388-71-0835 How do I enroll into the PACE program? Once you qualify for PACE, enrollment into the program is voluntary. However, before you can join, you must:

- (1) Not be enrolled in any other medical coverage plan that purchases services on a prepaid basis (e.g., HMO); and
- (2) Agree to receive services exclusively from the PACE provider.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0835, filed 9/13/99, effective 10/14/99.]

WAC 388-71-0840 How do I disenroll from the PACE program? (1) You may voluntarily choose to disenroll from the PACE program. To do so, you must give the provider written notice. If you give notice:

(a) Before the fifteenth of the month, disenrollment is effective at the end of the month.

(b) After the fifteenth, disenrollment is not effective until the end of the following month.

(2) The PACE provider may also end services, if you:

- (a) Move out of the designated service area;
- (b) Exhibit violent or abusive behavior or fail to cooperate with the provider to the point where the provider cannot effectively or safely provide services;
- (c) Refuse services and/or do not participate in your agreed-upon care plan;
- (d) Fail to pay or make arrangements to pay your part of the costs after the thirty-day grace period;
- (e) Become financially ineligible for Medicaid services, unless you choose to pay privately; or
- (f) Are enrolled with a provider that loses its license and/or contract.

(3) For any of the above reasons, the provider must give you written notice, explaining that they are terminating benefits. If the provider gives you notice:

(a) Before the fifteenth of the month, then you may be disenrolled at the end of the month.

(b) After the fifteenth, then you may be disenrolled at the end of the following month.

(4) Before the provider can disenroll you from the PACE program, the department must review and approve all proposed involuntary disenrollments.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0840, filed 9/13/99, effective 10/14/99.]

WAC 388-71-0845 What are my rights as a PACE participant? You have a right to:

(1) Receive any information regarding your care under PACE;

(2) Participate in creating or changing your treatment plan;

(3) Receive confidential treatment;

(4) Disenroll at any time; and

(5) Voice grievances when a disagreement exists. For information on resolving a disagreement, refer to your contract with the PACE provider.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0845, filed 9/13/99, effective 10/14/99.]

Chapter 388-78A WAC**BOARDING HOMES**

(Formerly chapter 246-316 WAC)

WAC

388-78A-020	Licensure—Initial, renewal, day care approval respite care, modifications.
388-78A-040	Administrator.
388-78A-050	Staff.
388-78A-055	Policies and procedures.
388-78A-150	Resident room—Room furnishings—Storage.
388-78A-240	Criteria for accepting and retaining residents.
388-78A-265	Limited nursing services.
388-78A-320	Resident health record.
388-78A-330	Adult day care.
388-78A-335	Residents—Dementia care.

WAC 388-78A-020 Licensure—Initial, renewal, day care approval respite care, modifications. (1) A person shall have a current license issued by the department before operating or advertizing a boarding home.

(2) An applicant for initial licensure shall submit to the department, forty-five days or more before commencing business:

(a) A completed application on forms provided by the department;

(b) Verification of department approval of facility plans submitted for construction review;

(c) A criminal history background check in accordance with WAC 388-78A-045(2);

(d) The fee specified in WAC 388-78A-990; and

(e) Other information as required by the department.

(3) A licensee shall apply for license renewal annually at least thirty days before the expiration date of the current license by submitting to the department:

(a) A completed application on forms provided by the department;

(b) A criminal history background check in accordance with WAC 388-78A-045(2);

(c) The fee specified in WAC 388-78A-990; and

(d) Other information as required by the department.

(4) A licensee, prior to accepting adults for day care, shall:

(a) Submit a letter to the department which includes:

(i) The maximum number of adults in the proposed day care program; and

(ii) An attestation of meeting the requirements in WAC 388-78A-330;

(b) Obtain written department approval, including the maximum approved capacity for day care adults; and

(c) Maintain and post written approval in a conspicuous place on the boarding home premises.

(5) A licensee may provide respite care within the licensed bed capacity.

(6) A licensee, prior to changing the licensed bed capacity, shall:

(a) Submit a letter requesting approval to the department at least thirty days before the intended change;

(b) Submit the prorated fee as determined by the department; and

(c) Obtain an amended license indicating the new bed capacity.

(7) A licensee, prior to changing the location or use of rooms listed on the licensed room list shall:

(a) Notify the department in writing thirty days or more before the intended change; and

(b) Maintain a copy of the licensed room list.

(8) At least thirty days before selling, leasing, or renting the boarding home or changing officers or partners, and immediately upon a change of administrator, the licensee shall submit to the department:

(a) Name and address of the boarding home;

(b) Type of change;

(c) Full names of the present and prospective licensee;

(d) Date of proposed change;

(e) Names and addresses of all responsible officers or controlling partners; and

(f) A signed statement attesting that any new controlling officers are in compliance with this chapter.

[Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-020, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-020, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-020, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.43.830 through 43.43.842. 93-16-030 (Order 381), § 246-316-020, filed 7/26/93, effective 8/26/93. Statutory Authority: RCW 18.20.090 and 34.05.220. 92-02-018 (Order 224), § 246-316-020, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-020, filed 12/27/90, effective 1/31/91. Statutory Authority: Chapter 34.05 RCW, RCW 34.05.220 (1)(a) and 18.20.909 [18.20.090]. 90-06-019 (Order 039), § 248-16-031, filed 2/28/90, effective 3/1/90. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-031, filed 4/14/89.]

WAC 388-78A-040 Administrator. (1) The licensee shall employ an administrator and designate an alternate administrator who are twenty-one or more years of age, and:

(a) Hold an associate degree in health, personal care, or business administration, such as:

(i) Social work;

(ii) Nursing;

(iii) Nutrition;

(iv) Physical therapy;

(v) Occupational therapy; or

(vi) Management; or

(b) Hold an advanced degree in a field specified in (a) of this subsection; or

(c) Are certified by a department-recognized national accreditation health or personal care organization, such as the American Association of Homes for the Aging; or

(d) Have a high school diploma or equivalent and two years experience as a resident-care staff person, including one year of caring for residents representative of the population in the boarding home; or

(e) Held the position of an administrator in a Washington state licensed boarding home or nursing home prior to August 1, 1994.

(2) The administrator, or alternate administrator when acting as the administrator, shall:

(a) Be responsible for the overall twenty-four-hour-per-day operation of the boarding home; and

(i) Provide for the care of residents; and

(ii) Comply with this chapter and policies of the licensee; and

(b) Be available in person or by telephone or electronic pager at all times.

(3) The administrator and alternate administrator shall meet the requirements for criminal history background checks in WAC 388-78A-045.

(4) Upon the appointment of a new administrator or alternate administrator, the licensee shall provide in writing to the department:

(a) The full name of the new administrator or alternate administrator; and

(b) A statement that the new administrator or alternate administrator is in compliance with this chapter.

[Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-040, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-040, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-040, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.43.830 through 43.43.842. 93-16-030 (Order 381), § 246-316-040, filed 7/26/93, effective 8/26/93. Statutory Authority: RCW 18.20.090. 92-02-018 (Order 224), § 246-316-040, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-040, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-036, filed 4/14/89.]

WAC 388-78A-050 Staff. (1) The licensee shall:

(a) Develop and maintain written job descriptions for the administrator and each staff position;

(b) Verify work references;

(c) Verify required credentialing is current and in good standing for licensed and certified staff;

(d) Document and retain weekly staffing schedules, as planned and worked, for the last twelve months;

(e) Provide sufficient, trained staff in each boarding home to:

(i) Furnish the services and care needed by residents;

(ii) Maintain the boarding home free of safety hazards; and

(iii) Implement fire and disaster plans;

(f) Assure one or more resident-care staff eighteen years of age or older, with current cardiopulmonary resuscitation and first-aid cards, is present to assist residents at all times:

(i) On the boarding home premises when one or more residents are present;

(ii) Off the boarding home premises during boarding home activities; and

(iii) When staff transport a resident;

(g) Assure staff provide "on-premises" supervision when any resident is working for, or employed by, the boarding home; and

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of boarding home;

- (ii) Physical boarding home layout;
- (iii) Specific duties and responsibilities; and
- (iv) Policies, procedures, and equipment necessary to perform duties.

(2) The licensee shall, in addition to following WISHA requirements, protect residents from tuberculosis by requiring each staff person to have, upon employment:

(a) A tuberculin skin test by the Mantoux method, unless the staff person:

(i) Documents a previous positive Mantoux skin test, which is ten or more millimeters of induration read at forty-eight to seventy-two hours;

(ii) Documents meeting the requirements of this subsection within the six months preceding the date of employment; or

(iii) Provides a written waiver from the department or authorized local health department stating the Mantoux skin test presents a hazard to the staff person's health;

(b) A second test one to three weeks after a negative Mantoux skin test for staff thirty-five years of age or older;

(c) A chest x-ray within seven days of any positive Mantoux skin test.

(3) The licensee shall report positive chest x-rays to the appropriate public health authority, and follow precautions ordered by a physician or public health authority.

(4) The licensee shall retain records of tuberculin test results, reports of x-ray findings, exceptions, physician or public health official orders, and waivers in the boarding home.

(5) The licensee shall assure that all resident-care staff including those transporting residents and supervising resident activities, except licensed staff whose professional training exceeds first-responder training, have within thirty days of employment:

(a) Current cardiopulmonary resuscitation cards from instructors certified by:

(i) American Red Cross;

(ii) American Heart Association;

(iii) United States Bureau of Mines; or

(iv) Washington state department of labor and industries; and

(b) Current first-aid cards from instructors certified as in (a) of this subsection, except nurses do not need first-aid cards.

(6) The licensee shall restrict a staff person's contact with residents when the staff person has a known communicable disease in the infectious stage which is likely to be spread in the boarding home setting or by casual contact.

(7) The licensee shall assure any staff person suspected or accused of abuse does not have access to any resident until the licensee investigates and takes action to assure resident safety to the satisfaction of the department.

(8) The licensee shall not interfere with the investigation of a complaint, coerce a resident, or conceal evidence of alleged improprieties occurring within the boarding home.

(9) The licensee shall prohibit an employee from being directly employed by a resident or a resident's family during the hours the employee is working for the boarding home.

(10) The licensee shall maintain the following documentation on the boarding home premises, during employment, and at least two years following termination of employment:

(a) Staff orientation and training pertinent to duties, including cardiopulmonary resuscitation, first-aid, tuberculin skin testing and HIV/AIDS training;

(b) Criminal history disclosure and background checks as required in WAC 388-78A-045; and

(c) Verification of contacting work references and professional licensing and certification boards as required by subsection (1) of this section.

[Statutory Authority: RCW 18.20.240, 99-15-067, § 388-78A-050, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-050, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090, 94-13-180, § 246-316-050, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.43.830 through 43.43.842, 93-16-030 (Order 381), § 246-316-050, filed 7/26/93, effective 8/26/93. Statutory Authority: RCW 43.70.040, 91-02-049 (Order 121), recodified as § 246-316-050, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090, 89-09-034 (Order 2786), § 248-16-046, filed 4/14/89.]

WAC 388-78A-055 Policies and procedures. (1) The licensee shall establish and observe the following written policies and procedures, consistent with this chapter and services provided:

(a) Accepting and retaining residents, including specific policies, if any, for accepting or retaining residents needing state income assistance;

(b) Anti-discrimination;

(c) Limited nursing services consistent with WAC 388-78A-265;

(d) Health care services arranged by a resident under the provisions of WAC 388-78A-268, specifying the types of services allowed in the boarding home, and who has the responsibility for each aspect of the resident's care;

(e) Infection control, including:

(i) Cleaning and disinfecting toilets, bathing fixtures, floors, furniture, and common areas;

(ii) Cleaning resident rooms and furnishings;

(iii) Handwashing;

(iv) Managing staff and residents with communicable disease;

(v) Reporting communicable diseases in accordance with the requirements in chapter 246-100 WAC;

(vi) Handling and storing supplies and equipment used for resident services;

(vii) Infectious waste disposal;

(viii) Bloodborne pathogens in accordance with chapter 296-62 WAC; and

(ix) Laundry and handling of soiled and clean linens;

(f) Supervising and monitoring residents;

(g) Managing aggressive, assaultive residents, including but not limited to:

(i) Controlling violent residents; and

(ii) When and how to seek outside intervention;

(h) Food services, including but not limited to:

(i) Food service sanitation;

(ii) Procuring and storing food;

(iii) Meal times;

(iv) Modified diets;

(v) Food preparation;

- (vi) Nutrient supplements; and
- (vii) Food and meal substitution;
- (i) Maintaining resident records and register;
- (j) Medication services for each service category offered in the boarding home;
- (k) Boarding home safety;
- (l) Adult day care;
- (m) Care of residents with dementia, delineating special services required;
- (n) Emergency medical care and first-aid, including:
 - (i) Major emergencies;
 - (ii) Minor emergencies; and
 - (iii) Staff actions upon finding a resident not responsive to appropriate stimuli;
- (o) Death of a resident;
- (p) Suspected abuse, neglect, or exploitation including but not limited to:
 - (i) Reporting requirements according to chapters 26.44 and 74.34 RCW;
 - (ii) Responsibility of staff to immediately contact the department directly regarding suspected or alleged abuse or other improprieties, without retaliation from the licensee or administrator;
 - (iii) Protocol to protect residents according to WAC 388-78A-050(7); and
 - (iv) Additional steps to take in the event of suspected rape or sexual abuse, including:
 - (A) Immediate medical examination of the alleged victim, with prior notice to the examining physician that the patient may have been raped or sexually abused;
 - (B) Arranging for a counselor or other professional knowledgeable in the field of rape and sexual assault to question or interview the resident, and provide counseling or intervention, when appropriate; and
 - (C) Allowing only staff with special training in the field of rape and sexual assault to question the victim or the suspected perpetrator regarding the alleged incident, unless the department, police or prosecutor's office instructs otherwise;
 - (q) Protecting residents and maintaining living accommodations during internal and external disasters, such as fires, explosions, earthquakes, flooding, hazardous environmental contamination, and other events that jeopardize the safety of residents, describing:
 - (i) On-duty staff responsibilities;
 - (ii) Provisions for summoning emergency assistance;
 - (iii) Plans for evacuating residents from area or building;
 - (iv) Alternative resident accommodations;
 - (v) Provisions for essential resident needs, supplies and equipment; and
 - (vi) Emergency communication plan;
 - (r) Advance directives as described in chapter 70.122 RCW, Natural Death Act;
 - (s) Resident's temporary absence from the boarding home;
 - (t) Confidentiality of resident information;
 - (u) Criminal history background checks in accordance with WAC 388-78A-045;
 - (v) Resident trust funds; and
 - (w) Smoking, including means to protect nonsmokers.

(2) The licensee shall make the policies and procedures specified in subsection (1) of this section available to staff at all times and residents and residents' representatives upon request.

[Statutory Authority: RCW 18.20.240, 99-15-067, § 388-78A-055, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-055, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090, 94-13-180, § 246-316-055, filed 6/21/94, effective 7/22/94.]

WAC 388-78A-150 Resident room—Room furnishings—Storage. (1) The licensee shall provide each resident sleeping room or area, except as permitted in subsection (3) of this section, with:

- (a) Eighty or more square feet of usable floor space in a one-person room or area;
- (b) Seventy or more square feet of usable floor space per individual in a room occupied by two or more individuals;
- (c) A minimum ceiling height of seven feet six inches over all square footage considered usable floor space;
- (d) A maximum room occupancy of:
 - (i) Four individuals if the boarding home was licensed before July 1, 1989, and licensed continuously thereafter; and
 - (ii) Two individuals if the boarding home applied for initial licensure or to increase the number of resident sleeping rooms after June 30, 1989;
- (e) Room identification and resident capacity consistent with the licensed room list;
- (f) Unrestricted direct access to a hallway, living room, outside, or other common-use area;
- (g) One or more outside windows with:
 - (i) A total clear glass area equal to at least one-tenth of the room area;
 - (ii) Minimum area of ten square feet;
 - (iii) Window sills no more than three feet eight inches from the floor; and
 - (iv) Window sills at or above grade, with grade extending horizontally ten or more feet from the building;
 - (v) Easy operation if necessary for fire exit or ventilation; and
 - (vi) Adjustable curtains, shades, blinds, or equivalent for visual privacy;
- (h) One or more duplex electrical outlets per bed if the boarding home was initially licensed after July 1, 1983;
- (i) A light control switch located by the entrance for a light fixture in the room;
- (j) Lighting at bedside when requested by a resident;
- (k) One or more noncombustible waste containers, and no combustible waste containers;
- (l) An individual towel and washcloth rack or equivalent;
- (m) When requested by the resident, a lockable drawer, cupboard or other secure space measuring at least one-half cubic foot with a minimum dimension of four inches;
- (n) Storage facilities in or immediately adjacent to the resident's sleeping room to adequately store a reasonable quantity of clothing and personal possessions;
- (o) A comfortable bed, thirty-six or more inches wide, appropriate for size, age and physical condition of the resident and room dimensions, including but not limited to:
 - (i) Standard household bed;
 - (ii) Studio couch;

- (iii) Hide-a-bed;
 - (iv) Day bed; or
 - (v) Water bed, if structurally and electrically safe;
 - (p) A bed mattress which:
 - (i) Fits the bed frame;
 - (ii) Is in good condition; and
 - (iii) Is at least four inches thick unless otherwise requested or necessary for resident health or safety;
 - (q) Beds spaced at least three feet from other beds unless otherwise requested by all affected residents;
 - (r) One or more comfortable pillows;
 - (s) Bedding, in good repair, changed weekly or more often as necessary to maintain cleanliness;
 - (t) Clean towels and washcloths provided weekly or more often as necessary to maintain cleanliness; and
 - (u) A sturdy, comfortable chair, appropriate for the age and physical condition of the resident.
- (2) The licensee shall not allow the use of a resident room for a passageway or corridor.
- (3) The licensee may, upon a resident's request, permit the resident to use personal furniture and furnishings when such usage does not jeopardize the health and safety of any resident.
- (4) The licensee shall:
- (a) Document the functional ability of each resident to use cooking facilities safely; and
 - (b) Limit access to cooking facilities by any resident deemed by the licensee unable to cook safely.
- (5) The licensee may use or allow use of carpets and other floor coverings when:
- (a) Securely fastened to the floor or provided with non-skid backing; and
 - (b) Kept clean and free of hazards such as curling edges or tattered sections.
- (6) The licensee shall, prior to the purchase and installation of carpeting, submit samples to the department for approval in accordance with WAC 388-78A-070.

[Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-150, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-150, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-150, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-150, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-150, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-121, filed 4/14/89.]

WAC 388-78A-240 Criteria for accepting and retaining residents. (1) The licensee shall evaluate the ability of staff and facilities to meet a prospective resident's housing, domiciliary, dementia, and nursing care needs, based on:

- (a) Space, equipment and furniture requirements;
- (b) General behavior including the tendency to wander, fall, act verbally or physically abusive or socially inappropriate;
- (c) Current medication status and need for assistance in obtaining or administering medications;
- (d) Height, weight and age;
- (e) Functional abilities, including but not limited to:
 - (i) Ambulatory status and need for mobility aides;
 - (ii) Mental status and behavioral problems;

- (iii) Ability to perform activities of daily living independently or with assistance; and
 - (iv) Conditions requiring staff monitoring or care of the resident.
- (2) If the licensee accepts residents requiring limited nursing services, in addition to the information specified in subsection (1) of this section, the licensee shall consider:
- (a) Medical diagnosis;
 - (b) Blood pressure;
 - (c) Any chewing, swallowing, mouth and dental problems and treatments;
 - (d) Any infections, skin rashes, ulcers and open lesion problems and treatments;
 - (e) Appetite and hydration status;
 - (f) Need for chemotherapy, radiation and dialysis; and
 - (g) Any urethral catheter use and type.
- (3) The licensee shall accept and retain an individual as a resident only when:
- (a) The individual is ambulatory unless the boarding home is approved by the Washington state director of fire protection to care for semi-ambulatory or nonambulatory residents;
 - (b) The individual does not need medical or nursing care exceeding that allowed by WAC 388-78A-265 and 388-78A-268;
 - (c) A nonsmoking individual can be accommodated with a smoke-free room and smoke-free common-use areas;
 - (d) A smoking individual can be accommodated by areas meeting the requirements in WAC 388-78A-140(2);
 - (e) The individual can be accommodated by:
 - (i) The physical plant, facilities and spaces;
 - (ii) Furniture and equipment;
 - (iii) Staff who are available and sufficient to provide the type of domiciliary care required and desired by the individual; and
 - (iv) Staff who are available and sufficient to provide limited nursing services, as required by the individual, if the boarding home provides such services;
 - (f) The appropriate medication service type pursuant to RCW 18.20.160 and WAC 388-78A-300 is available in the boarding home; and
 - (g) The individual meets the acceptance criteria defined in the boarding home policies and procedures.
- (4) The licensee shall not accept or retain individuals:
- (a) Exhibiting continuing overt acts which present a risk of harming self or others, including but not limited to self-mutilation, suicide attempts, and hitting or striking out at others;
 - (b) Having major areas of skin breakdown and open wounds; or
 - (c) Whose needs can only be met by inpatient care in a hospital, nursing home, or other facility licensed under chapter 18.51, 71.12, or 70.41 RCW; and
- (5) Upon admitting a resident, the licensee shall document in the resident's health record, the resident's choice regarding:
- (a) Definite arrangements with a health care practitioner; and
 - (b) The identity of individuals to contact in case of an emergency, illness or death.

[Statutory Authority: RCW 18.20.240, 99-15-067, § 388-78A-240, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-240, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090, 94-13-180, § 246-316-240, filed 6/21/94, effective 7/22/94; 94-01-058, § 246-316-240, filed 12/8/93, effective 1/8/94; 92-02-018 (Order 224), § 246-316-240, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040, 91-02-049 (Order 121), recodified as § 246-316-240, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090, 89-09-034 (Order 2786), § 248-16-213, filed 4/14/89; 83-13-068 (Order 264), § 248-16-213, filed 6/16/83; Order 147, § 248-16-213, filed 6/29/77.]

WAC 388-78A-265 Limited nursing services. This section applies only to licensees who choose to provide limited nursing services. This section does not apply when residents care for themselves or arrange for independent nursing or health care services pursuant to WAC 388-78A-268.

(1) The licensee shall employ or contract directly or indirectly with a RN or physician to:

(a) Provide or supervise limited nursing services;

(b) Assess, or supervise a LPN's assessment of each resident needing limited nursing services upon admittance, and develop the nursing component of the individual's resident plan;

(c) Reassess, or supervise a LPN's reassessment of the resident's nursing needs when staff notice a change in the resident's functional ability or health status, and amend the nursing component of the individual's resident plan accordingly; and

(d) Be available in person, by pager, or by telephone during hours of limited nursing services.

(2) A licensee shall ensure the following services are only provided by a RN, or a LPN under the supervision of a RN:

(a) Insertion of urethral catheters, including indwelling;

(b) Any other nursing service requested by the licensee and approved in writing by the department.

(3) The licensee may allow unlicensed staff to provide the following services under the delegation and supervision of a RN:

(a) Routine ostomy care that is well-established, with no breakdown or maintenance care;

(b) Enema;

(c) Uncomplicated routine colostomy and urethral care when the resident is unable to supervise these activities;

(d) Care of wounds that are superficial without drainage or infection; and

(e) Assistance with glucometer testing if the resident can perform the finger stick.

(4) The licensee shall not provide the following nursing services on the premises:

(a) Respiratory ventilation;

(b) Intravenous procedures;

(c) Suctioning;

(d) Feeding tube insertion or site maintenance; and

(e) Care of residents who are bed-bound for more than fourteen consecutive days as a result of a medical condition.

(5) A licensee providing limited nursing services shall assure that employed or contracted nursing services are consistent with chapters 18.78 and 18.88 RCW.

(6) A licensee providing limited nursing services shall provide for safe and sanitary:

(a) Storage and handling of clean and sterile nursing equipment and supplies;

(b) Storage and handling of soiled laundry and linens;

(c) Cleaning and disinfecting soiled equipment; and

(d) Refuse and infectious waste disposal.

(7) In new construction designed for limited nursing services, or upon starting a limited nursing services program within an existing boarding home, the licensee shall provide the following, accessible only by staff:

(a) A clean utility area for the purposes of storing and preparing clean and sterile nursing supplies, equipped with:

(i) A work counter or table; and

(ii) Adjacent handwashing sink, with soap and paper towels or other approved hand-drying device; and

(b) A soiled utility area for the purposes of storing soiled linen, cleaning and disinfecting soiled nursing care equipment, and disposing of refuse and infectious waste, equipped with:

(i) A work counter or table;

(ii) Sinks for handwashing and cleaning/sanitizing, with soap and paper towels or other approved hand-drying device.

[Statutory Authority: RCW 18.20.240, 99-15-067, § 388-78A-265, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-265, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090, 94-13-180, § 246-316-265, filed 6/21/94, effective 7/22/94.]

WAC 388-78A-320 Resident health record. (1) The licensee shall maintain a health record with entries in ink, typewritten or equivalent, for each resident including:

(a) Full name, date of birth, and former address of resident;

(b) Date of moving in and moving out;

(c) The name, address, and telephone number of individuals to contact in case of an emergency, illness or death;

(d) Resident's representative, if any;

(e) Name, address, and telephone number of resident's personal physician or health care practitioner;

(f) Resident admitting information, including any medical diagnoses pertinent to care services needed by the resident and provided by the boarding home;

(g) Documented staff entries about:

(i) Dates and descriptions of the resident's illnesses, accidents, and incidents;

(ii) Changes in the resident's physical, mental, emotional and social abilities to cope with the affairs and activities of daily living, physical and mental coordination; and

(iii) Actions of staff related to (g)(i) and (ii) of this subsection;

(h) Orders documented by the resident's health care practitioner for any modified diet, concentrate or supplement provided by the boarding home;

(i) Medication orders and records as specified in WAC 388-78A-300;

(j) Clinical information such as weight, temperature, blood pressure, blood sugar and other laboratory tests that are ordered or required by the individual's resident plan;

(k) Advance notice for relocation as specified in chapter 214, Laws of 1994, long-term care facilities—resident rights;

(l) Notice of relocation as specified in WAC 388-78A-280; and

(m) Proof of resident's receipt of the list of resident rights and rules and regulations governing resident conduct and responsibilities as required by chapter 214, Laws of 1994, long-term care facilities—resident rights.

(2) The licensee shall:

(a) Maintain a systematic and secure method of identifying and filing resident health records for easy access;

(b) Allow authorized representatives of the department and other authorized regulatory agencies access to resident records;

(c) Provide any individual or organization access to resident records upon written consent of the resident or the resident's representative, unless state or federal law provide for broader access;

(d) Maintain resident records and health care information for residents receiving category B or C medication services or limited nursing services in accordance with chapter 70.02 RCW; and

(e) Retain each resident health record at least five years after the resident moves from the boarding home.

[Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-320, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-320, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-320, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-320, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-320, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-235, filed 4/14/89; 83-13-068 (Order 264), § 248-16-235, filed 6/16/83.]

WAC 388-78A-330 Adult day care. A licensee approved by the department to provide adult day care services for less than a contiguous twenty-four-hour period shall:

(1) Accept only those adults meeting the resident criteria in WAC 388-78A-240;

(2) Provide dining room and day room facilities according to WAC 388-78A-170 and 388-78A-180;

(3) Provide toilets and handwashing sinks according to WAC 388-78A-160;

(4) Provide sufficient furniture for the comfort of day care adults, in addition to furniture provided for residents, including:

(a) Sturdy comfortable chairs, appropriate for the age and physical condition of the day care adults; and

(b) Napping furniture such as lounge chairs, recliners, or couches which are placed three or more feet apart if needed or requested;

(5) Provide staff to supervise and assist day care adults in activities of daily living, limited nursing services and medication services as described in WAC 388-78A-260, 388-78A-265 and 388-78A-300;

(6) Provide a meal, which meets at least one-third of the recommended dietary allowance described in WAC 388-78A-170(2), during every five-hour period of stay or no more than fourteen hours between the evening meal and breakfast;

(7) Ensure rights according to WAC 388-78A-250;

(8) Provide services, notification, and safety as described in WAC 388-78A-260, 388-78A-265, 388-78A-280, and 388-78A-290;

(9) Maintain a separate register of all day care adults using the format described in WAC 388-78A-310; and

(10) Maintain a health record for each day care adult as described for residents in WAC 388-78A-320.

[Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-330, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-330, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-330, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-330, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-330, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-300, filed 4/14/89.]

WAC 388-78A-335 Residents—Dementia care. (1) If a licensee accepts residents with dementia care needs, the licensee must:

(a) Provide qualified staff, present at all times, to care for and supervise residents with dementia care needs including:

(i) Dressing, grooming and personal hygiene;

(ii) Eating;

(iii) Orientation and activities;

(iv) Ensuring the safety of all residents; and

(v) Assisting residents during an emergency; and

(b) Take one or more of the following measures to prevent wandering from the boarding home:

(i) Staff sufficient to monitor and care for residents with dementia care needs;

(ii) An alarm and monitoring system to alert staff when a resident exits the building or enclosed outdoor area; or

(iii) A dementia care unit meeting the standards described in subsection (2) of this section.

(2) A licensee providing a dementia care unit shall, except as provided in subsection (4) of this section:

(a) Assure the dementia care unit meets the fire and life safety requirements for boarding homes according to the Washington State Building Code;

(b) Provide a room which may be used for dining, socializing and recreation;

(c) Design floor and wall surfaces in such a way to augment resident orientation;

(d) Provide slip-resistant floors free of abrupt changes;

(e) Provide access to a secured outdoor space with:

(i) Walls or fences at least seventy-two inches high;

(ii) Walking surfaces that are firm, stable, slip-resistant and free from abrupt changes;

(iii) Outdoor furniture; and

(iv) Nontoxic plants;

(f) Provide an approved supervised automatic fire detection system and supervised automatic sprinkler system electrically interconnected with the fire alarm system;

(g) If exiting doors restrict egress, provide automatic locking and unlocking exiting doors from the dementia care unit, which:

(i) Release automatically when:

(A) The fire alarm is activated;

(B) Power to the building is lost; and

(C) An override switch is used in case of emergency;

(ii) Are equipped with alarms;

(iii) Have directions for lock releasing devices posted by doors and accessible to residents; and

(iv) Are approved for use by the local official enforcing the Uniform Building Code and the Uniform Fire Code prior to approval by the Washington state director of fire protection.

(3) A licensee shall obtain written consent from a resident, or if the resident is unable to give informed consent as defined in RCW 11.88.010 (1)(e), from an individual as set forth in RCW 7.70.065, prior to placing the resident in a dementia care unit.

(4) A licensee using a dementia care unit as of August 1, 1994, shall:

(a) Assure the unit is designed and maintained for safe and adequate care of residents;

(b) Meet the requirements in subsection (2)(a), (b), (c), (d), (e), and (g) of this section upon construction of a new dementia care unit or January 1, 2000, whichever occurs first; and

(c) Meet the requirements in subsection (2)(f) of this section upon construction of a new dementia care unit or June 30, 2002, whichever occurs first.

[Statutory Authority: RCW 18.20.090. 00-01-086, § 388-78A-335, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-335, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-335, filed 6/21/94, effective 7/22/94.]

Chapter 388-86 WAC

MEDICAL CARE—SERVICES PROVIDED

WAC

388-86-022	Repealed.
388-86-045	Repealed.
388-86-047	Repealed.
388-86-073	Repealed.
388-86-097	Repealed.
388-86-098	Repealed.
388-86-112	Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-86-022	School medical services for special education students. [Statutory Authority: RCW 74.08.090. 95-21-051 (Order 3908), § 388-86-022, filed 10/11/95, effective 11/11/95; 93-21-002 (Order 3650), § 388-86-022, filed 10/6/93, effective 11/6/93; 92-22-052 (Order 3474), § 388-86-022, filed 10/28/92, effective 11/28/92; 90-17-119 and 90-18-033 (Orders 3053 and 3053A), § 388-86-022, filed 8/21/90 and 8/27/90, effective 9/21/90 and 9/1/90.] Repealed by 00-01-088, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.04.050 and 74.08.090.
388-86-045	Home health services. [Statutory Authority: RCW 74.08.090. 94-03-052 (Order 3686), § 388-86-045, filed 1/12/94, effective 2/12/94; 82-21-024 (Order 1891), § 388-86-045, filed 10/13/82; 80-13-020 (Order 1542), § 388-86-045, filed 9/9/80; 78-02-024 (Order 1265), § 388-86-045, filed 1/13/78; Order 1112, § 388-86-045, filed 4/15/76; Order 592, § 388-86-045, filed 8/25/71; Order 435, § 388-86-045, filed 3/31/70; Order 264 (part), § 388-86-045, filed 11/24/67.] Repealed by 99-16-069, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090 and 74.09.530.
388-86-047	Hospice services. [Statutory Authority: RCW 74.08.090. 93-16-040 (Order 3601), § 388-86-047, filed 7/28/93, effective 8/28/93; 92-13-030 (Order 3402), § 388-86-047, filed 6/9/92, effective 8/1/92. Statutory Authority: 1989 c 427. 89-18-034 (Order 2853), § 388-86-047, filed 8/29/89, effective 9/29/89.] Repealed by 99-09-007, filed 4/9/99, effective 5/10/99. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24.

388-86-073	Occupational therapy. [Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-86-073, filed 10/25/95, effective 10/28/95; 94-07-030 (Order 3714), § 388-86-073, filed 3/9/94, effective 4/9/94; 94-01-065 (Order 3679), § 388-86-073, filed 12/8/93, effective 1/8/94; 90-17-119 and 90-18-033 (Orders 3053 and 3053A), § 388-86-073, filed 8/21/90 and 8/27/90, effective 9/21/90 and 9/1/90.] Repealed by 99-16-068, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090 and 74.09.520.
388-86-097	Respiratory therapy services. [Statutory Authority: RCW 74.08.090. 86-02-031 (Order 2321), § 388-86-097, filed 12/27/85; Order 1077, § 388-86-097, filed 12/24/75.] Repealed by 99-13-049, filed 6/9/99, effective 7/10/99. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530.
388-86-098	Speech therapy services. [Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-86-098, filed 10/25/95, effective 10/28/95; 94-07-030 (Order 3714), § 388-86-098, filed 3/9/94, effective 4/9/94; 94-01-065 (Order 3679), § 388-86-098, filed 12/8/93, effective 1/8/94; 90-17-119 and 90-18-033 (Orders 3053 and 3053A), § 388-86-098, filed 8/21/90 and 8/27/90, effective 9/21/90 and 9/1/90; 88-15-010 (Order 2649), § 388-86-098, filed 7/8/88; 86-02-031 (Order 2321), § 388-86-098, filed 12/27/85; 82-10-062 (Order 1801), § 388-86-098, filed 5/5/82; 82-01-001 (Order 1725), § 388-86-098, filed 12/3/81; 81-16-033 (Order 1685), § 388-86-098, filed 7/29/81; 78-02-024 (Order 1265), § 388-86-098, filed 1/13/78; Order 1202, § 388-86-098, filed 4/1/77.] Repealed by 99-16-071, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090 and 74.09.520.
388-86-112	Physical medicine and rehabilitation evaluation and treatment. [Statutory Authority: RCW 74.08.090. 85-17-037 (Order 2272), § 388-86-112, filed 8/15/85; 81-16-033 (Order 1685), § 388-86-112, filed 7/29/81; 78-02-024 (Order 1265), § 388-86-112, filed 1/13/78; Order 964, § 388-86-112, filed 8/19/74.] Repealed by 99-17-111, filed 8/18/99, effective 9/18/99. Statutory Authority: RCW 74.08.090 and 74.09.520.

WAC 388-86-022 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-86-045 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-86-047 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-86-073 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-86-097 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-86-098 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-86-112 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-87 WAC

MEDICAL CARE—PAYMENT

WAC

388-87-020	Repealed.
388-87-025	Repealed.
388-87-065	Repealed.
388-87-080	Repealed.
388-87-105	Repealed.

388-87-250 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-87-020 Subrogation. [Statutory Authority: RCW 74.08.090 and 74.09.522, 97-04-005, § 388-87-020, filed 1/24/97, effective 2/24/97. Statutory Authority: SSB 5419(6) and RCW 74.08.090, 95-20-031 (Order 3900), § 388-87-020, filed 9/27/95, effective 10/28/95; Order 264 (part), § 388-87-020, filed 11/24/67.] Repealed by 00-01-088, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.04.050 and 74.08.090.

388-87-025 Services requiring approval. [Statutory Authority: RCW 74.08.090, 91-23-081 (Order 3283), § 388-87-025, filed 11/19/91, effective 12/20/91; 86-02-031 (Order 2321), § 388-87-025, filed 12/27/85; 82-01-001 (Order 1725), § 388-87-025, filed 12/3/81; 81-16-032 (Order 1684), § 388-87-025, filed 7/29/81; 81-10-016 (Order 1648), § 388-87-025, filed 4/27/81; 80-15-034 (Order 1554), § 388-87-025, filed 10/9/80; 79-06-034 (Order 1402), § 388-87-025, filed 5/16/79; 79-01-002 (Order 1359), § 388-87-025, filed 12/8/78; 78-06-087 (Order 1301), § 388-87-025, filed 6/2/78; 78-02-024 (Order 1265), § 388-87-025, filed 1/13/78; Order 1244, § 388-87-025, filed 10/10/77; Order 1202, § 388-87-025, filed 4/1/77; Order 1196, § 388-87-025, filed 3/3/77; Order 1151, § 388-87-025, filed 9/8/76; Order 1098, § 388-87-025, filed 2/13/76; Order 1077, § 388-87-025, filed 12/24/75; Order 1019, § 388-87-025, filed 4/30/75; Order 1015, § 388-87-025, filed 3/27/75; Order 964, § 388-87-025, filed 8/19/74; Order 938, § 388-87-025, filed 5/23/74; Order 911, § 388-87-025, filed 3/1/74; Order 837, § 388-87-025, filed 7/26/73; Order 714, § 388-87-025, filed 9/14/72; Order 681, § 388-87-025, filed 5/10/72; Order 582, § 388-87-025, filed 7/20/71; Order 500, § 388-87-025, filed 12/2/70; Order 485, § 388-87-025, filed 10/13/70; Order 435, § 388-87-025, filed 3/31/70; Order 419, § 388-87-025, filed 12/31/69; Order 386, filed 8/27/69; Order 336, § 388-87-025, filed 2/3/69; Order 304, § 388-87-025, filed 9/6/68; Order 264 (part), § 388-87-025, filed 11/24/67.] Repealed by 00-01-088, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.04.050 and 74.08.090.

388-87-065 Payment—Home health agency. [Statutory Authority: RCW 74.08.090, 82-21-024 (Order 1891), § 388-87-065, filed 10/13/82; 80-13-020 (Order 1542), § 388-87-065, filed 9/9/80; Order 1112, § 388-87-065, filed 4/15/76; Order 593, § 388-87-065, filed 8/25/71; Order 264 (part), § 388-87-065, filed 11/24/67.] Repealed by 99-16-069, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090 and 74.09.530.

388-87-080 Payment—Oxygen. [Statutory Authority: RCW 74.08.090, 86-02-031 (Order 2321), § 388-87-080, filed 12/27/85; 82-01-001 (Order 1725), § 388-87-080, filed 12/3/81; 81-06-003 (Order 1610), § 388-87-080, filed 2/19/81; 78-02-024 (Order 1265), § 388-87-080, filed 1/13/78; Order 995, § 388-87-080, filed 12/31/74; Order 386, § 388-87-080, filed 8/27/69; Order 264 (part), § 388-87-080, filed 11/24/67.] Repealed by 99-13-049, filed 6/9/99, effective 7/10/99. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530.

388-87-105 Payment—Medical care outside state of Washington. [Statutory Authority: RCW 74.08.090, 92-22-059 (Order 3479), § 388-87-105, filed 10/29/92, effective 12/1/92. Statutory Authority: 1991 c 103, 91-20-050 (Order 3248), § 388-87-105, filed 9/24/91, effective 10/25/91. Statutory Authority: RCW 74.08.090, 87-12-056 (Order 2501), § 388-87-105, filed 6/1/87; 82-01-001 (Order 1725), § 388-87-105, filed 12/3/81; 81-16-032 (Order 1684), § 388-87-105, filed 7/29/81; 81-10-016 (Order 1648), § 388-87-105, filed 4/27/81; 80-13-020 (Order 1542), § 388-87-105, filed 9/9/80; Order 1203, § 388-87-105, filed 4/1/77; Order 1112, § 388-87-105, filed 4/15/76; Order 1061, § 388-87-105, filed 10/8/75; Order 879, § 388-87-105, filed 11/29/73; Order 667, § 388-87-105, filed 3/23/72; Order 567, § 388-87-105, filed 5/19/71; Order 336, § 388-87-105, filed 2/3/69; Order 304, § 388-87-105, filed 9/6/68; Order 264 (part), § 388-87-105, filed 11/24/67.] Repealed by 00-01-088, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.04.050 and 74.08.090.

388-87-250 Third-party resources. [Statutory Authority: RCW 74.08.090, 93-22-030 (Order 3658), § 388-87-250, filed 10/27/93, effective 11/27/93.] Repealed by 00-01-088, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.04.050 and 74.08.090.

WAC 388-87-020 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-87-025 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-87-065 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-87-080 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-87-105 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-87-250 Repealed. See Disposition Table at beginning of this chapter.

**Chapter 388-96 WAC
NURSING FACILITY MEDICAID PAYMENT
SYSTEM**

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WAC 388-96-010 Definitions. Unless the context indicates otherwise, the following definitions apply in this chapter.

"Accounting" means activities providing information, usually quantitative and often expressed in monetary units, for:

- (1) Decision-making;
- (2) Planning;
- (3) Evaluating performance;
- (4) Controlling resources and operations; and
- (5) External financial reporting to investors, creditors, regulatory authorities, and the public.

"Administration and management" means activities used to maintain, control, and evaluate the efforts and resources of an organization for the accomplishment of the objectives and policies of that organization.

"Allowable costs" means documented costs that are necessary, ordinary, and related to the care of Medicaid recipients, and are not expressly declared nonallowable by this chapter or chapter 74.46 RCW. Costs are ordinary if they are of the nature and magnitude that prudent and cost conscious management would pay.

"Allowable depreciation costs" means depreciation costs of tangible assets, whether owned or leased by the contractor, meeting the criteria specified in RCW 74.46.330.

"Anticipated resident or patient days" are calculated by multiplying the nursing facility's number of licensed beds on the effective date of the recalculated Medicaid payment rate allocation by the number of calendar days in the cost report period on which the department based the Medicaid payment rate allocation that it is recalculating. Then, the product is multiplied by the greater of either the nursing facility's occupancy percentage for the cost report period on which the department based the Medicaid payment rate that it is recalculating or eighty-five percent.

"Anticipated resident occupancy percentage" is determined by multiplying the number of calendar days in the nursing facility's cost report period on which the department based the Medicaid payment rate that it is recalculating by the number of licensed beds on the effective date of the recalculated Medicaid payment rate allocation. Then, the nursing facility's anticipated resident days are divided by the product. In all determinations that require an anticipated resident occupancy percentage, the department will use the greater of either the nursing facility's anticipated resident occupancy percentage or eighty-five percent.

"Assignment of contract" means:

- (1) A new nursing facility licensee has elected to care for Medicaid residents;
- (2) The department finds no good cause to object to continuing the Medicaid contract at the facility; and
- (3) The new licensee accepts assignment of the immediately preceding contractor's contract at the facility.

"Capitalized lease" means a lease required to be recorded as an asset and associated liability in accordance with generally accepted accounting principles.

"Cash method of accounting" means a method of accounting in which revenues are recorded when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for those expenditures and assets.

"Change of ownership" means a substitution of the individual operator or operating entity contracting with the department to deliver care services to medical care recipients in a nursing facility and ultimately responsible for the daily operational decisions of the nursing facility.

(1) Events which constitute a change of ownership include, but are not limited to, the following:

(a) Changing the form of legal organization of the contractor, e.g., a sole proprietor forms a partnership or corporation;

(b) Transferring ownership of the nursing facility business enterprise to another party, regardless of whether ownership of some or all of the real property and/or personal property assets of the facility are also transferred;

(c) Dissolving of a partnership;

(d) Dissolving the corporation, merging the corporation with another corporation, which is the survivor, or consolidating with one or more other corporations to form a new corporation;

(e) Transferring, whether by a single transaction or multiple transactions within any continuous twenty-four-month period, fifty percent or more of the stock to one or more:

(i) New or former stockholders; or

(ii) Present stockholders each having held less than five percent of the stock before the initial transaction; or

(f) Substituting of the individual operator or the operating entity by any other event or combination of events that results in a substitution or substitution of control of the individual operator or the operating entity contracting with the department to deliver care services.

(2) Ownership does not change when the following, without more, occurs:

(a) A party contracts with the contractor to manage the nursing facility enterprise as the contractor's agent, i.e., subject to the contractor's general approval of daily operating and management decisions; or

(b) The real property or personal property assets of the nursing facility change ownership or are leased, or a lease of them is terminated, without a substitution of individual operator or operating entity and without a substitution of control of the operating entity contracting with the department to deliver care services.

"Charity allowance" means a reduction in charges made by the contractor because of the indigence or medical indigence of a patient.

"Component rate allocation(s)" means the initial component rate allocation(s) of the rebased rate for a rebase period effective July 1. If a month and a day, other than July 1, with a year precedes "component rate allocation(s)," it means the initial component rate allocation(s) of the rebased rate of the rebase period has been amended or updated effective

tive the date that precedes it, e.g., October 1, 1999 direct care component rate allocation.

"Contract" means an agreement between the department and a contractor for the delivery of nursing facility services to medical care recipients.

"Cost report" means all schedules of a nursing facility's cost report submitted according to the department's instructions.

"Courtesy allowances" means reductions in charges in the form of an allowance to physicians, clergy, and others, for services received from the contractor. Employee fringe benefits are not considered courtesy allowances.

"Donated asset" means an asset the contractor acquired without making any payment for the asset either in cash, property, or services. An asset is not a donated asset if the contractor:

(1) Made even a nominal payment in acquiring the asset;

or

(2) Used donated funds to purchase the asset.

"Equity capital" means total tangible and other assets which are necessary, ordinary, and related to patient care from the most recent provider cost report minus related total long-term debt from the most recent provider cost report plus working capital as defined in this section.

"Fiscal year" means the operating or business year of a contractor. All contractors report on the basis of a twelve-month fiscal year, but provision is made in this chapter for reports covering abbreviated fiscal periods. As determined by context or otherwise, **"fiscal year"** may also refer to a state fiscal year extending from July 1 through June 30 of the following year and comprising the first or second half of a state fiscal biennium.

"Gain on sale" means the actual total sales price of all tangible and intangible nursing facility assets including, but not limited to, land, building, equipment, supplies, goodwill, and beds authorized by certificate of need, minus the net book value of such assets immediately prior to the time of sale.

"Intangible asset" is an asset that lacks physical substance but possesses economic value.

"Interest" means the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user.

"Multiservice facility" means a facility at which two or more types of health or related care are delivered, e.g., a hospital and nursing facility, or a boarding home and nursing facility.

"Nonadministrative wages and benefits" means wages, benefits, and corresponding payroll taxes paid for nonadministrative personnel, not to include administrator, assistant administrator, or administrator-in-training.

"Nonallowable costs" means the same as **"unallowable costs."**

"Nonrestricted funds" means funds which are not restricted to a specific use by the donor, e.g., general operating funds.

"Nursing facility occupancy percentage" is determined by multiplying the number of calendar days for the cost report period by the number of licensed beds for the same cost report period. Then, the nursing facility's actual

resident days for the same cost report period is divided by the product. In all determinations that require a nursing facility occupancy percentage, the department will use the greater of either a nursing facility's occupancy percentage or eighty-five percent.

"Per diem (per patient day or per resident day) costs" means total allowable costs for a fiscal period divided by total patient or resident days for the same period.

"Prospective daily payment rate" means the rate assigned by the department to a contractor for providing service to medical care recipients prior to the application of settlement principles.

"Recipient" means a Medicaid recipient.

"Related care" includes:

- (1) The director of nursing services;
- (2) Activities and social services programs;
- (3) Medical and medical records specialists; and
- (4) Consultation provided by:
 - (a) Medical directors; and
 - (b) Pharmacists.

"Relative" includes:

- (1) Spouse;
- (2) Natural parent, child, or sibling;
- (3) Adopted child or adoptive parent;
- (4) Stepparent, stepchild, stepbrother, stepsister;
- (5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law;
- (6) Grandparent or grandchild; and
- (7) Uncle, aunt, nephew, niece, or cousin.

"Start-up costs" means the one-time preopening costs incurred from the time preparation begins on a newly constructed or purchased building until the first patient is admitted. Start-up costs include:

- (1) Administrative and nursing salaries;
- (2) Utility costs;
- (3) Taxes;
- (4) Insurance;
- (5) Repairs and maintenance; and
- (6) Training costs.

Start-up costs do not include expenditures for capital assets.

"Total rate allocation" means the initial rebased rate for a rebase period effective July 1. If a month and a day, other than July 1, with a year precedes "total rate allocation," it means the initial rebased rate of the rebase period has been amended or updated effective the date that precedes it, e.g., October 1, 1999 direct care component rate allocation.

"Unallowable costs" means costs which do not meet every test of an allowable cost.

"Uniform chart of accounts" means a list of account titles identified by code numbers established by the department for contractors to use in reporting costs.

"Vendor number" means a number assigned to each contractor delivering care services to medical care recipients.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-010, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-010, filed 9/25/98, effective 10/1/98; 97-17-040, § 388-96-010, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-010, filed 9/12/95, effective 10/13/95. Statutory

Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-010, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-010, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-010, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-010, filed 4/17/90, effective 5/18/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-010, filed 12/23/87. Statutory Authority: RCW 74.09.120 and 74.46.800. 85-13-060 (Order 2240), § 388-96-010, filed 6/18/85. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-010, filed 12/4/84. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-010, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-010, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-010, filed 10/13/82; 81-22-081 (Order 1712), § 388-96-010, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-010, filed 2/25/81. Statutory Authority: RCW 74.09.120. 80-09-083 (Order 1527), § 388-96-010, filed 7/22/80; 79-04-061 (Order 1381), § 388-96-010, filed 3/28/79. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-010, filed 6/1/78; Order 1262, § 388-96-010, filed 12/30/77.]

WAC 388-96-202 Scope of audit or department audit. (1) The department will review the contractor's record-keeping and accounting practices and, where appropriate, make written recommendations for improvements.

(2) The department's audit will result in a schedule of summarizing adjustments to the contractor's cost report. The schedule will show whether such adjustments eliminate costs reported or include costs not reported. Each adjustment listed will include an explanation for the adjustment, the cost report account, and the dollar amount. In accordance with chapter 74.46 RCW, the department will comply with the purpose of department audits by verifying that:

(a) Supporting records are in agreement with reported data;

(b) Only those assets, liabilities, and revenue and expense items the department has specified as allowable have been included by the contractor in computing the costs of services provided under its contract;

(c) Allowable costs have been accurately determined and are necessary, ordinary, and related to resident care;

(d) Related organizations and beneficial ownerships or interests have been correctly disclosed;

(e) Home office or central office costs have been reported and allocated in accordance with the provisions of this chapter and chapter 74.46 RCW;

(f) Recipient and non-Medicaid resident trust funds have been properly maintained and disbursed;

(g) Facility receivables do not include benefits or payments to which the provider is not entitled; and

(h) The contractor is otherwise in compliance with the provisions of this chapter and chapter 74.46 RCW.

(3) In complying with the purpose of department audits in chapter 74.46 RCW, the department may select any or all schedules of a facility's cost report. The department will audit cost reports, resident trust fund accounts, and facility receivables of each nursing facility participating in the Medicaid payment system as determined necessary by the department.

(4) When determining the contractor's final settlement, the department will apply to reported costs adjustments written under subsection (2), whether used for the purpose of establishing component rate allocations as described in chapter 74.46 RCW or to ascertain contractor compliance with subsection (2).

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-202, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 8 and RCW 74.46.800. 98-20-023, § 388-96-202, filed 9/25/98, effective 10/1/98.]

WAC 388-96-218 Proposed, preliminary, and final settlements. (1) For each component rate, the department shall calculate a settlement at the lower of prospective payment rate or audited allowable costs, except as otherwise provided in this chapter.

(2) In the proposed settlement report, a contractor shall compare the contractor's payment rates during a report period, weighted by the number of resident days reported for the period when each rate was in effect, to the contractor's allowable costs for the reporting period. The contractor shall take into account all authorized shifting, retained savings, and upper limits to rates on a cost center basis.

(a) Within one hundred twenty days after a proposed settlement report is received, the department shall:

(i) Review the proposed settlement report for accuracy; and

(ii) Either accept or reject the proposal of the contractor. If accepted, the proposed settlement report shall become the preliminary settlement report. If rejected, the department shall issue, by cost center, a preliminary settlement report fully substantiating disallowed costs, refunds, or underpayments due and adjustments to the proposed preliminary settlement.

(b) A contractor shall have twenty-eight days after receipt of a preliminary settlement report to contest such report under WAC 388-96-901 and 388-96-904. Upon expiration of the twenty-eight-day period, the department shall not review or adjust a preliminary settlement report. Any administrative review of a preliminary settlement shall be limited to calculation of the settlement, to the application of settlement principles and rules, or both, and shall not encompass rate or audit issues.

(3) The department shall issue a final settlement report to the contractor after the completion of the department audit process, including exhaustion or termination of any administrative review and appeal of audit findings or determinations requested by the contractor, but not including judicial review as may be available to and commenced by the contractor.

(a) The department shall prepare a final settlement by cost center and shall fully substantiate disallowed costs, refunds, underpayments, or adjustments to the cost report and financial statements, reports, and schedules submitted by the contractor. The department shall take into account all authorized shifting, savings, and upper limits to rates on a cost center basis. For the final settlement report, the department shall compare:

(i) The payment rate the contractor was paid for the facility in question during the report period, weighted by the number of allowable resident days reported for the period each rate was in effect to the contractor's;

(ii) Audited allowable costs for the reporting period; or
(iii) Reported costs for the nonaudited reporting period.

(b) A contractor shall have twenty-eight days after the receipt of a final settlement report to contest such report pursuant to WAC 388-96-901 and 388-96-904. Upon expiration of the twenty-eight-day period, the department shall not

review a final settlement report. Any administrative review of a final settlement shall be limited to calculation of the settlement, the application of settlement principles and rules, or both, and shall not encompass rate or audit issues.

(c) The department shall reopen a final settlement if it is necessary to make adjustments based upon findings resulting from a department audit performed pursuant to RCW 74.46.100. The department may also reopen a final settlement to recover an industrial insurance dividend or premium discount under RCW 51.16.035 in proportion to a contractor's Medicaid recipients.

(4) In computing a preliminary or final settlement, a contractor may shift savings and/or overpayment in the support services cost center to cover a deficit and/or underpayment in the direct care or therapy cost centers up to the amount of the savings as provided in RCW 74.46.165(4). The provider's payment rate is subject to the provisions of RCW 74.46.421.

(5) If an administrative or judicial remedy sought by the facility is not granted or is granted only in part after exhaustion or mutual termination of all appeals, the facility shall refund all amounts due the department within sixty days after the date of decision or termination plus interest as payment on judgments from the date the review was requested pursuant to WAC 388-96-901 and WAC 388-96-904 to the date the repayment is made.

(6) In determining whether a facility has forfeited unused rate funds in its direct care, therapy care and support services component rates under authority of RCW 74.46.165(3), the following rules shall apply:

(a) Federal or state survey officials shall determine when a facility is not in substantial compliance or is providing substandard care, according to federal and state nursing facility survey regulations;

(b) Correspondence from state or federal survey officials notifying a facility of its compliance status shall be used to determine the beginning and ending dates of any period(s) of noncompliance; and

(c) Forfeiture shall occur if the facility was out of substantial compliance more than ninety days during the settlement period. The ninety-day period need not be continuous if the number of days of noncompliance exceed ninety days during the settlement period regardless of the length of the settlement period. Also, forfeiture shall occur if the nursing facility was determined to have provided substandard quality of care at any time during the settlement period.

(7)(a) For calendar year 1998, the department will calculate two settlements covering the following periods:

- (i) January 1, 1998 through September 30, 1998; and
- (ii) October 1, 1998 through December 31, 1998.

(b) The department will use Medicaid rates weighted by total patient days (i.e., Medicaid and non-Medicaid days) to divide 1998 costs between the two settlement periods identified in subsection (7)(a) of this section.

(c) The department will net the two settlements for 1998 to determine a nursing facility's 1998 settlement.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207, 99-24-084, § 388-96-218, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 9 and 10 and RCW 74.46.800, 98-20-023, § 388-96-218, filed 9/25/98, effective 10/1/98.]

WAC 388-96-384 Liquidation or transfer of resident personal funds. (1) Upon the death of a resident, the facility shall promptly convey the resident's personal funds held by the facility with a final accounting of such funds to the department or to the individual or probate jurisdiction administering the resident's estate.

(a) If the deceased resident was a recipient of long-term care services paid for in whole or in part by the state of Washington then the personal funds held by the facility and the final accounting shall be sent to the state of Washington, department of social and health services, office of financial recovery (or successor office).

(b) The personal funds of the deceased resident and final accounting must be conveyed to the individual or probate jurisdiction administering the resident's estate or to the state of Washington, department of social and health services, office of financial recovery (or successor office) no later than the thirtieth day after the date of the resident's death.

(i) When the personal funds of the deceased resident are to be paid to the state of Washington, those funds shall be paid by the facility with a check, money order, certified check or cashier's check made payable to the secretary, department of social and health services, and mailed to the Office of Financial Recovery, Estate Recovery Unit, P.O. Box 9501, Olympia, Washington 98507-9501, or such address as may be directed by the department in the future.

(ii) The check, money order, certified check or cashier's check or the statement accompanying the payment shall contain the name and social security number of the deceased individual from whose personal funds account the monies are being paid.

(c) The department of social and health services shall establish a release procedure for use of funds necessary for burial expenses.

(2) In situations where the resident leaves the nursing home without authorization and the resident's whereabouts is unknown:

(a) The nursing facility shall make a reasonable attempt to locate the missing resident. This includes contacting:

- (i) Friends,
- (ii) Relatives,
- (iii) Police,
- (iv) The guardian, and
- (v) The community services office in the area.

(b) If the resident cannot be located after ninety days, the nursing facility shall notify the department of revenue of the existence of "abandoned property," outlined in chapter 63.29 RCW. The nursing facility shall deliver to the department of revenue the balance of the resident's personal funds within twenty days following such notification.

(3) Prior to the sale or other transfer of ownership of the nursing facility business, the facility operator shall:

(a) Provide each resident or resident representative with a written accounting of any personal funds held by the facility;

(b) Provide the new operator with a written accounting of all resident funds being transferred; and

(c) Obtain a written receipt for those funds from the new operator.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207, 99-24-084, § 388-96-384, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18, 95-19-037 (Order 3896), § 388-96-384, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800, 74.42.620 and 74.09.120, 90-20-075 (Order 3070), § 388-96-384, filed 9/28/90, effective 10/1/90. Statutory Authority: 1987 c 476, 88-01-126 (Order 2573), § 388-96-384, filed 12/23/87. Statutory Authority: RCW 74.09.120, 82-21-025 (Order 1892), § 388-96-384, filed 10/13/82; Order 1168, § 388-96-384, filed 11/3/76; Order 1114, § 388-96-384, filed 4/21/76.]

WAC 388-96-559 Cost basis of land and depreciation base. (1) For all partial or whole rate periods after December 31, 1984 unless otherwise provided or limited by this chapter or by this section, chapter 388-96 WAC or chapter 74.46 RCW, the total depreciation base of depreciable assets and the cost basis of land shall be the lowest of:

- (a) The contractor's appraisal, if any;
- (b) The department's appraisal obtained through the department of general administration of the state of Washington, if any; or
- (c) The historical purchase cost of the contractor, or lessor if the assets are leased by the contractor, in acquiring ownership of the asset in an arm's-length transaction, and preparing the asset for use, less goodwill, and less accumulated depreciation, if applicable, incurred during periods the assets have been used in or as a facility by any and all contractors. Such accumulated depreciation is to be measured in accordance with subsection (5) of this section and WAC 388-96-561, 388-96-565, and 388-96-567. Where the straight-line or sum-of-the-years digits method of depreciation is used the contractor:
 - (i) May deduct salvage values from historical costs for each cloth based item, e.g., mattresses, linen, and draperies; and
 - (ii) Shall deduct salvage values from historical costs of at least:
 - (A) Five percent of the historical value for each noncloth item included in moveable equipment; and
 - (B) Twenty-five percent of the historical value for each vehicle.

(2) Unless otherwise provided or limited by this chapter or by chapter 74.46 RCW, the department shall, in determining the total depreciation base of a depreciable real or personal asset owned or leased by the contractor, deduct depreciation relating to all periods subsequent to the more recent of:

- (a) The date such asset was first used in the medical care program; or
- (b) The most recent date such asset was acquired in an arm's-length purchase transaction which the department is required to recognize for Medicaid cost reimbursement purposes.

No depreciation shall be deducted for periods such asset was not used in the medical care program or was not used to provide nursing care.

(3) The department may have the fair market value of the asset at the time of purchase established by appraisal through the department of general administration of the state of Washington if:

- (a) The department challenges the historical cost of an asset; or

(b) The contractor cannot or will not provide the historical cost of a leased asset and the department is unable to determine such historical cost from its own records or from any other source.

The contractor may allocate or reallocate values among land, building, improvements, and equipment in accordance with the department's appraisal.

If an appraisal is conducted, the depreciation base of the asset and cost basis of land will not exceed the fair market value of the asset. An appraisal conducted by or through the department of general administration shall be final unless the appraisal is shown to be arbitrary and capricious.

(4) If the land and depreciable assets of a newly constructed nursing facility were never used in or as a nursing facility before being purchased from the builder, the cost basis and the depreciation base shall be the lesser of:

- (a) Documented actual cost of the builder; or
- (b) The approved amount of the certificate of need issued to the builder.

When the builder is unable or unwilling to document its costs, the cost basis and the depreciation base shall be the approved amount of the certificate of need.

(5) For leased assets, the department may examine documentation in its files or otherwise obtainable from any source to determine:

- (a) The lessor's purchase acquisition date; or
- (b) The lessor's historical cost at the time of the last arm's-length purchase transaction.

If the department is unable to determine the lessor's acquisition date by review of its records or other records, the department, in determining fair market value as of such date, may use the construction date of the facility, as found in the state fire marshal's records or other records, as the lessor's purchase acquisition date of leased assets.

(6) For all rate periods past or future, where depreciable assets or land are acquired from a related organization, the contractor's depreciation base and land cost basis shall not exceed the base and basis the related organization had or would have had under a contract with the department.

(7) If a contractor cannot or will not provide the lessor's purchase acquisition cost of assets leased by the contractor and the department is unable to determine historical purchase cost from another source, the appraised asset value of land, building, or equipment, determined by or through the department of general administration shall be adjusted, if necessary, by the department using the *Marshall and Swift Valuation Guide* to reflect the value at the lessor's acquisition date. If an appraisal has been prepared for leased assets and the assets subsequently sell in the first arm's-length transaction since January 1, 1980, under subsection (9) of this section, the *Marshall and Swift Valuation Guide* will be used to adjust, if necessary, the asset value determined by the appraisal to the sale date. If the assets are located in a city for which the *Marshall and Swift Valuation Guide* publishes a specific index, or if the assets are located in a county containing that city, the city-specific index shall be used to adjust the appraised value of the asset. If the assets are located in a city or county for which a specific index is not calculated, the *Western District Index* calculated by Marshall and Swift shall be used.

(8) For new or replacement building construction or for substantial building additions requiring the acquisition of land and which commenced to operate on or after July 1, 1997, the department shall determine allowable land costs of the additional land acquired for the new or replacement construction or for substantial building additions to be the lesser of:

(a) The contractor's or lessor's actual cost per square foot; or

(b) The square foot land value as established by an appraisal that meets the latest publication of the *Uniform Standards of Professional Appraisal Practice (USPAP)* and the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (FIRREA). The department shall obtain a USPAP appraisal that meets FIRREA first from:

(i) An arms'-length lender that has accepted the ordered appraisal; or

(ii) If the department is unable to obtain from the arms'-length lender a lender-approved appraisal meeting USPAP and FIRREA standards or if the contractor or lessor is unable or unwilling to provide or cause to be provided a lender-approved appraisal meeting USPAP and FIRREA standards, then:

(A) The department shall order such an appraisal; and

(B) The contractor shall immediately reimburse the department for the costs incurred in obtaining the USPAP and FIRREA appraisal.

(9) Except as provided for in subsection (8) of this section, for all rates effective on or after January 1, 1985, if depreciable assets or land are acquired by purchase which were used in the medical care program on or after January 1, 1980, the depreciation base or cost basis of such assets shall not exceed the net book value existing at the time of such acquisition or which would have existed had the assets continued in use under the previous Medicaid contract with the department; except that depreciation shall not be accumulated for periods during which such assets were not used in the medical care program or were not in use in or as a nursing care facility.

(10)(a) Subsection (9) of this section shall not apply to the most recent arm's-length purchase acquisition if it occurs ten years or more after the previous arm's-length transfer of ownership nor shall subsection (9) of this section apply to the first arm's-length purchase acquisition of assets occurring on or after January 1, 1980, for facilities participating in the Medicaid program before January 1, 1980. The depreciation base or cost basis for such acquisitions shall not exceed the lesser of the fair market value as of the date of purchase of the assets determined by an appraisal conducted by or through the department of general administration or the owner's acquisition cost of each asset, land, building, or equipment. An appraisal conducted by or through the department of general administration shall be final unless the appraisal is shown to be arbitrary and capricious. Should a contractor request a revaluation of an asset, the contractor must document ten years have passed since the most recent arm's-length transfer of ownership. As mandated by Section 2314 of the Deficit Reduction Act of 1984 (P.L. 98-369) and state statutory amendments, and under RCW 74.46.840, for all partial or whole rate periods after July 17, 1984, this subsection is

inoperative for any transfer of ownership of any asset, including land and all depreciable or nondepreciable assets, occurring on or after July 18, 1984, leaving subsection (9) of this section to apply without exception to acquisitions occurring on or after July 18, 1984, except as provided in subsections (10)(b) and (11) of this section.

(b) For all rates after July 17, 1984, subsection (8)(a) shall apply, however, to transfers of ownership of assets:

(i) Occurring before January 1, 1985, if the costs of such assets have never been reimbursed under Medicaid cost reimbursement on an owner-operated basis or as a related party lease; or

(ii) Under written and enforceable purchase and sale agreements dated before July 18, 1984, which are documented and submitted to the department before January 1, 1988.

(c) For purposes of Medicaid cost reimbursement under this chapter, an otherwise enforceable agreement to purchase a nursing home dated before July 18, 1984, shall be considered enforceable even though the agreement contains:

(i) No legal description of the real property involved; or

(ii) An inaccurate legal description, notwithstanding the statute of frauds or any other provision of law.

(11)(a) In the case of land or depreciable assets leased by the same contractor since January 1, 1980, in an arm's-length lease, and purchased by the lessee/contractor, the lessee/contractor shall have the option to have the:

(i) Provisions of subsection (10) of this section apply to the purchase; or

(ii) Component rate allocations for property and financing allowance calculated under the provisions of chapter 74.46 RCW. Component rate allocations will be based upon provisions of the lease in existence on the date of the purchase, but only if the purchase date meets the criteria of RCW 74.46.360 (6)(c)(ii)(A) through (D).

(b) The lessee/contractor may select the option in subsection (11)(a)(ii) of this section only when the purchase date meets one of the following criteria. The purchase date is:

(i) After the lessor has declared bankruptcy or has defaulted in any loan or mortgage held against the leased property;

(ii) Within one year of the lease expiration or renewal date contained in the lease;

(iii) After a rate setting for the facility in which the reimbursement rate set, under this chapter and under chapter 74.46 RCW, no longer is equal to or greater than the actual cost of the lease; or

(iv) Within one year of any purchase option in existence on January 1, 1988.

(12) For purposes of establishing the property and financing allowance component rate allocations, the value of leased equipment, if unknown by the contractor, may be estimated by the department using previous department of general administration appraisals as a data base. The estimated value may be adjusted using the *Marshall and Swift Valuation Guide* to reflect the value of the asset at the lessor's purchase acquisition date.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-559, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.360. 97-17-040, § 388-96-559, filed 8/14/97,

effective 9/14/97. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-559, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-559, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-559, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.46.800. 88-16-079 (Order 2660), § 388-96-559, filed 8/2/88; 86-10-055 (Order 2372), § 388-96-559, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-559, filed 8/19/85. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-559, filed 12/4/84; 81-22-081 (Order 1712), § 388-96-559, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-559, filed 2/25/81; Order 1262, § 388-96-559, filed 12/30/77.]

WAC 388-96-565 Lives. (1) Except for new buildings replacement buildings, major remodels and major repair projects as defined in subsection (5) of this section, to compute allowable depreciation, the contractor must use lives reflecting the estimated actual useful life of the assets (e.g., land improvements, buildings, including major remodels and major repair projects, equipment, leasehold improvements, etc.). However the lives used must not be shorter than guidelines lives in the most current edition of *Estimated Useful Lives of Depreciable Hospital Assets* published by American Hospital Publishing, Inc.

(2) To compute allowable depreciation for major remodels and major repair projects as defined in subsection (5) of this section that began operating:

(a) Before July 1, 1997, the contractor must use the shortest lives in the most recently published lives for construction classes as defined and described in the *Marshall Valuation Service* published by the Marshall Swift Publication Company; or

(b) After July 1, 1997, the contractor must use the shortest lives of the guideline lives in the most current edition of *Estimated Useful Lives of Depreciable Hospital Assets* published by American Hospital Publishing, Inc.

(3) To compute allowable depreciation for new buildings and replacement buildings as defined in subsection (5) of this section that:

(a) Began operating before July 1, 1997, the contractor must use the construction classes as defined and described in *Marshall Valuation Service* published by the Marshall Swift Publication Company; *provided that*, thirty years is the shortest life that may be used;

(b) Began operating on or after July 1, 1997, the contractor must use the most current edition of *Estimated Useful Lives of Depreciable Hospital Assets* published by American Hospital Publishing, Inc.; *provided that*, thirty years is shortest life that may be used; and

(c) Received certificate of need approval or certificate of need exemptions under chapter 70.38 RCW on or after July 1, 1999, the contractor must use the most current edition of *Estimated Useful Lives of Depreciable Assets* published by American Hospital Publishing, Inc.; *provided that*, forty years is the shortest life that may be used.

(4) To compute allowable depreciation, the contractor must:

(a) Measure lives from the most recent of either the date on which the assets were first used in the medical care program or the last date of purchase of the asset through an arm's-length acquisition; and

(b) Extend lives to reflect periods, if any, during which assets were not used in a nursing facility or as a nursing facility.

(5) New buildings, replacement buildings, major remodels, and major repair projects are those projects that meet or exceed the expenditure minimum established by the department of health pursuant to chapter 70.38 RCW.

(6) Contractors shall depreciate building improvements other than major remodels and major repairs defined in subsection (5) of this section over the remaining useful life of the building, as modified by the improvement, but not less than fifteen years.

(7) Improvements to leased property which are the responsibility of the contractor under the terms of the lease shall be depreciated over the useful life of the improvement in accordance with American Hospital Association guidelines.

(8) A contractor may change the estimate of an asset's useful life to a longer life for purposes of depreciation.

(9) For new or replacement building construction or for major renovations receiving certificate of need approval or exemption under chapter 70.38 RCW on or after July 1, 1999, the department will depreciate fixed equipment the same number of years as the life of the building to which it is affixed.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-565, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.310, [74.46.]320 and [74.46.]330. 97-17-040, § 388-96-565, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-565, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-565, filed 12/21/88. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-565, filed 4/20/87; 86-10-055 (Order 2372), § 388-96-565, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-565, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-565, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-565, filed 2/25/81; Order 1262, § 388-96-565, filed 12/30/77.]

WAC 388-96-572 Handling of gains and losses upon retirement of depreciable assets—Other periods. (1) This section shall apply in the place of WAC 388-96-571 effective January 1, 1981, for purposes of settlement for settlement periods subsequent to that date, and for purposes of setting rates for rate periods beginning July 1, 1982, and subsequently.

(2) A gain or loss on the retirement of an asset shall be the difference between the remaining undepreciated base and any proceeds received for, or to compensate for loss of, the asset.

(3) If the retired asset is replaced, the gain or loss shall be applied against or added to the cost of the replacement asset, provided that a loss will only be so applied if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset.

(4) If the retired asset is not replaced, any gain shall be offset against property expense for the period during which it is retired and any loss shall be expensed subject to the provisions of WAC 388-96-554.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-572, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051

(Order 3555), § 388-96-572, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-572, filed 9/16/83. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-572, filed 2/25/81.]

WAC 388-96-585 Unallowable costs. (1) The department shall not allow costs if not documented, necessary, ordinary, and related to the provision of care services to authorized patients. Unallowable costs listed in subsection (2) of this section represent a partial summary of such costs, in addition to those unallowable under chapter 74.46 RCW and this chapter.

(2) The department shall include, but not limit, unallowable costs to the following:

(a) Costs in excess of limits or violating principles set forth in this chapter;

(b) Costs resulting from transactions or the application of accounting methods circumventing principles set forth in this chapter;

(c) Bad debts. Beginning July 1, 1983, the department shall allow bad debts of Title XIX recipients only if:

(i) The debt is related to covered services;

(ii) It arises from the recipient's required contribution toward the cost of care;

(iii) The provider can establish reasonable collection efforts were made;

(iv) The debt was actually uncollectible when claimed as worthless; and

(v) Sound business judgment established there was no likelihood of recovery at any time in the future.

Reasonable collection efforts shall consist of at least three documented attempts by the contractor to obtain payment demonstrating that the effort devoted to collecting the bad debts of Title XIX recipients is the same devoted by the contractor to collect the bad debts of non-Title XIX recipients;

(d) Any portion of trade association dues attributable to legal and consultant fees and costs in connection with lawsuits or other legal action against the department shall be unallowable;

(e) Legal and consultant fees in connection with a fair hearing against the department relating to those issues where:

(i) A final administrative decision is rendered in favor of the department or where otherwise the determination of the department stands at the termination of administrative review; or

(ii) In connection with a fair hearing, a final administrative decision has not been rendered; or

(iii) In connection with a fair hearing, related costs are not reported as unallowable and identified by fair hearing docket number in the period they are incurred if no final administrative decision has been rendered at the end of the report period; or

(iv) In connection with a fair hearing, related costs are not reported as allowable, identified by docket number, and prorated by the number of issues decided favorably to a contractor in the period a final administrative decision is rendered;

(f) All interest costs not specifically allowed in this chapter or chapter 74.46 RCW; and

(g) Increased costs resulting from a series of transactions between the same parties and involving the same assets, e.g., sale and lease back, successive sales or leases of a single facility or piece of equipment.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-585, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-585, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.190, [74.46.]460 and [74.46.]800. 97-17-040, § 388-96-585, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-585, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-585, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-585, filed 5/26/94, effective 6/26/94; 93-17-033 (Order 3615), § 388-96-585, filed 8/11/93, effective 9/11/93. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-585, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-585, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 74.09.120 and 74.46.800. 90-09-061 (Order 2970), § 388-96-585, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.46.800. 89-17-030 (Order 2847), § 388-96-585, filed 8/8/89, effective 9/8/89. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-585, filed 12/21/88. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-585, filed 4/20/87; 86-10-055 (Order 2372), § 388-96-585, filed 5/7/86, effective 7/1/86; 84-12-039 (Order 2105), § 388-96-585, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-585, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-585, filed 10/13/82; 82-11-065 (Order 1808), § 388-96-585, filed 5/14/82; 81-22-081 (Order 1712), § 388-96-585, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-585, filed 2/25/81. Statutory Authority: RCW 74.09.120. 79-04-102 (Order 1387), § 388-96-585, filed 4/4/79. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-585, filed 6/1/78; Order 1262, § 388-96-585, filed 12/30/77.]

WAC 388-96-708 Reinstatement of beds previously removed from service under chapter 70.38 RCW—Effect on prospective payment rate. (1) After removing beds from service (banked) under the provisions of chapter 70.38 RCW the contractor may bring back into service beds that were previously banked.

(2) When the contractor returns to service beds banked under the provisions of chapter 70.38 RCW, the department will recalculate the contractor's prospective payment rate allocations based on the facility's anticipated resident occupancy level following the increase in licensed bed capacity.

(3) The effective date of the recalculated prospective rate for beds returned to service:

(a) Before the sixteenth of a month, shall be the first of the month in which the banked beds returned to service; or

(b) After the fifteenth of a month, shall be the first of the month following the month in which the banked beds returned to service.

(4) The recalculated prospective payment rate shall comply with all the provisions of rate setting contained in chapter 74.46 RCW or in this chapter, including all lids and maximums unless otherwise specified in this section.

(5) The recalculated prospective Medicaid payment rate shall be subject to adjustment if required by RCW 74.46.421.

(6) After the department recalculates the contractor's prospective Medicaid component rate allocations using the increased number of licensed beds and until the number of licensed beds changes, the department will use the contractor's post unbanking number of licensed beds in all rate setting.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-708, filed 11/30/99, effective 12/31/99. Statutory Authority: 1998 c 322 § 19(11). 98-20-023, § 388-96-708, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-708, filed 7/16/96, effective 8/16/96.]

WAC 388-96-709 Prospective rate revisions—Reduction in licensed beds. (1) The department will revise a contractor's prospective Medicaid payment rate when the contractor reduces the number of its licensed beds and:

(a) Provides a copy of the new bed license and documentation of the number of beds sold, exchanged or otherwise placed out of service, along with the name of the contractor that received the beds, if any; and

(b) Requests a rate revision.

(2) The revised prospective Medicaid payment rate will comply with all the provisions of rate setting contained in chapter 74.46 RCW and in this chapter, including all lids and maximums, unless otherwise specified in this section.

(3) The revised prospective Medicaid payment rate will be effective the first of a month determined as follows:

(a) When the contractor complies with subsection (1)(a) and (b) of this section and the effective date of the licensed bed reduction falls:

(i) Between the first and the fifteenth of the month, then the revised prospective Medicaid payment rate is effective the first of the month in which the licensed bed reduction occurs; or

(ii) Between the sixteenth and the end of the month, then the revised prospective Medicaid payment rate is effective the first of the month following the month in which the licensed bed reduction occurs.

(b) The department will revise a nursing facility's prospective Medicaid payment rate to reflect a reduction in licensed beds as follows:

(i) The department will use the reduced total number of licensed beds to determine the nursing facility's anticipated resident occupancy percentage used to calculate the direct care, therapy care, support services, operations and variable return component rate allocations. If the actual nursing facility occupancy percentage from the rate base cost report is:

(A) At or above eighty-five percent before the reduction and the anticipated resident occupancy percentage is at or above eighty-five percent, the department will recompute the component rate allocations using anticipated resident days;

(B) Less than eighty-five percent before the reduction and the anticipated resident occupancy percentage is at or above eighty-five percent, the department will recompute the component rate allocations using anticipated resident days resident days; or

(C) Less than eighty-five percent before the reduction and the anticipated residency occupancy percentage is below eighty-five percent, the department will recompute the component rate allocations using anticipated resident days.

(ii) To determine occupancy used to calculate the property and financing allowance rate component allocations, the department will use the facility's anticipated resident occupancy level subsequent to the decrease in licensed bed capacity as long as the occupancy for the reduced number of beds is at or above eighty-five percent and in no case shall the

department use less than eighty-five percent occupancy of the facility's reduced licensed bed capacity.

(4) After the department recalculates the contractor's prospective Medicaid component rate allocations using the decreased number of licensed beds and until the number of licensed beds changes, the department will use the contractor's post banking number of licensed beds in all rate setting.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-709, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(11) and RCW 74.46.800. 98-20-023, § 388-96-709, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.510. 97-17-040, § 388-96-709, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-709, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-709, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-709, filed 5/26/93, effective 6/26/93.]

WAC 388-96-710 Prospective payment rate for new contractors. (1) The department shall establish an initial prospective Medicaid payment rate for a new contractor as defined under WAC 388-96-026 within sixty days following the new contractor's application and approval for a license to operate the facility under chapter 18.51 RCW. The rate shall take effect as of the effective date of the contract, except as provided in this section, and shall comply with all the provisions of rate setting contained in chapter 74.46 RCW and in this chapter, including all lids and maximums set forth.

(2) Except for quarterly updates per RCW 74.46.501 (7)(c), the rate established for a new contractor as defined in WAC 388-96-026 (1)(a) or (b) shall remain in effect for the nursing facility until the rate can be reset effective July 1 using the first cost report for that facility under the new contractor's operation containing at least six months' data from the prior calendar year, regardless of whether reported costs for facilities operated by other contractors for the prior calendar year in question will be used to cost rebase their July 1 rates. The new contractor's rate thereafter shall be cost rebased only as provided in this chapter and chapter 74.46 RCW.

(3) To set the initial prospective Medicaid payment rate for a new contractor as defined in WAC 388-96-026 (1)(a) and (b), the department shall:

(a) Determine whether the new contractor nursing facility belongs to the metropolitan statistical area (MSA) peer group or the non-MSA peer group using the latest information received from the office of management and budget or the appropriate federal agency;

(b) Select all nursing facilities from the department's records of all the current Medicaid nursing facilities in the new contractor's peer group with the same bed capacity plus or minus ten beds. If the selection does not result in at least seven facilities, then the department will increase the bed capacity by plus or minus five bed increments until a sample of at least seven nursing facilities is obtained;

(c) Based on the information for the nursing facilities selected under subsection (3)(b) of this section and available to the department on the day the new contractor began participating in the Medicaid payment rate system at the facility, rank from the highest to the lowest the component rate allo-

cation in direct care, therapy care, support services, and operations cost centers and based on this ranking:

(i) Determine the middle of the ranking and then identify the rate immediately above the median for each cost center identified in subsection (3)(c) of this section. The rate immediately above the median will be known as the "selected rate" for each cost center;

(ii) Set the new contractor's nursing facility component rate allocation for therapy care, support services, and operations at the "selected rate";

(iii) Set the direct care rate using data from the direct care "selected" rate facility identified in (c) of this subsection as follows:

(A) The cost per case mix unit shall be the rate base allowable case mixed direct care cost per patient day for the direct care "selected" rate facility, whether or not that facility is held harmless under WAC 388-96-728 and 388-96-729, divided by the facility average case mix index per WAC 388-96-741;

(B) The cost per case mix unit determined under (c)(iii)(A) of this subsection shall be multiplied by the Medicaid average case mix index per WAC 388-96-740. The product shall be the new contractor's direct care rate under case mix; and

(C) The department shall not apply RCW 74.46.506 (5)(k) to any direct care rate established under subsection (5)(e) or (f) of this section. A new contractor whose direct care rate was established under subsection (5)(e) or (f) of this section is not eligible to be paid by a "hold harmless" rate as determined under RCW 74.46.506 (5)(k);

(iv) Set the property rate in accordance with the provisions of this chapter and chapter 74.46 RCW; and

(v) Set the financing allowance and variable return component rate allocations in accordance with the provisions of this chapter and chapter 74.46 RCW. In computing the variable return component rate allocation, the department shall use for direct care, therapy care, support services and operations rate allocations set pursuant to subsection (3)(c)(i), (ii) and (iii) of this section.

(d) Any subsequent revisions to the rate component allocations of the sample members will not impact a "selected rate" component allocation of the initial prospective rate established for the new contractor under this subsection.

(4) For the WAC 388-96-026 (1)(a) or (b) new contractor, the department shall establish rate component allocations for:

(a) Direct care, therapy care, support services and operations based on the "selected rates" as determined under subsection (3)(c) of this section that are in effect on the date the new contractor began participating in the program;

(b) Property in accordance with the provisions of this chapter and chapter 74.46 RCW using for the new contractor as defined under:

(i) WAC 388-96-026 (1)(a), information from the certificate of need; or

(ii) WAC 388-96-026 (1)(b), information provided by the new contractor within ten days of the date the department requests the information in writing. If the contractor as defined under WAC 388-96-026 (1)(b), has not provided the requested information within ten days of the date requested,

then the property rate will be zero. The property rate will remain zero until the information is received;

(c) Variable return in accordance with the provisions of this chapter and chapter 74.46 RCW using the "selected rates" established under subsection (3)(c) of this section that are in effect on the date the new contractor began participating in the program; and

(d) Financing allowance using for the new contractor as defined under:

(i) WAC 388-96-026 (1)(a), information from the certificate of need; or

(ii) WAC 388-96-026 (1)(b), information provided by the new contractor within ten days of the date the department requests the information in writing. If the contractor as defined under WAC 388-96-026 (1)(b), has not provided the requested information within ten days of the date requested, then the net book value of allowable assets will be zero. The financing allowance rate component allocation will remain zero until the information is received.

(5) The initial prospective payment rate for a new contractor as defined under WAC 388-96-026 (1)(a) or (b) shall be established under subsections (3) and (4) of this section. If the WAC 388-96-026 (1)(a) or (b) contractor's initial rate:

(a) Was set before January 1, 1997, and the contractor does not have six months or greater of cost report data for 1996, the October 1, 1998, rate will be set using the contractor's 1997 cost report. Its July 1, 1999, and July 1, 2000, rates will not be cost rebased;

(b) Was set between January 1, 1997, and June 30, 1997, the October 1, 1998, rate will be set using the contractor's 1997 cost report. Its July 1, 1999, and July 1, 2000, rates will not be cost rebased;

(c) Was set between July 1, 1997, and June 30, 1998, the October 1, 1998, rate will be the revised initial sample based rate using October 1, 1998, rate data for direct care, therapy care, support services, and operations, and following the steps identified in subsection (3)(c)(i) and (ii) of this section. There will be no change to the facilities identified in the initial rate under subsection (3)(b) of this section. There will be no change to the property rate. The financing allowance will be revised. The contractor's July 1, 1999, rate will be rebased using 1998 cost report data. Its July 1, 2000, rate will not be cost rebased;

(d) Was set between July 1, 1998, and September 30, 1998, the October 1, 1998, rate will be the revised initial sample based rate using October 1, 1998, rate data for direct care, therapy care, support services, and operations, and following the steps identified in subsection (3)(c)(i) and (ii) of this section. There will be no change to the facilities identified in the initial rate under subsection (3)(b) of this section. There will be no change to the property rate. The financing allowance will be revised. The July 1, 1999, rate will be revised in the same manner using July 1, 1999, rate data. The July 1, 2000, rate will be rebased using 1999 cost report data;

(e) Is set between October 1, 1998, and June 30, 1999, the initial rate is set in accordance with subsections (3) and (4) of this section. The July 1, 1999, rate will be the revised initial sample based rate using July 1, 1999, rate data for direct care, therapy care, support services, and operations, and following the steps identified in subsection (3)(c)(i) and

(ii) of this section. There will be no change to the facilities identified in the initial rate under subsection (3)(b) of this section. There will be no change to the property and the financing allowance component rate allocations. The department will revise the variable return component rate allocation. The July 1, 2000, rate will be rebased using 1999 cost report data; or

(f) Is set between July 1, 1999, and June 30, 2000, the initial rate is set in accordance with subsections (3) and (4) of this section. The July 1, 2000, rate will be the revised initial sample based rate using July 1, 2000, rate data for direct care, therapy care, support services, and operations, and following the steps identified in subsection (3)(c)(i) and (ii) of this section. There will be no change to the facilities identified in the initial rate under subsection (3)(b) of this section. There will be no change to the property and the financing allowance component rate allocations. The department will revise the variable return component rate allocation.

(6) For the WAC 388-96-026 (1)(c) new contractor, the initial prospective payment rate shall be the last prospective payment rate the department paid to the Medicaid contractor operating the nursing facility immediately prior to the effective date of the new Medicaid contract or assignment. If the WAC 388-96-026 (1)(c) contractor's initial rate:

(a) Was set before January 1, 1997, and the new contractor does not have a cost report containing at least six months' data from 1996, its October 1, 1998, rate will be set by using twelve months of cost report data derived from the old contractor's data and the new contractor's data for the 1996 cost report year and its July 1, 1999, and July 1, 2000, rates will not be cost rebased;

(b) Was set between January 1, 1997, and September 30, 1998, its October 1, 1998, rate will be set by using the old contractor's 1996 twelve months' cost report data and its July 1, 1999, and July 1, 2000, rates will not be cost rebased; or

(c) Is set on or after October 1, 1998, its July 1, 1999, and July 1, 2000, rates will not be cost rebased.

(7) A prospective payment rate set for all new contractors shall be subject to adjustments for economic trends and conditions as authorized and provided in this chapter and in chapter 74.46 RCW. For the WAC 388-96-026 (1)(a) or (b) new contractor, to adjust the October 1, 1998, payment rate for economic trends and conditions, the department shall apply a 2.96 percent inflation factor to direct care, therapy care, support services, and operations rate components.

(8) For a WAC 388-96-026 (1)(a), (b) or (c), the Medicaid case mix index and facility average case mix index shall be determined in accordance with this chapter and chapter 74.46 RCW.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-710, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(11) and RCW 74.46.800. 98-20-023, § 388-96-710, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-710, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-710, filed 5/26/94, effective 6/26/94; 93-17-033 (Order 3615), § 388-96-710, filed 8/11/93, effective 9/11/93. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-710, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-710, filed 7/23/92, effective 8/23/92. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-710, filed 12/23/87. Statutory

Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-710, filed 4/20/87. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-710, filed 9/16/83; 78-02-013 (Order 1264), § 388-96-710, filed 1/9/78.]

WAC 388-96-714 Nursing facility Medicaid rate allocations—Economic trends and conditions adjustment factors. (1)(a) For July 1, 1999, the department will increase the following component rate allocations for each nursing facility by two percent:

(i) Direct care based on case mix requirements of RCW 74.46.506 (5)(g);

(ii) Therapy care;

(iii) Support services; and

(iv) Operations.

(b) For direct care based on case mix, the department will apply the two percent increase allowed under subsection (1)(a)(i) of this section to the total of the component rate allocations identified in subsection (1)(a) of this section after the direct care component rate allocation is adjusted for case-mix changes and before application of any reductions required by RCW 74.46.421.

(c) For July 1, 1999, the department will increase by one percent the direct care component rate allocation based on the requirements of RCW 74.46.506 (5)(k)(i).

(2) For July 1, 2000, the department will increase each nursing facility's component rate allocations in the same manner as described in subsection (1) of this section. The department will base the direct care component rate allocation of subsection (1)(c) of this section on the requirements of RCW 74.46.506 (5)(k)(ii).

(3)(a) After applying subsection (1) of this section, the department will determine whether a nursing facility's July 1 total rate allocation will be adjusted by an additional economic trends and conditions factor. The department will adjust a nursing facility's July 1 total rate allocation set pursuant to this chapter and chapter 74.46 RCW when it is less than its April 1, 1999 total rate allocation adjusted for case mix changes. Whether the April 1, 1999 or July 1 direct care rate allocation is determined by case mix under RCW 74.46.506 (a) through (j) or a hold harmless rate under RCW 74.46.506(k), the department will determine whether the July 1 total rate allocation is less than the April 1, 1999 total rate allocation adjusted for case mix changes by:

(i) Calculating the nursing facility's April 1, 1999 direct care component rate allocation by applying the case mix index (CMI) used to set the nursing facility's July 1 direct care component rate allocation;

(ii) Comparing the April 1, 1999 direct care component rate allocation determined by applying the CMI used to determine the nursing facility's July 1 direct care component rate allocation with its direct care component rate allocation of September 30, 1998.

(iii) Adding the higher of the April 1, 1999 direct care component rate allocation based on the CMI used to set the July 1 direct care component rate allocation or the nursing facility's September 30, 1998 direct care component rate allocation to the remaining April 1, 1999 component rate allocations to establish the April 1, 1999 total rate allocation adjusted for case mix changes;

(iv) Comparing the April 1, 1999 total rate allocation adjusted for case mix changes pursuant to subsection (3)(a)(i), (ii), and (iii) of this section with the July 1 total rate allocation set pursuant to this chapter and chapter 74.46 RCW; and

(v) Determining an additional economic trends and conditions factor for the nursing facility when its April 1, 1999 total rate allocation adjusted for case mix changes pursuant to subsection (3)(a)(i), (ii), and (iii) of this section is greater than the facility's July 1 total rate allocation.

(b) The department will determine the additional economic trends and conditions factor by determining the percentage that the April 1, 1999 total rate allocation determined pursuant to subsection (3)(a)(i), (ii), and (iii) of this section is greater than the July 1 total rate allocation. The percentage is the additional economic trends and condition factor.

(c) For each nursing facility whose April 1, 1999 total rate allocation adjusted for case mix changes pursuant to subsection (3)(a) of this section is greater than its July 1 total rate allocation, the department will increase each of its July 1 component rate allocations by the nursing facility's additional economic trends and condition factor determined pursuant to subsection (3)(a) and (b) of this section. A nursing facility's additional economic trends and condition factor will be reduced proportionately by the percentage by which total supplemental payments to all nursing facilities would exceed the funds provided for such payments in the biennial appropriations act.

(d) The department will adjust by an additional economic trends and conditions factor determined pursuant to subsection (3)(a) and (b) of this section only the amount of a nursing facility's total rate allocation or its amended or updated total rate allocation that has not resulted from the nursing facility, under WAC 388-96-708, reinstating beds that were previously removed from service (i.e., banked) under chapter 70.38 RCW.

(4) After the initial determination under subsection (3) of this section of whether a nursing facility's July 1 total rate allocation will be adjusted by an additional economic trends and conditions factor, the department may amend or update a nursing facility's April 1, 1999 total rate allocation including any or all component rate allocations and/or its July 1 total rate allocation including any or all component rate allocations. If any amendments or updates occur, then the department will apply subsection (3) using the newly amended or updated April 1, 1999 total rate allocation and/or component rate allocation(s) and/or the amended or updated total rate allocation and/or component rate allocation(s).

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-714, filed 11/30/99, effective 12/31/99.]

WAC 388-96-718 Public process for determination of rates. (1) The purpose of this section is to describe the manner in which the department will comply with the federal Balanced Budget Act of 1997, Section 4711 (a)(1), codified at 42 U.S.C. 1396a (a)(13)(A).

(2) For all material changes to the methodology for determining nursing facility Medicaid payment rates occurring after October 1, 1997, and requiring a Title XIX state plan amendment to be submitted to and approved by the

Health Care Financing Administration under applicable federal laws, the department shall follow the following public process:

(a) The proposed estimated initial payment rates, the proposed new methodologies for determining the payment rates, and the underlying justifications shall be published. Publication shall be:

(i) In the Washington State Register; or

(ii) In the Seattle Times and Spokane Spokesman Review newspapers.

(b) The department shall maintain and update as needed a mailing list of all individuals and organizations wishing to receive notice of changes to the nursing facility Medicaid payment rate methodology, and all materials submitted for publication shall be sent postage prepaid by regular mail to such individuals and organizations. Individuals and organizations wishing to receive notice shall notify the department in writing.

(c) Nursing facility contractors, their associations, nursing facility Medicaid beneficiaries, representatives of contractors or beneficiaries, and other concerned members of the public shall be given a reasonable opportunity to review and comment on the proposed estimated rates, methodologies and justifications. The period allowed for review and comment shall not be less than fourteen calendar days after the date of the Washington State Register containing the published material or the date the published material has appeared in both the Seattle Times and the Spokane Spokesman Review.

(d) If, after receiving and considering all comments, the department decides to move ahead with any change to its nursing facility Medicaid payment rate methodology, it shall adopt needed further changes in response to comments, if any, and shall publish the final estimated initial rates, final rate determination methodologies and justifications. Publication shall be:

(i) In the Washington State Register; or

(ii) In the Seattle Times and Spokane Spokesman Review newspapers.

(e) Unless an earlier effective date is required by state or federal law, implementation of final changes in methodologies and commencement of the new rates shall not occur until final publication has occurred in the Register or in both designated newspapers. The department shall not be authorized to delay implementation of, or to alter, ignore or violate requirements of, state or federal laws in response to public process comments.

(f) Publication of proposed estimated initial payment rates and final estimated initial payment rates shall be deemed complete once the department has published:

(i) The statewide average proposed estimated initial payment rate weighted by adjusted Medicaid resident days for all Medicaid facilities from the most recent cost report year, including the change from the existing statewide average payment rate weighted by adjusted Medicaid resident days for all Medicaid facilities from the most recent cost report year; and

(ii) The statewide average final estimated initial payment rate weighted by adjusted Medicaid resident days for all Medicaid facilities from the most recent cost report year, including the change from the existing statewide average

payment rate weighted by adjusted Medicaid resident days for all Medicaid facilities from the most recent cost report year.

(3) Nothing in this section shall be construed to prevent the department from commencing or completing the public process authorized by this section even though the proposed changes to the methodology for determining nursing facility Medicaid payment rates are awaiting federal approval, or are the subject of pending legislative, gubernatorial or rule-making action and are yet to be finalized in statute and/or regulation.

(4)(a) Neither a contractor nor any other interested person or organization shall challenge, in any administrative appeals or exception procedure established in rule by the department under the provisions of chapter 74.46 RCW, the adequacy or validity of the public process followed by the department in proposing or implementing a change to the payment rate methodology, regardless of whether the challenge is brought to obtain a ruling on the merits or simply to make a record for subsequent judicial or other review. Such challenges shall be pursued only in courts of proper jurisdiction as may be provided by law.

(b) Any challenge to the public process followed by the department that is brought in the course of an administrative appeals or exception procedure shall be dismissed by the department or presiding officer, with prejudice to further administrative review and record-making, but without prejudice to judicial or other review as may be provided by law.

(5) The public process required and authorized by this section shall not apply to any change in the payment rate methodology that does not require a Title XIX state plan amendment under applicable federal laws, including but not limited to:

(a) Prospective or retrospective changes to nursing facility payment rates or to methodologies for establishing such rates ordered by a court or administrative tribunal, after exhaustion of all appeals by either party as may be authorized by law, or the expiration of time to appeal; or

(b) Changes to nursing facility payment rates for one or more facilities resulting from the application of authorized payment rate methodologies, principles or adjustments, including but not limited to: partial or phased-in termination or implementation of rate methodologies; scheduled cost rebasing; quarterly or other updates to reflect changes in case mix or other private or public source data used to establish rates; adjustments for inflation or economic trends and conditions; rate funding for capital improvements or new requirements imposed by the department; changes to resident-specific or exceptional care rates; and changes to correct errors or omissions by the contractor or the department.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-718, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800, 74.09.500 and 74.08.090. 98-19-062, § 388-96-718, filed 9/16/98, effective 10/17/98.]

WAC 388-96-723 How often will the department compare the state-wide weighted average payment rate for the capital and noncapital portions of the rate for all nursing facilities with the state-wide weighted average payment rate for the capital and noncapital portions of

the rate identified in the Biennial Appropriations Act? (1) On a monthly basis, the department will compare the state-wide weighted average payment rate for the capital and noncapital portions of the rate for all nursing facilities with the state-wide weighted average payment rate for the capital and noncapital portions of the rate identified in the biennial appropriations act.

(2) To determine the state-wide weighted average payment rate for the capital and/or noncapital portion of the rate, the department will use total billed Medicaid days incurred in the calendar year immediately preceding the current fiscal year for the purpose of weighting the July 1 capital and/or noncapital rates that have been adjusted, or updated pursuant to chapter 74.46 RCW and this chapter.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-723, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.421 and 74.46.800. 98-20-023, § 388-96-723, filed 9/25/98, effective 10/1/98.]

WAC 388-96-724 How much advance notice will a nursing facility receive of a rate reduction? (1) The department will notify the nursing facility at least twenty-eight calendar days in advance of the effective date of a reduction taken under RCW 74.46.421.

(2) A rate reduction taken under RCW 74.46.421 will be effective the first day of the month following the twenty-eight calendar day advance notice.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-724, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.421 and 74.46.800. 98-20-023, § 388-96-724, filed 9/25/98, effective 10/1/98.]

WAC 388-96-725 After a RCW 74.46.421 rate reduction when will a nursing facility's rates return to their previous level? (1) The department will not reverse any rate reductions taken in accordance with RCW 74.46.421.

(2) If after a reduction a nursing facility is eligible to receive an increase in a capital and/or noncapital component rate for some unrelated change (e.g., a change in the Medicaid case mix index causes the direct care rate to increase), the department will apply the increase to the rate reduced by application of RCW 74.46.421.

(3) Reductions made under RCW 74.46.421 are cumulative. The department will reduce the capital and/or noncapital component rates for all nursing facilities without reversing any previous reductions.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-725, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.421 and 74.46.800. 98-20-023, § 388-96-725, filed 9/25/98, effective 10/1/98.]

WAC 388-96-726 If a nursing facility's capital and/or noncapital component rates are below the state-wide weighted average payment rate for the capital and/or noncapital portion(s) of the rate identified in the Biennial Appropriations Act, will the department reduce the facility's capital and/or noncapital component rates when it reduces rates under RCW 74.46.421? (1) Even if an individual nursing facility's capital and/or noncapital component rates are below the state-wide weighted average payment rate

for the capital and/or noncapital portion(s) of the rate identified in the biennial appropriations act, the department will reduce the nursing facility's capital and/or noncapital component rates as required under RCW 74.46.421.

(2) The department will not exempt any nursing facility from a component rates reduction required by RCW 74.46.421 for any circumstance, e.g., billed Medicaid days, under-spending of the biennial appropriation for nursing facility rates, etc.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-726, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.421 and 74.46.800. 98-20-023, § 388-96-726, filed 9/25/98, effective 10/1/98.]

WAC 388-96-730 How will the department reduce a nursing facility's capital and/or noncapital portion(s) of its rate so that the statewide weighted average payment rate for the capital and/or noncapital portion(s) of the rate is equal to or less than the statewide weighted average for the capital and/or noncapital portion(s) of the rate identified in the Biennial Appropriations Act? (1) The department will determine a percentage reduction factor (PRF) that, when applied to all nursing facilities' capital and/or noncapital portion(s) of their rates will result in a statewide weighted average payment rate for the capital and/or noncapital portion(s) of their rates that is equal to or less than the statewide weighted average payment rate for capital and/or noncapital portion(s) of the rate identified in the biennial appropriations act.

(2) By applying various percentages to the capital and/or noncapital portion(s) of the rates for all nursing facilities, the department will identify the percentage(s) that reduce(s) the statewide weighted average payment rate for the capital and/or noncapital portion(s) of the rate to be equal to or less than the statewide weighted average payment rate for the capital and/or noncapital portion(s) of the rate identified in the biennial appropriations act.

(3) The percentage(s) identified in subsection (2) of this section will be the PRF(s). The department will apply the PFR(s) equally to all rate component allocations of each nursing facility's capital and/or noncapital portions of the rate.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-730, filed 11/30/99, effective 12/31/99.]

WAC 388-96-731 When will the department reduce all nursing facilities capital and/or noncapital portion(s) of their rates? (1) Under RCW 74.46.421, the department will reduce the capital portion of the rate for each nursing facility when the statewide weighted average payment rate for the capital portion of the rate for all nursing facilities exceeds or is likely to exceed the statewide weighted average payment rate for the capital portion of the rate identified in the biennial appropriations act.

(2) Under RCW 74.46.421, the department will reduce the noncapital portion of the rate for each nursing facility when the statewide weighted average payment rate for the noncapital portion of the rate exceeds or is likely to exceed the statewide weighted average payment rate for the noncap-

ital portion of the rate identified in the biennial appropriations act.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-731, filed 11/30/99, effective 12/31/99.]

WAC 388-96-748 Financing allowance component rate allocation. (1) Beginning July 1, 1999, for each Medicaid nursing facility, the department will establish a financing allowance component rate allocation. The financing allowance component rate allocation will be rebased annually, effective July 1st, in accordance with this chapter and chapter 74.46 RCW.

(2) The department will determine the financing allowance component rate allocation by:

(a) Multiplying the net invested funds of each nursing facility by the applicable factor identified in subsection (3) of this section; and

(b) Dividing the sum of the products by the greater of:

(i) A nursing facility's total resident days from the most recent cost report period; or

(ii) Resident days calculated on eighty-five percent facility occupancy.

(3)(a) The multiplication factor required by subsection (2) (a) of this section is determined by the acquisition date of the tangible fixed asset(s). For each nursing facility, the department will multiply the net invested funds for assets acquired:

(i) Before May 17, 1999 by a factor of .10; and/or

(ii) On or after May 17, 1999 by a factor of .085.

(b) The department will apply the factor of .10 to the net invested funds pertaining to new construction or major renovations:

(i) That received certificate of need approval before May 17, 1999;

(ii) That received an exemption from certificate of need requirements under chapter 70.38 RCW before May 17, 1999; or

(iii) for which the nursing facility submitted working drawings to the department of health for construction review before May 17, 1999.

(c) For a new contractor as defined under WAC 388-96-026 (1)(c), assets acquired from the former contractor will retain their initial acquisition dates when determining the new contractor's financing allowance under this section.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-748, filed 11/30/99, effective 12/31/99.]

WAC 388-96-766 Notification of rates. (1) The department will notify each contractor in writing of its prospective Medicaid payment rate allocation. Unless otherwise specified at the time it is issued, the Medicaid payment rate allocation and/or component rate allocation(s) will be effective from the first day of the month in which it (they) is (are) issued. If a Medicaid payment rate allocation and/or component rate allocation(s) is amended as the result of an appeal in accordance with WAC 388-96-904, it will be effective as of the date the rate appealed from became effective.

(2) If a total Medicaid payment rate allocation and/or component rate allocation(s) is (are) adjusted, updated or amended after the calendar year in which the adjustment or

update was effective, then the department will account for any amounts owed through the settlement process.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-766, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-766, filed 1/9/78.]

WAC 388-96-767 Appraisal values. If a contractor is unwilling or unable to provide and document the lessor's historical cost of leased assets, the department shall arrange for an appraisal of such assets to be conducted by the state of Washington department of general administration. If such an appraisal is conducted, it shall be the basis for all property and financing allowance component rate allocations, except that: If documentation subsequently becomes available to the department establishing the lessor's historical cost is less than the appraisal value, the historical cost shall be the basis for all property and financing allowance component rate allocations.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-767, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-767, filed 5/30/84.]

WAC 388-96-771 Receivership. (1) If the nursing home is providing care to recipients of state medical assistance, the receiver shall:

- (a) Become the Medicaid contractor for the duration of the receivership period;
- (b) Assume all reporting responsibilities for new contractors;
- (c) Assume all other responsibilities for new contractors set forth in this chapter; and
- (d) Be responsible for the refund of Medicaid rate payments in excess of costs during the period of receivership.

(2) In establishing the prospective rate during receivership the department shall consider:

- (a) Compensation, if any, ordered by the court for the receiver. Such compensation may already be available to the receiver through the rate as follows:
 - (i) Financing allowance and variable return component rate allocations, or
 - (ii) The administrator's salary in the case of facilities where the receiver is also the administrator.

If these existing sources of compensation are less than what was ordered by the court, additional costs may be allowed in the rate up to the compensation amount ordered by the court.

(b) Start-up costs and costs of repairs, replacements, and additional staff needed for patient health, security, and welfare. To the extent such costs can be covered through the financing allowance and the variable return component rate allocations, no additional monies will be added to the rate;

(c) Any other allowable costs as set forth in this chapter.

(3)(a) Upon order of the court, the department shall provide emergency or transitional financial assistance to a receiver not to exceed thirty thousand dollars.

(b) The department shall recover any emergency or transitional expenditure made by the department on behalf of a nursing home not certified to participate in the Medicaid Title

XIX program from revenue generated by the facility which is not obligated to the operation of the facility.

(c) In order to help recover an emergency or transitional expenditure, regardless of whether the facility is certified to participate in the Medicaid Title XIX program or not, the department may:

(i) File an action against the former licensee or owner at the time the expenditure is made to recover such expenditure; or

(ii) File a lien on the facility or on the proceeds of the sale of the facility.

(4) If recommendations on receiver's compensation are solicited from the department by the court, the department shall consider the following:

- (a) The range of compensation for nursing home managers;
- (b) Experience and training of the receiver;
- (c) The size, location, and current condition of the facility;
- (d) Any additional factors deemed appropriate by the department.

(5) When the receivership terminates, the department may revise the nursing home's Medicaid reimbursement. The Medicaid reimbursement rate for:

(a) The former owner or licensee shall be what it was before receivership, unless the former owner or licensee requests prospective rate revisions from the department as set forth in this chapter; and

(b) Licensed replacement operators shall be determined consistent with rules governing prospective reimbursement rates for new contractors as set forth in this chapter.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-771, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-771, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.120. 88-06-085 (Order 2602), § 388-96-771, filed 3/2/88.]

WAC 388-96-776 Add-ons to the payment rate—Capital improvements. (1) The department shall grant an add-on to a payment rate for any capitalized additions or replacements made as a condition for licensure or certification; provided, the net rate effect is ten cents per patient day or greater.

(2) The department shall grant an add-on to a prospective rate for capitalized improvements done under RCW 74.46.431(12); provided, the legislature specifically appropriates funds for capital improvements for the biennium in which the request is made and the net rate effect is ten cents per patient day or greater. Physical plant capital improvements include, but are not limited to, capitalized additions, replacements or renovations made as a result of an approved certificate of need or exemption from the requirements for certificate of need for the replacement of existing nursing facility beds pursuant to RCW 70.38.115 (13)(a) or capitalized additions or renovations for the removal of physical plant waivers.

(3) Rate add-ons granted pursuant to subsection (1) or (2) of this section shall be limited in total amount each fiscal year to the total current legislative appropriation, if any, specifically made to fund the Medicaid share of such rate add-

ons for the fiscal year. Rate add-ons are subject to the provisions of RCW 74.46.421.

(4) When physical plant improvements made under subsection (1) or (2) of this section are completed in phases, the department shall not grant a rate add-on for any addition, replacement or improvement until each phase is completed and fully utilized for the purpose for which it was intended. The department shall limit rate add-on to only the actual cost of the depreciable tangible assets meeting the criteria of RCW 74.46.330 and as applicable to that specific completed and fully utilized phase.

(5) When the construction class of any portion of a newly constructed building will improve as the result of any addition, replacement or improvement occurring in a later, but not yet completed and fully utilized phase of the project, the most appropriate construction class, as applicable to that completed and fully utilized phase, will be assigned for purposes of calculating the rate add-on. The department shall not revise the rate add-on retroactively after completion of the portion of the project that provides the improved construction class. Rather, the department shall calculate a new rate add-on when the improved construction class phase is completed and fully utilized and the rate add-on will be effective in accordance with subsection (9) of this section using the date the class was improved.

(6) The department shall not add on construction fees as defined in WAC 388-96-747 and other capitalized allowable fees and costs as related to the completion of all phases of the project to the rate until all phases of the entire project are completed and fully utilized for the purpose it was made. At that time, the department shall add on these fees and costs to the rate, effective no earlier than the earliest date a rate add-on was established specifically for any phase of this project. If the fees and costs are incurred in a later phase of the project, the add-on to the rate will be effective on the same date as the rate add-on for the actual cost of the tangible assets for that phase.

(7) The contractor requesting an adjustment under subsection (1) or (2) shall submit a written request to the office of rates management separate from all other requests and inquiries of the department, e.g., WAC 388-96-904 (1) and (5). A complete written request shall include the following:

(a) A copy of documentation requiring completion of the addition or replacements to maintain licensure or certification for adjustments requested under subsection (1) of this section;

(b) A copy of the new bed license, whether the number of licensed beds increases or decreases, if applicable;

(c) All documentation, e.g., copies of paid invoices showing actual final cost of assets and/or service, e.g., labor purchased as part of the capitalized addition or replacements;

(d) Certification showing the completion date of the capitalized additions or replacements and the date the assets were placed in service per RCW 74.46.360;

(e) A properly completed depreciation schedule for the capitalized additions or replacement as provided in this chapter;

(f) A written justification for granting the rate increase; and

(g) For capitalized additions or replacements requiring certificate of need approval, a copy of the approval and description of the project.

(8) The department's criteria used to evaluate the request may include, but is not limited to:

(a) The remaining functional life of the facility and the length of time since the facility's last significant improvement;

(b) The amount and scope of the renovation or remodel to the facility and whether the facility will be better able to serve the needs of its residents;

(c) Whether the improvement improves the quality of living conditions of the residents;

(d) Whether the improvement might eliminate life safety, building code, or construction standard waivers;

(e) Prior survey results; and

(f) A review of the copy of the approval and description of the project.

(9) The department shall not grant a rate add-on effective earlier than sixty days prior to the receipt of the initial written request by the office of rates management and not earlier than the date the physical plant improvements are completed and fully utilized. The department shall grant a rate add-on for an approved request as follows:

(a) If the physical plant improvements are completed and fully utilized during the period from the first day to the fifteenth day of the month, then the rate will be effective on the first day of that month; or

(b) If the physical plant improvements are completed and fully utilized during the period from the sixteenth day and the last day of the month, the rate will be effective on the first day of the following month.

(10) If the initial written request is incomplete, the department will notify the contractor of the documentation and information required. The contractor shall submit the requested information within fifteen calendar days from the date the contractor receives the notice to provide the information. If the contractor fails to complete the add-on request by providing all the requested documentation and information within the fifteen calendar days from the date of receipt of notification, the department shall deny the request for failure to complete.

(11) If, after the denial for failure to complete, the contractor submits a written request for the same project, the date of receipt for the purpose of applying subsection (9) of this section will depend upon whether the subsequent request for the same project is complete, i.e., the department does not have to request additional documentation and information in order to make a determination. If a subsequent request for funding of the same project is:

(a) Complete, then the date of the first request may be used when applying subsection (9) of this section; or

(b) Incomplete, then the date of the subsequent request must be used when applying subsection (9) of this section even though the physical plant improvements may be completed and fully utilized prior to that date.

(12) The department shall respond, in writing, not later than sixty calendar days after receipt of a complete request.

(13) If the contractor does not use the funds for the purpose for which they were granted, the department shall immediately recoup the misspent or unused funds.

(14) When any physical plant improvements made under subsection (1) or (2) of this section results in a change in licensed beds, any rate add-on granted will be subject to the provisions regarding the number of licensed beds, patient days, occupancy, etc., included in this chapter and chapter 74.46 RCW.

(15) All rate components to fund the Medicaid share of nursing facility new construction or refurbishing projects costing in excess of one million two hundred thousand dollars, or projects requiring state or federal certificate of need approval, shall be based upon a minimum facility occupancy of eighty-five percent for the direct care, therapy care, support services, operations, property, financing allowance, and variable return component rate allocations, during the initial rate period in which the adjustment is granted. These same component rate allocations shall be based upon a minimum facility occupancy of eighty-five percent for all rate periods after the initial rate period.

(16) When a capitalized addition or replacement results in an increased licensed bed capacity during the calendar year following the capitalized addition or replacement:

(a) The department shall for:

(i) Property, use the facility's anticipated resident occupancy level subsequent to the increase in licensed bed capacity; and

(ii) The financing allowance, multiply the net invested funds in accordance with WAC 388-96-748(3) and divide by the facility's anticipated resident occupancy level subsequent to the increase in licensed bed capacity; and

(b) The anticipated resident occupancy for the increased number of beds must be at or above eighty-five percent. In all cases the department shall use at least eighty-five percent occupancy of the facility's increased licensed bed capacity.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207, 99-24-084, § 388-96-776, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(12) and RCW 74.46.800, 98-20-023, § 388-96-776, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.465, 97-17-040, § 388-96-776, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800, 96-15-056, § 388-96-776, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18, 95-19-037 (Order 3896), § 388-96-776, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800, 94-12-043 (Order 3737), § 388-96-776, filed 5/26/94, effective 6/26/94.]

Chapter 388-165 WAC

CHILDREN'S ADMINISTRATION CHILD CARE SUBSIDY PROGRAMS

WAC

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WAC 388-165-108 What are the types of child care subsidies? This chapter relates to the following programs:

- (1) Seasonal child care;
- (2) Teen parent child care;
- (3) Child protective services child care;
- (4) Child welfare services child care; and
- (5) Employed foster parent child care.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090, 99-22-011, § 388-165-108, filed 10/22/99, effective 11/22/99.]

WAC 388-165-110 Definitions. The following definitions apply to WAC 388-15-171, 388-15-174, 388-15-175 and 388-15-176.

"Child" means a person twelve years of age or younger or a person under nineteen years of age who is physically, mentally, or emotionally incapable of self care as verified by a licensed medical practitioner or masters level or above mental health professional.

"Co-payment" means the amount of money the family is responsible to pay the child care provider toward the cost of child care each month.

"Income" means the gross earned income minus the average payroll and income tax paid at that income level, plus any unearned income.

"In-home/relative child care provider" see definition for **"in-home/relative provider"** under WAC 388-290-020.

"Parent" see definition for **"parent"** under WAC 388-290-020.

"Teen parent" means a parent twenty-one years of age or younger.

[99-15-076, recodified as § 388-165-110, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903, 98-22-008, § 388-15-170, filed 10/22/98, effective 11/22/98. Statutory Authority: RCW 74.12.340 and 45 CFR Part 98.41 Child Care and Development Block Grant, 93-10-021 (Order 3535), § 388-15-170, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.12.340 and 45 CFR 98.20, 98.30, 98.43 and 98.45; and 45 CFR 257.21, 257.30, 257.31 and 257.41, 92-11-062 (Order 3393), § 388-15-170, filed 5/19/92, effective 6/19/92. Statutory Authority: RCW 74.08.090, 88-24-023 (Order 2732), § 388-15-170, filed 12/2/88; 86-12-051 (Order 2387), § 388-15-170, filed 6/3/86; 86-03-078 (Order 2333), § 388-15-170, filed 1/22/86; 83-02-028 (Order 1931), § 388-15-170, filed 12/29/82. Statutory Authority: RCW

43.20A.550. 82-14-048 (Order 1839), § 388-15-170, filed 6/30/82. Statutory Authority: RCW 74.08.090. 82-01-051 (Order 1735), § 388-15-170, filed 12/16/81; 81-10-034 (Order 1650), § 388-15-170, filed 4/29/81; 80-15-010 (Order 1552), § 388-15-170, filed 10/6/80. Statutory Authority: RCW 43.20A.550. 78-04-004 (Order 1276), § 388-15-170, filed 3/2/78; Order 1238, § 388-15-170, filed 8/31/77; Order 1204, § 388-15-170, filed 4/1/77; Order 1147, § 388-15-170, filed 8/26/76; Order 1124, § 388-15-170, filed 6/9/76; Order 1120, § 388-15-170, filed 5/13/76; Order 1088, § 388-15-170, filed 1/19/76.]

WAC 388-165-120 Subsidized child care for teen parents. (1) The department may authorize teen parent child care within available funds for parents who:

- (a) Are twenty-one years of age or younger;
- (b) Are enrolled in an approved secondary education or general equivalency diploma (GED) program;
- (c) Are not receiving a temporary assistance for needy families (TANF) grant; and
- (d) Have an income at or below one hundred seventy-five percent of the Federal Poverty Level (FPL).

(2) All teen parents contribute to the cost of child care by making a monthly co-payment to the child care provider which is:

- (a) Determined by the teen parent's income; and
- (b) Calculated by using the rules under WAC 388-290-090 (2)(a), (b), and (c)(i) and (ii).

(3) The department funds child care only during the portion of the day when the child's parent(s) is unable to provide necessary care and supervision due to the parents participation in DSHS approved activities.

[99-15-076, recodified as § 388-165-120, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-171, filed 10/22/98, effective 11/22/98.]

WAC 388-165-130 Subsidized child care for seasonal workers. (1) The department may purchase seasonal child care within available funds for children residing in Washington state where:

- (a) Both parents, or the single parent (in the case of the one-parent family), are currently employed or seeking work in agriculturally related work;
- (b) Fifty percent or more of the family's annual income is derived from agriculturally related work;
- (c) In a two-parent household, the primary wage earner is employed in agricultural work for eleven months or less with any given employer, in the twelve months previous to the time of application;
- (d) In a one-parent household, the single parent is employed in agricultural work for eleven months or less with any given employer, in the twelve months previous to the time of application; and
- (e) The family's monthly income, averaged for the twelve months prior to the time of application, is at or below one hundred and seventy-five percent of the FPL.

(2) Failure of the parent(s) to meet the requirements of (b) of this subsection due to receipt of TANF within the past twelve months shall not result in ineligibility for seasonal child care.

(3) The parent(s) participates in the cost of child care by making a monthly co-payment to the child care provider which is:

- (a) Determined by the parent's income averaged for the twelve months prior to the time of application; and
- (b) Calculated by using the rules under WAC 388-290-090 (2)(a), (b), and (c)(i) and (ii).

(4) The department will fund child care during the portion of the day described under WAC 388-15-171(3).

[99-19-087, recodified as § 388-165-130, filed 9/17/99, effective 9/17/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-174, filed 10/22/98, effective 11/22/98.]

WAC 388-165-140 Child care for child protective services (CPS) and child welfare services (CWS). The department may purchase CPS/CWS child care within available funds for children of families in need of support as part of a CPS/CWS case plan. This service is short-term and time-limited. Social workers must determine if other resources are available to meet this need before authorizing payment by the department.

[99-15-076, recodified as § 388-165-140, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-175, filed 10/22/98, effective 11/22/98.]

WAC 388-165-179 When are DSHS child care subsidy rates in this chapter effective? (1) DSHS child care subsidy rates in this chapter are effective on or after November 1, 1999 when a family:

- (a) Has a change that requires their authorization to be updated;
- (b) Is newly authorized to receive child care subsidies; or
- (c) Is reauthorized to continue receiving child care subsidies.

(2) DSHS child care subsidy rates are authorized at the provider's usual rate or the DSHS maximum child care subsidy rate, whichever is less.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-179, filed 10/22/99, effective 11/22/99.]

WAC 388-165-180 What are the maximum child care subsidy rates DSHS pays for child care in a licensed or certified child care center? DSHS pays directly to a licensed or certified child care center, whichever is less:

- (1) The provider's usual rate for that child; or
- (2) The DSHS maximum child care subsidy rate for that child as listed in the following table.

DSHS Maximum Child Care Subsidy Rate for Licensed Child Care Centers

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$22.73	\$19.85	\$18.00	\$16.70
	Half-Day	\$11.36	\$9.93	\$9.00	\$8.35
Region 2	Full-Day	\$23.18	\$20.45	\$17.75	\$16.82
	Half-Day	\$11.59	\$10.23	\$8.88	\$8.41
Region 3	Full-Day	\$30.18	\$26.00	\$22.00	\$19.77
	Half-Day	\$15.09	\$13.00	\$11.00	\$9.89
Region 4	Full-Day	\$37.80	\$29.55	\$26.14	\$23.40
	Half-Day	\$18.90	\$14.77	\$13.07	\$11.70
Region 5	Full-Day	\$25.82	\$22.18	\$19.45	\$17.50
	Half-Day	\$12.91	\$11.09	\$9.73	\$8.75
Region 6	Full-Day	\$25.59	\$22.73	\$20.00	\$20.00
	Half-Day	\$12.80	\$11.36	\$10.00	\$10.00

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-180, filed 10/22/99, effective 11/22/99.]

WAC 388-165-185 What are the maximum child care subsidy rates DSHS pays for child care in a licensed or certified family child care home? DSHS pays directly to a licensed or certified family child care provider, whichever is less:

- (1) The provider's usual rate for that child; or
- (2) The DSHS maximum child care subsidy rate for that child as listed in the following table.

DSHS Maximum Child Care Subsidy Rate for Licensed Family Child Care Homes

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$19.00	\$17.60	\$17.00	\$15.00
	Half-Day	\$9.50	\$8.80	\$8.50	\$7.50
Region 2	Full-Day	\$18.00	\$18.00	\$16.00	\$15.00
	Half-Day	\$9.00	\$9.00	\$8.00	\$7.50
Region 3	Full-Day	\$28.00	\$24.00	\$22.00	\$20.00
	Half-Day	\$14.00	\$12.00	\$11.00	\$10.00
Region 4	Full-Day	\$30.00	\$27.27	\$25.00	\$22.50
	Half-Day	\$15.00	\$13.64	\$12.50	\$11.25
Region 5	Full-Day	\$21.00	\$20.00	\$19.00	\$17.00
	Half-Day	\$10.50	\$10.00	\$9.50	\$8.50
Region 6	Full-Day	\$20.50	\$20.00	\$18.00	\$17.00
	Half-Day	\$10.25	\$10.00	\$9.00	\$8.50

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-185, filed 10/22/99, effective 11/22/99.]

WAC 388-165-190 When can DSHS pay in addition to the maximum DSHS child care subsidy rate? DSHS pays additional subsidies to a licensed or certified family child care home or center when:

(1) Care is for nonstandard hours (see WAC 388-165-195 and 388-165-200);

(2) The infant bonus is authorized (see WAC 388-165-205);

(3) A child has a documented special need(s) (see WAC 388-165-210, 388-165-215, or 388-165-220); or

(4) Care is not available at the DSHS rate and the provider's usual rate is authorized.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-190, filed 10/22/99, effective 11/22/99.]

WAC 388-165-195 What is nonstandard hour child care? DSHS authorizes nonstandard hour child care when fifteen or more hours of care are needed per month, that are:

(1) Before 6:00 a.m. or after 6:00 p.m. Monday through Friday; and/or

(2) Anytime on Saturday or Sunday.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-195, filed 10/22/99, effective 11/22/99.]

WAC 388-165-200 How does DSHS pay for non-standard hour child care? DSHS authorizes the nonstandard hour bonus to licensed or certified child care providers, DSHS pays:

(1) The DSHS maximum child care subsidy rate as listed in WAC 388-165-180 or 388-165-185 or the provider's usual rate for that child, whichever is less; and

(2) The monthly nonstandard hour bonus as listed in the table below.

Monthly Nonstandard Hour Bonus	
Region 1	\$74.00
Region 2	\$73.00
Region 3	\$91.00
Region 4	\$108.00
Region 5	\$80.00
Region 6	\$83.00

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-200, filed 10/22/99, effective 11/22/99.]

WAC 388-165-205 Does DSHS pay a bonus for infants who receive child care subsidies? DSHS child care subsidy programs pay a two hundred and fifty dollar infant bonus directly to the licensed or certified family child care home or center if:

(1) The child care facility has not already received a bonus for that infant;

(2) The infant was first enrolled in the child care facility after August 30, 1998;

(3) The infant is less than one year old; and

(4) The provider cares for the infant a total of five or more days before the child's first birthday.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-205, filed 10/22/99, effective 11/22/99.]

WAC 388-165-210 How does DSHS determine that a child qualifies for a special needs rate? To qualify for the DSHS child care programs special needs subsidy rate the child must:

(1) Be under nineteen years old;

(2) Have a verified physical, mental, emotional, or behavioral condition that requires a higher level of care; and

(3) Have their condition and need for higher level of care verified by a health, mental health, or education professional with at least a master's degree.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-210, filed 10/22/99, effective 11/22/99.]

WAC 388-165-215 What is the DSHS child care subsidy rate for children with special needs in a licensed or certified child care center? DSHS pays child care subsidies for a child with special needs to licensed or certified child care centers as described in WAC 388-165-180 and whichever of the following is greater:

(1) The provider's documented additional cost associated with the care of that child with special needs; or

(2) The rate listed in the table below.

Licensed Child Care Centers Special Needs Rate

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$6.82	\$5.96	\$5.40	\$5.01
	Half-Day	\$3.41	\$2.98	\$2.70	\$2.51
Region 2	Full-Day	\$6.95	\$6.14	\$5.33	\$5.05
	Half-Day	\$3.48	\$3.07	\$2.66	\$2.52
Region 3	Full-Day	\$9.05	\$7.80	\$6.60	\$5.93
	Half-Day	\$4.53	\$3.90	\$3.30	\$2.97
Region 4	Full-Day	\$11.34	\$8.86	\$7.84	\$7.02
	Half-Day	\$5.67	\$4.43	\$3.92	\$3.51
Region 5	Full-Day	\$7.75	\$6.65	\$5.84	\$5.25
	Half-Day	\$3.87	\$3.33	\$2.92	\$2.63
Region 6	Full-Day	\$7.68	\$6.82	\$6.00	\$6.00
	Half-Day	\$3.84	\$3.41	\$3.00	\$3.00

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-215, filed 10/22/99, effective 11/22/99.]

WAC 388-165-220 What is the DSHS child care subsidy rate for children with special needs in a licensed or certified family child care home? DSHS pays child care subsidies for a child with special needs to licensed or certified family child care homes as described in WAC 388-165-195 and whichever of the following is greater:

(1) The provider's documented additional cost associated with the care of that child with special needs; or

(2) The rate listed in the table below.

Licensed Family Child Care Homes Special Needs Bonus

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$5.70	\$5.28	\$5.10	\$4.50
	Half-Day	\$2.85	\$2.64	\$2.55	\$2.25
Region 2	Full-Day	\$5.40	\$5.40	\$4.80	\$4.50
	Half-Day	\$2.70	\$2.70	\$2.40	\$2.25
Region 3	Full-Day	\$8.40	\$7.20	\$6.60	\$6.00
	Half-Day	\$4.20	\$3.60	\$3.30	\$3.00
Region 4	Full-Day	\$9.00	\$8.18	\$7.50	\$6.75
	Half-Day	\$4.50	\$4.09	\$3.75	\$3.38
Region 5	Full-Day	\$6.30	\$6.00	\$5.70	\$5.10
	Half-Day	\$3.15	\$3.00	\$2.85	\$2.55
Region 6	Full-Day	\$6.15	\$6.00	\$5.40	\$5.10
	Half-Day	\$3.08	\$3.00	\$2.70	\$2.55

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-220, filed 10/22/99, effective 11/22/99.]

WAC 388-165-225 What is the DSHS in-home/relative child care rate for children with special need? DSHS subsidy programs pay in-home/relative child care providers for care of a child with special needs (as described in WAC

388-15-185) two dollars per hour plus whichever is greater of the following:

(1) Sixty-two cents per hour; or

(2) The provider's documented additional cost associated with the care for that child with special needs.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-225, filed 10/22/99, effective 11/22/99.]

WAC 388-165-230 What is the maximum child care subsidy rate DSHS pays for in-home/relative child care?

(1) The DSHS child care subsidy programs pay toward the cost of child care directly to the parent, who is the employer. DSHS pays whichever of the following that is less:

(a) Two dollars and six cents per hours for the child who needs the greatest amount of care and one dollar and three cents per hour for the care of each additional child in the family; or

(b) The provider's usual rate for that care.

(2) DSHS may pay above the maximum rate for children who have special needs as stated in WAC 388-165-225.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-230, filed 10/22/99, effective 11/22/99.]

WAC 388-165-235 In-home/relative child care. (1)

When the parent(s) chooses in-home/relative child care, the parent(s) will give the in-home/relative child care provider's name and address to the department and make the following assurances at the time child care is authorized:

(a) The in-home/relative provider is:

(i) Eighteen years of age or older;

(ii) Of sufficient physical, emotional, and mental health to meet the needs of the child in care. If requested by the department, the parent(s) must provide written evidence that the in-home child care provider of the parent's choice is of sufficient physical, emotional, and mental health to be a safe child care provider;

(iii) Able to work with the child without using corporal punishment or psychological abuse;

(iv) Able to accept and follow instructions;

(v) Able to maintain personal cleanliness; and

(vi) Prompt and regular in job attendance.

(b) The child is current on the immunization schedule as described in the National Immunization Guidelines, developed by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices;

(c) The home where care is provided is safe for the care of the child; and

(d) The in-home/relative child care provider is informed about basic health practices, prevention and control of infectious disease, immunizations, and home and physical premises safety relevant to the care of the child.

(2) The in-home/relative child care provider's primary function while on duty is to provide child care. The in-home/relative child care provider will have the following responsibilities:

(a) Provide constant care and supervision of the child for whom the provider is responsible throughout the arranged time of care in accordance with the needs of the child; and

(b) Provide developmentally appropriate activities for the child who is under the in-home/relative child care provider's care.

(3) The department provides the parent(s) with information about basic health practices, prevention and control of infectious diseases, immunizations, and building and physical premises safety relevant to the care of the child.

[99-15-076, recodified as § 388-165-235, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-176, filed 10/22/98, effective 11/22/98.]

WAC 388-165-240 What are the parent/guardian payment responsibilities when they choose in-home/relative child care? The parent is the employer of the in-home/relative provider. The parent:

- (1) Pays the provider the entire amount that DSHS gives them toward the cost of care;
- (2) Pays the provider the amount that was authorized for a co-payment;
- (3) Requires the in-home/relative provider to sign a receipt when they receive payment;
- (4) Keeps the receipts for DSHS to review at the next eligibility determination; and
- (5) Keeps accurate attendance records.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-240, filed 10/22/99, effective 11/22/99.]

WAC 388-165-245 What is the responsibility of DSHS regarding child care subsidies for in-home/relative child care? (1) On all payments DSHS makes toward the cost of in-home/relative child care, DSHS pays the employer's share of:

- (a) Social Security taxes;
- (b) Medicare taxes;
- (c) Federal Unemployment Taxes (FUTA); and
- (d) State unemployment taxes (SUTA) when applicable.

(2) On all payments DSHS makes toward the cost of in-home/relative child care DSHS withholds the following taxes:

- (a) Social security taxes up to the wage base limit; and
- (b) Medicare taxes.

(3) If an in-home/relative child care provider receives less than one thousand one hundred dollars per family in a calendar year, DSHS refunds all withheld taxes to the provider.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-245, filed 10/22/99, effective 11/22/99.]

WAC 388-165-250 When can DSHS pay toward the cost of in-home/relative child care provided outside the child's home? DSHS will pay toward the cost of child care provided in the relative's home by the following adult relative of the child:

- (1) Siblings and stepsiblings living outside the child's home;
- (2) Grandparents;
- (3) Aunts;
- (4) Uncles;
- (5) First cousins;

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- (6) Great grandparents;
- (7) Great aunts;
- (8) Great uncles; and
- (9) Extended family members as determined by law or custom of the Indian child's tribe.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-250, filed 10/22/99, effective 11/22/99.]

Chapter 388-290 WAC

WORKING CONNECTIONS CHILD CARE

WAC

- 388-290-010 What is the purpose of the working connections child care program?
- 388-290-015 What basic steps does the department take to decide if I'm eligible for WCCC?
- 388-290-020 Repealed.
- 388-290-025 Repealed.
- 388-290-030 Repealed.
- 388-290-035 Repealed.
- 388-290-050 Repealed.
- 388-290-055 Repealed.
- 388-290-060 Repealed.
- 388-290-070 Repealed.
- 388-290-075 Who is a consumer in WCCC?
- 388-290-080 Repealed.
- 388-290-090 Repealed.
- 388-290-105 Repealed.
- 388-290-125 What activities can the department pay WCCC for if I get a temporary aid for needy families (TANF) grant?
- 388-290-150 What activities can the department pay WCCC for if I don't get a TANF grant?
- 388-290-200 Can the department pay WCCC if I'm self-employed?
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- 388-290-600 How does the department figure my countable income, and what is countable income used for?
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- 388-290-905 What responsibilities does the department have under the WCCC program?
- 388-290-910 What responsibilities do I have under the WCCC program?
- 388-290-915 When do WCCC payments start?
- 388-290-920 When does the department provide me with advance and adequate notice of WCCC payment changes?
- 388-290-925 When do advance and adequate notice rules not apply?
- 388-290-930 Under what circumstances does my eligibility for WCCC end?
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**DISPOSITION OF SECTIONS FORMERLY
 CODIFIED IN THIS CHAPTER**

- 388-290-020 Subsidized child care—Definitions. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-020, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-020, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-020, filed 11/8/95, effective 12/9/95.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-025 Subsidy units and copayments. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-025, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-025, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-030 Responsibilities for the department, the consumer, and the provider under the subsidized child care program. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-030, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-035 Providers eligible for payment under the subsidized child care program. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-035, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-035, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-050 Eligible children and consumers under the subsidized child care program. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-050, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-050, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-055 Payment for subsidized child care. [Statutory Authority: RCW 74.04.050. 98-21-005, § 388-290-055, filed 10/9/98, effective 11/9/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-055, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-060 Adequate notice requirements and effective dates. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-060, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-070 Self-employment and subsidized child care. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-070, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-080 Subsidized child care—Fair hearings. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

97-20-130, § 388-290-080, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

- 388-290-090 Subsidized child care—Income eligibility, copayments rates, and when to calculate copayments. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-090, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-090, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
- 388-290-105 Subsidized child care—Overpayments. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-105, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.

WAC 388-290-010 What is the purpose of the working connections child care program? Working connections child care (WCCC) helps low-income families with children pay for child care to find jobs, keep their jobs, and get better jobs.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-010, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050. 98-21-005, § 388-290-010, filed 10/9/98, effective 11/9/98. Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-010, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-010, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-010, filed 11/8/95, effective 12/9/95.]

WAC 388-290-015 What basic steps does the department take to decide if I'm eligible for WCCC? We take the following basic steps to decide if you're eligible for WCCC:

"We," for the purposes of this chapter, means the department of social and health services.

(1) We determine:

(a) If you're participating in an approved activity (see WAC 388-290-125, 388-290-150, or 388-290-200);

(b) If you and your children are otherwise eligible for WCCC (see WAC 388-290-300);

(c) Your family size under WCCC guidelines (see WAC 388-290-400);

(d) Your countable income, which must be at or below one hundred seventy-five percent of the Federal Poverty Level (FPL) (see WAC 388-290-600);

(e) Your share of the child care cost, called a copayment (see WAC 388-290-650);

(2) After you make your own child care arrangements, we decide if we can pay your child care provider under WCCC guidelines (see WAC 388-290-850).

(3) We look at other WCCC program requirements, when needed (see WAC 388-290-900, 1000, 1050, 1100, 1150, 1200, 1250, and 1300).

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-015, filed 6/28/99, effective 7/1/99.]

WAC 388-290-020 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-025 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-030 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-035 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-050 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-055 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-060 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-070 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-075 Who is a consumer in WCCC? In WCCC, consumer means one of the following individuals who has parental control and applies for or receives WCCC for one or more children:

- (1) Parents, stepparents, or legal guardians;
- (2) Adult siblings or step-siblings, first cousins, nephews or nieces;
- (3) Aunts, uncles, grandparents or any of these relatives with the prefix great, such as great-aunt.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-075, filed 6/28/99, effective 7/1/99.]

WAC 388-290-080 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-090 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-105 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-290-125 What activities can the department pay WCCC for if I get a temporary aid for needy families (TANF) grant? (1) If you get TANF or SFA, we can pay WCCC for your hours of participation in the following activities:

- (a) An approved WorkFirst activity under chapter 388-310 WAC;
- (b) Employment or self-employment under WAC 388-290-200;
- (c) Your education or training program if you have a prior approved JOBS plan for that program and you are:

- (i) Making progress that is satisfactory or better, as defined by your program; and
- (ii) Working twenty or more hours per week, or sixteen or more hours per week in a workstudy job.
- (d) Your training program for up to twelve months if:
 - (i) You don't have a prior approved JOBS plan;
 - (ii) The program is adult basic education (ABE), English as a second language (ESL), high school/GED, vocational education or job skills training under chapter 388-310 WAC;
 - (iii) You're making progress that is satisfactory or better, as defined by your program;
 - (iv) You're working twenty or more hours per week, or sixteen or more hours per week in a workstudy job; and
 - (v) You're enrolled at least half-time in your program as defined in chapter 388-310 WAC.

(2) If required, we can also pay WCCC for:

- (a) Transportation time between your place of employment or approved activity and the location of child care; and
- (b) Sleep time directly related to your job, such as if you work nights and sleep days.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-125, filed 6/28/99, effective 7/1/99.]

WAC 388-290-150 What activities can the department pay WCCC for if I don't get a TANF grant? If you don't get TANF, we can pay WCCC for your hours of participation in the following activities:

If you are:	Then to get WCCC you must be:
(1) Employed or self-employed.	Employed or self-employed under WAC 388-290-200
(2) In an education or training program.	(a) Enrolled in adult basic education (ABE), English as a second language (ESL), high school/GED, vocational education or job skills training under chapter 388-310 WAC; (b) Making progress that is satisfactory or better as defined by your program; (c) Working: (i) Twenty or more hours per week; or (ii) Sixteen or more hours per week in a workstudy job; and (d) Participating in the program for no longer than thirty-six months.
(3) In same-day job search.	A TANF applicant whom we have determined has potential for immediate employment or re-employment.
(4) In an employment retention activity under chapter 388-310 WAC.	Engaged in employment retention: (a) For no more than one year following your exit from TANF; and (b) Working: (i) Twenty or more hours per week; or (ii) Sixteen or more hours per week in a workstudy job.

If you are:	Then to get WCCC you must be:
(5) In a labor exchange activity under chapter 388-310 WAC.	Engaged in labor exchange: (a) For no more than two years following your exit from TANF; and (b) Working: (i) Twenty or more hours per week; or (ii) Sixteen or more hours per week in a workstudy job.
(6) A food stamp recipient.	Eligible for the food stamp employment and training program under chapter 388-444 WAC.
(7) In the re-employ Washington workers (RWW) program, operated by the employment security department.	Enrolled in the RWW program under chapter 388-310 WAC.

(8) If required, we can also pay WCCC for:

- (a) Transportation time between your place of employment or approved activity and the location of child care; and
- (b) Sleep time directly related to your job, such as if you work nights and sleep days.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-150, filed 6/28/99, effective 7/1/99.]

WAC 388-290-200 Can the department pay WCCC if I'm self-employed? We can pay WCCC if you're self-employed, as follows:

(1) If you get TANF, you must have an approved self-employment plan under chapter 388-310 WAC. The amount of WCCC you can get for self-employment is equal to the number of hours in your approved plan.

(2) If you don't get TANF, for your first six months of self-employment starting from when you become eligible for WCCC, the amount of WCCC you can get each month is based on the greater of:

- (a) A written statement from you on the number of hours you need based on the number of hours you work; or
- (b) The number of hours equal to dividing your monthly self-employment income by the federal or state minimum wage, whichever is lower.

"Self-employment income" means your gross income from self-employment minus allowable business expenses in WAC 388-450-0085.

(3) After the first six months, the amount of WCCC you can get each month is based on the lesser of subsections (2)(a) or (b) of this section.

(4) You must make available to the department records which show all your business expenses and income.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-200, filed 6/28/99, effective 7/1/99.]

WAC 388-290-270 Can the department authorize WCCC if I'm not working or in an approved activity right now? (1) We can authorize WCCC payments for up to

two weeks if you get TANF and you're waiting to enter an approved activity.

(2) We can authorize WCCC payments for up to four weeks if you experience a gap in employment, or approved activity, and you meet all the following conditions:

- (a) The gap happens for reasons out of your control, such as a layoff;
- (b) Employment, or the approved activity, will resume within that period or you're looking for another job; and
- (c) You received WCCC immediately before the gap in employment, or approved activity.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-270, filed 6/28/99, effective 7/1/99.]

WAC 388-290-280 Can the department pay WCCC for activity fees or bonuses? (1) We can pay initial and ongoing annual registration fees up to fifty dollars per child to your child care provider, only if the fees are:

- (a) Required of all parents whose child(ren) are in care with that provider; and
 - (b) Needed to maintain a child care arrangement.
- (2) We can pay ongoing activity fees of up to twenty dollars per month per child to your child care provider if the conditions in subsections (1)(a) and (1)(b) of this section are met.

(3) We can pay child care providers a one-time bonus of up to two hundred fifty dollars for each infant they newly enroll in care if all the following conditions are met:

- (a) The child being cared for is less than twelve months of age;
 - (b) The child care provider is licensed or certified by the department; and
 - (c) We expect care to be provided for five days or more.
- (4) We can pay child care providers a nonstandard hour bonus under chapter 388-15 WAC.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-280, filed 6/28/99, effective 7/1/99.]

WAC 388-290-300 Which children and consumers can and cannot get WCCC? Depending on your circumstances, or those of your child(ren), you might be eligible for WCCC as follows:

If this situation describes you:	Then am I or my children eligible for WCCC?
(1) You are: (a) An employee of the same child care facility where your child(ren) is receiving care; and (b) Caring for your own child(ren) during the time WCCC is authorized.	No. The child(ren) in this situation are not eligible for WCCC.
(c) In sanction status;	Yes, but you can only get WCCC: (i) For an activity needed to remove the sanction; or (ii) For employment.

If this situation describes you:	Then am I or my children eligible for WCCC?
(d) A parent in a two-parent family and the other parent is able and available to provide care for your child(ren) while you are working, looking for work, or preparing for work. "Able" means an adult physically, mentally, and emotionally capable of caring for a child in a responsible manner. "Available" means an adult able to provide care due to not participating in an approved work activity under WAC 388-290-125, 150, and 200 during the time you need child care.	No. You are not eligible for WCCC during the time the other parent is able and available to provide child care.
(2) Your child or children is: (a) Birth through twelve years old;	Yes. The child(ren) in this situation are eligible for WCCC. If the child(ren) has a special need it must be verified according to subsection (2)(b)(ii) of this section.
(b) Thirteen to nineteen years old;	Yes, but the child(ren) must be: (i) Under court supervision; or (ii) Physically, mentally, or emotionally incapable of self-care, as verified by a doctor, nurse, nurse practitioner, or masters-level or above mental health, education, or social service professional.
(c) Not legally residing in the country.	No. The child(ren) in this situation are not eligible for WCCC.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-300, filed 6/28/99, effective 7/1/99.]

WAC 388-290-350 If I'm in an approved activity, what are the steps the department takes to figure my WCCC copayment? If you're in an approved activity, we take the following steps to figure your WCCC copayment:

- (1) Determine your family size (see WAC 388-290-400);
- (2) Verify and calculate all nonexempt income that is received directly by your family (see WAC 388-290-450);
- (3) Figure your family's expected average monthly earned and unearned income (see WAC 388-290-500 and 525);
- (4) Figure your family's adjusted earned income based on your expected average monthly earnings (see WAC 388-290-550);

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(5) Add your expected average monthly unearned income and the result of subsection (4) of this section together to get your family's countable income (see WAC 388-290-600).

(6) Use your family's countable income to figure your WCCC copayment (see WAC 388-290-650).

(7) Assess the minimum copayment if:

(a) You're a minor parent and meet certain guidelines (see WAC 388-290-700); or

(b) You meet other guidelines not specifically for minor parents (see WAC 388-290-750).

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-350, filed 6/28/99, effective 7/1/99.]

WAC 388-290-375 How is the income that my family receives used in WCCC? All nonexempt income that your family receives directly is used to:

- (1) Determine your eligibility for WCCC;
- (2) Figure your expected average monthly income; and
- (3) Calculate your WCCC copayment.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-375, filed 6/28/99, effective 7/1/99.]

WAC 388-290-400 What makes up a family in the WCCC program? "Family" in WCCC means one or more individuals who live together in the same household. Only you and the people living in your household can be included in family size, as follows:

If these are the people living in my household (including myself):	Then is my household considered a family in WCCC?
(1) Related adults, other than spouses, and their respective child(ren).	No, but see subsections (2) - (4), and (6) of this section, below.
(2) Unmarried parents and their mutual child(ren).	Yes.
(3) Married parents with or without a mutual child(ren).	Yes.
(4) Married or unmarried parents and their mutual and nonmutual children, if there is at least one mutual child.	Yes.
(5) Unmarried adults with no mutual child(ren).	No, but see subsection (6) of this section, below.
(6) An unmarried parent and their child(ren).	Yes.
(7) A non-TANF minor parent living independently with one or more children.	Yes.
(8) Child(ren) related by blood, marriage, or adoption who live with a WCCC consumer who is not legally and financially responsible for the child(ren).	No. Only the child(ren) are included in family size.

(9) Child(ren) not related by blood, marriage, or adoption who live in a situation described in subsection (8) of this section, above.	No. Each unrelated child(ren) is considered a separate family.
(10) A minor parent and the minor parent's children only, who are living in a situation described in WAC 388-290-700.	Yes.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-400, filed 6/28/99, effective 7/1/99.]

WAC 388-290-450 What income does the department count in WCCC? (1) We count the following as earned income when figuring your copayment:

- (a) Earnings from employment or self-employment;
- (b) Military housing and food allowance;
- (c) Income in-kind.

"Income in-kind" means income received in a form other than cash, such as goods, services, or room and board.

(2) We count the following as unearned income when figuring your WCCC copayment:

- (a) Your TANF grant, except when exempt under WAC 388-290-475;
- (b) Child support payments;
- (c) General assistance;
- (d) Supplemental Security Income (SSI);
- (e) Other social security payments, such as SSA and SSDI;
- (f) Refugee assistance payments;
- (g) Payments from the Veterans' Administration, disability payments, or payments from labor and industries (L&I);
- (h) Unemployment compensation; and
- (i) Other types of unearned income not exempted in WAC 388-290-475.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-450, filed 6/28/99, effective 7/1/99.]

WAC 388-290-475 What income does the department exempt in WCCC? We exempt the following when figuring your copayment:

- (1) Income types in WAC 388-450-0015, WAC 388-450-0035, WAC 388-450-0040, and WAC 388-450-0055;
- (2) The earned income of a child, unless otherwise indicated in WAC 388-290-400;
- (3) Compensatory awards, such as an insurance settlement or court-ordered payment for personal injury, damage, or loss of property;
- (4) Reimbursements, such as an income tax refund;
- (5) Diversion Cash Assistance; and
- (6) The TANF grant for the first three consecutive calendar months after you start a new job. The first calendar month is the month in which you start working.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-475, filed 6/28/99, effective 7/1/99.]

WAC 388-290-500 What are the different kinds of income in WCCC the department uses to get my expected average monthly income? (1) There are two kinds of income in WCCC that the department uses to get your expected average monthly income. They are:

- (a) Ongoing income; and
- (b) Lump sum payments.

(2) Ongoing income means:

- (a) You expect to receive the income more than once, such as a paycheck;
- (b) The income is not exempt in WCCC; and
- (c) You have enough income history to make an accurate estimate of your future income; or
- (d) Evidence of your income in the future is available, such as a letter from your employer.

(3) Lump sum payment means a one-time payment that is not exempt in WCCC, such as back child support, an inheritance, or gambling winnings.

(4) Expected average monthly income means the average monthly income amount used to figure your countable income.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-500, filed 6/28/99, effective 7/1/99.]

WAC 388-290-525 How does the department figure my expected average monthly income? (1) If you have ongoing income, we figure your expected average monthly income by:

- (a) Verifying that the income presented to us is an accurate amount;
- (b) Dividing the amount in subsection (1)(a) of this section by the number of months it took your family to get the income; or
- (c) Using the best available estimate of your family's current and expected nonexempt income, if:
 - (i) Multiple months of past income are not available; or
 - (ii) You don't have the income history to make an accurate estimate of your future income.

(2) If you get a lump sum payment during your WCCC authorization period, we:

- (a) Verify that the income presented to us is an accurate amount;
- (b) Divide the lump sum payment by twelve; and
- (c) Count the result of subsection (2)(b) of this section as part of your expected average monthly income.
- (4) If you have a combination of ongoing income and one or more lump sum payments, we use the appropriate guideline for each kind of income to figure your expected average monthly income.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-525, filed 6/28/99, effective 7/1/99.]

WAC 388-290-550 How does the department figure my adjusted earned income? We figure your adjusted earned income as follows:

(1) If your family's gross expected average monthly earnings are at or below one hundred percent of the FPL, then...	We multiply gross earnings by ninety percent to get adjusted earned income.
(2) If your family's gross expected average monthly earnings are above one hundred percent of the FPL up to and including one hundred seventy-five percent of the FPL, then...	We multiply gross earnings by eighty-five percent to get adjusted earned income.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-550, filed 6/28/99, effective 7/1/99.]

WAC 388-290-600 How does the department figure my countable income, and what is countable income used for? (1) To get your countable income, we add together the following kinds of expected average monthly income:

- (a) Adjusted earned income; and
 - (b) Unearned income that is not exempt (see WAC 388-290-450).
- (2) All countable income received directly by your family is used to calculate your WCCC copayment except if you automatically pay the minimum copayment under WAC 388-290-700 or 388-290-750.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-600, filed 6/28/99, effective 7/1/99.]

WAC 388-290-650 How does the department figure my copayment, once my countable income is known?

If your family's countable income falls within this range...	...Then your copayment is...
(1) At or below seventy-four percent of the Federal Poverty Level (FPL).	Ten dollars.
(2) Above seventy-four percent and up to one hundred percent FPL.	Twenty dollars.
(3) Over one hundred percent of the FPL.	The greater of: (a) Twenty dollars, or; (b) Forty-seven percent of your countable income over one hundred percent of the FPL.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-650, filed 6/28/99, effective 7/1/99.]

WAC 388-290-700 Does the department set the minimum copayment if I'm a minor parent? We set the minimum copayment if you are a minor parent, and

- (1) Receiving TANF and living independently; or
- (2) Part of your parent or relative's TANF grant.

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[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-700, filed 6/28/99, effective 7/1/99.]

WAC 388-290-750 Are there other times when the department sets the minimum copayment? We also set the minimum copayment:

- (1) In the first full month following the month you get a job, if you get TANF at the time of application for WCCC;
- (2) In all the months you are a WCCC consumer, if your family's only source of income during this time is a TANF grant; or
- (3) In the first month you apply for WCCC, if you don't get TANF at the time of application for WCCC.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-750, filed 6/28/99, effective 7/1/99.]

WAC 388-290-800 When does the department calculate copayments? We calculate your copayment:

- (1) At the time of the initial eligibility determination;
- (2) At least every six months, starting from the first month of eligibility;
- (3) When your monthly income decreases, except if your TANF grant goes down due to a sanction;
- (4) When your family size changes; or
- (5) When you are no longer eligible for:
 - (i) The three-month TANF grant exemption under WAC 388-290-475; or
 - (ii) The minimum copayment under WAC 388-290-700 or 750.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-800, filed 6/28/99, effective 7/1/99.]

WAC 388-290-850 What child care providers can the department pay under the WCCC program? To receive payment under the WCCC program, your child care provider must fall into one of the following categories:

- (1) Licensed as required by chapter 74.15 RCW and chapters 388-73, 388-155 (Minimum licensing requirements for family child day care homes), or 388-150 WAC (Minimum licensing requirements for child day care centers).
 - (2) Exempt from licensing but certified by the department, including:
 - (a) Tribal child care facilities meeting the requirements of tribal law;
 - (b) Child care facilities on a military installation;
 - (c) Child care facilities operated on public school property by a school district.
 - (3) Exempt from licensing and certification, but the provider must:
 - (a) Be a U.S. citizen or legally residing in the country;
 - (b) Be one of the following adult relatives providing care in either the child's or relative's home:
 - (i) An adult sibling living outside the child's home; or
 - (ii) A grandparent, aunt, uncle, first cousin, or great-grandparent, great-aunt, or great-uncle; and
 - (iii) Not the child's biological, adoptive, or step-parent;
- or

(iv) An extended tribal family member under chapter 74.15 RCW.

(c) Be an adult friend or neighbor providing care in the child's own home; and

(d) Meet the in-home relative provider requirements in chapter 388-15 WAC. We can refuse to pay toward the cost of in-home/relative care if we have evidence your in-home/relative provider does not meet these requirements.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-850, filed 6/28/99, effective 7/1/99.]

WAC 388-290-900 When can the department establish a protective payee to pay my in-home/relative provider? We can establish a protective payee to receive WCCC warrants for you when:

(1) You do not pay your in-home/relative child care provider; and

(2) We issued a child care warrant to the correct address and twelve or more working days have passed since the issuance date;

(3) You have not reported the WCCC warrant lost, stolen, or destroyed; or

(4) You have a history of failing to pay your in-home/relative provider(s).

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-900, filed 6/28/99, effective 7/1/99.]

WAC 388-290-905 What responsibilities does the department have under the WCCC program? We will:

(1) Inform you of your rights and responsibilities under the WCCC program;

(2) Inform you which child care providers we can pay;

(3) Permit you to choose your own child care provider, as long as we can pay the provider under WAC 388-290-850;

(4) Inform you of the community resources that can help you select child care, if needed;

(5) Only authorize payment when no adult in your family is able and available to care for your children;

(6) Only authorize payment to child care providers who allow you to see your children whenever they are in care;

(7) Respond to you within ten days if you report a change of circumstance;

(8) Provide prompt child care payments to your licensed or certified provider; and

(9) Notify you whenever we establish or change your WCCC copayment.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-905, filed 6/28/99, effective 7/1/99.]

WAC 388-290-910 What responsibilities do I have under the WCCC program? You will:

(1) Be responsible to choose your provider and make your own child care arrangements;

(2) Notify the department of any change in providers within five days;

(3) Pay your in-home/relative provider after we send you a check for in-home/relative care;

(4) Pay, or make arrangements to pay, your WCCC copayment directly to your child care provider;

(5) Supply the department with necessary information to allow us to correctly determine your eligibility and make proper payment to your provider;

(6) Notify your provider within ten days when we change your child care authorization;

(7) Provide notice to the department within ten days of any change in family size or income level; and

(8) Assure your in-home/relative provider provides a valid social security number to the department, if you choose an in-home/relative provider.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-910, filed 6/28/99, effective 7/1/99.]

WAC 388-290-915 When do WCCC payments start?

If you are eligible for WCCC, the department authorizes WCCC payments the date you apply for the program, or the date you choose a child care provider we can pay under WAC 388-290-850, whichever is later.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-915, filed 6/28/99, effective 7/1/99.]

WAC 388-290-920 When does the department provide me with advance and adequate notice of WCCC payment changes? (1) We provide you with advance and adequate notice for changes in payment when the change results in a suspension, reduction, termination, or forces a change in child care arrangements, except as noted in WAC 388-290-1200, below.

(2) "Advance notice," means a notice of a WCCC reduction, suspension, or termination that is mailed at least ten days before the date of the intended action.

(3) "Adequate notice" means a written statement of the action the department intends to take, the facts relating to the decision, the Washington Administrative Code (WAC) supporting the action, and your right to request a fair hearing.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-920, filed 6/28/99, effective 7/1/99.]

WAC 388-290-925 When do advance and adequate notice rules not apply? Advance and adequate notice requirements don't apply in the following circumstances:

(1) You tell the department you no longer want WCCC;

(2) Your whereabouts are unknown to the department;

(3) You are receiving duplicate child care benefits; or

(4) Your normal WCCC authorization period is scheduled to end.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-925, filed 6/28/99, effective 7/1/99.]

WAC 388-290-930 Under what circumstances does my eligibility for WCCC end? Your eligibility for WCCC ends if:

(1) Copayment fees assessed by the department are not paid; and

(2) Mutually acceptable payment arrangements are not made with your child care provider; or

(3) You don't meet other WCCC eligibility requirements.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-930, filed 6/28/99, effective 7/1/99.]

WAC 388-290-935 When might I be eligible for WCCC again? You might be eligible for WCCC again when:

(1) Back copayment fees are paid; or

(2) Mutually acceptable payment arrangements are made with your child care provider(s); and

(3) You meet other WCCC eligibility requirements.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-935, filed 6/28/99, effective 7/1/99.]

WAC 388-290-940 Do I have the right to request a fair hearing? WCCC consumers and child care providers can request fair hearings under chapter 388-08 WAC on any action affecting WCCC benefits except for mass changes resulting from a change in policy or law.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-940, filed 6/28/99, effective 7/1/99.]

WAC 388-290-945 Can I get WCCC pending the outcome of a fair hearing? (1) If you are a WCCC consumer, you can get WCCC pending the outcome of a fair hearing if you request the fair hearing:

(a) On or before the effective date of an action; or

(b) No more than ten days after the department sends you a notice of adverse action.

"Adverse action" means an action to reduce or terminate your WCCC, or to set up a protective payee to receive your WCCC warrant for you.

(2) If you lose the fair hearing, any WCCC you use between the date of the adverse action and the date of the fair hearing or fair hearing decision is an overpayment to you, the consumer.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-945, filed 6/28/99, effective 7/1/99.]

WAC 388-290-950 When does the department collect overpayments? (1) In areas not covered by this section, WCCC consumers are subject to chapter 388-410 WAC (Benefit errors).

(2) When setting up an overpayment, we reduce the WCCC overpayment by the amount of the WCCC underpayment when applicable.

(3) We recover WCCC overpayments from you, regardless of whether you are a current or past WCCC consumer, if:

(a) The amount we overpay is more than three hundred dollars; and

(b) Your child(ren) attend child care when not authorized by the department to do so;

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(c) A member of a different overpaid family later becomes a member of your family;

(d) Cost of recovery does not exceed the overpayment amount;

(e) You:

(i) Do not report a change of circumstance within ten days under WAC 388-290-1050; and

(ii) Use WCCC during a period of time when you would otherwise have been ineligible or eligible for a smaller amount of care; or

(f) You knowingly fail to give the department information that affects the amount of WCCC you are eligible for.

(4) Recovery of overpayments cannot force a change in your child care arrangements.

(5) We recover WCCC overpayments from child care providers, if:

(a) The amount we overpay is more than three hundred dollars;

(b) The provider receives payment for WCCC services not provided; or

(c) We pay the provider more than the cost of providing WCCC under chapter 388-15 WAC; and

(d) The cost of recovery does not exceed the overpayment amount.

(6) We set up overpayments starting the date that:

(a) You use WCCC when not authorized by the department to do so; or

(b) The child care provider provides care when not authorized by the department to do so.

[Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-950, filed 6/28/99, effective 7/1/99.]

Chapter 388-310 WAC WORKFIRST

WAC

388-310-0100	WorkFirst—Purpose.
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388-310-1850	Re-employ Washington workers (RWW).
388-310-1900	WorkFirst—Services for American Indian tribal members and other American Indians.

WAC 388-310-0100 WorkFirst—Purpose. (1) **What is the WorkFirst program?**

The WorkFirst program offers services and activities to help people in low-income families find jobs, keep their jobs, find better jobs and become self-sufficient. The program

links families to a variety of state, federal and community resources to meet this goal. When you enter the WorkFirst program, you will be asked to work, look for work and/or prepare for work.

(2) Who does the WorkFirst program serve?

The WorkFirst program serves three groups:

- (a) Parents and children age sixteen or older who receive cash assistance under the temporary assistance for needy families (TANF), general assistance for pregnant women (GA-S) or state family assistance (SFA) programs; and
- (b) Parents who no longer receive cash assistance and need some continuing support to remain self-sufficient; and
- (c) Low income parents who support their family without applying for or relying on cash assistance.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-08-051, § 388-310-0100, filed 4/1/99, effective 5/2/99; 97-20-129, § 388-310-0100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0200 WorkFirst—Activities. (1) Who is required to participate in WorkFirst activities?

(a) You are required to participate in WorkFirst activities, and become what is called a "mandatory participant," if you:

- (i) Receive TANF, GA-S or SFA cash assistance; and
- (ii) Are a custodial parent or age sixteen or older; and
- (iii) Are not exempt. (You can only get this exemption if you are caring for a child under twelve months of age. See WAC 388-310-0300 for more details).

(b) Participation is voluntary for all other WorkFirst participants (those who no longer receive or have never received TANF, GA-S or SFA cash assistance).

(2) What activities do I participate in when I enter the WorkFirst program?

When you enter the WorkFirst program, you will participate in one or more of the following activities (which are described in more detail in other sections of this chapter):

- (a) Paid employment (see WAC 388-310-400(1)(a) and 388-310-1500);
- (b) Self employment (see WAC 388-310-1700);
- (c) Job search (see WAC 388-310-0600);
- (d) Community jobs (see WAC 388-310-1300)
- (e) Work experience (see WAC 388-310-1100);
- (f) On-the-job training (see WAC 388-310-1200);
- (g) Vocational educational training (see WAC 388-310-1000);
- (h) Basic education activities (see WAC 388-310-0900);
- (i) Job skills training (see WAC 388-310-1050);
- (j) Community service (see WAC 388-310-1400); and/or
- (k) Activities provided by tribal governments for tribal members and other American Indians (see WAC 388-310-1400(1) and 388-310-1900).

(3) If I am a mandatory participant, how much time must I spend doing WorkFirst activities?

If you are a mandatory participant, you will be required to spend up to forty hours a week working, looking for work or preparing for work. You will have an individual responsibility plan (described in WAC 388-310-500) that includes the number of hours a week that you are required to participate.

(4) What activities do I participate in after I get a job?

You may participate other activities, which are called "post employment services" (described in WAC 388-310-1800) once you are working twenty hours or more a week. Work can include a paid, unsubsidized job, self-employment, college work study or a community jobs placement. Services include:

- (a) Activities that help you keep a job (called an "employment retention" service); and/or
- (b) Activities that help you get a better job (called a "wage and skill progression" service).

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-08-051, § 388-310-0200, filed 4/1/99, effective 5/2/99; 97-20-129, § 388-310-0200, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0300 WorkFirst—Exemptions for mandatory participants. (1) If I am a mandatory participant, when can I be exempted from participating in WorkFirst activities?

You can claim an exemption from participating in WorkFirst activities during months that you are needed in the home to personally provide care for a child under twelve months of age. You can only claim this exemption for up to twelve months in your lifetime.

(2) Can I participate in WorkFirst while I am exempt?

You can participate in WorkFirst while you are exempt, and the time you participate does not count against your twelve-month limit. If you decide later to stop participating, and you still qualify for an exemption, you will be put back into exempt status with no financial penalty.

(3) Does an exemption from participation affect my sixty-month time limit for receiving TANF or SFA benefits?

An exemption from participation does not affect your sixty-month time limit for receiving TANF or SFA benefits (described in WAC 388-484-0005). Even if exempt from participation, you will use up one of your sixty months of TANF/SFA benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-0300, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0300, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0400 WorkFirst—Entering the WorkFirst program as a mandatory participant. (1) What happens when I enter the WorkFirst program as a mandatory participant?

If you are a mandatory participant, WorkFirst requires you to look for a job as your first activity unless you are temporarily deferred from job search. You must follow instructions as written in your individual responsibility plan (see WAC 388-310-0500) while you are in job search.

(2) May I be temporarily deferred from looking for a job?

If you are a mandatory participant, your case manager will ask you if you are exempt or have any reasons why you cannot go to job search. You may be temporarily deferred from looking for a job for any of the following reasons:

(a) You work twenty or more hours a week. "Work" means to engage in any legal, income generating activity which is taxable under the United States Tax Code or which would be taxable with or without a treaty between an Indian Nation and the United States; or

(b) You work sixteen or more hours a week in the federal or state work study program and you attend a Washington state community or technical college at least half-time; or

(c) You are under the age of eighteen, have not completed high school, GED or its equivalent and are in school full-time; or

(d) You are eighteen or nineteen years of age and are attending high school or an equivalent full-time; or

(e) Your situation prevents you from looking for a job. (For example, you may be unable to look for a job while you have health problems, are homeless and/or dealing with family violence.)

(3) What are my requirements if I am temporarily deferred from job search?

If and when your job search is temporarily deferred, you may be required to take part in an evaluation of your employability as part of your individual responsibility plan. Your individual responsibility plan will describe what you need to do to be able to enter job search and then find a job (see WAC 388-310-0500 and 0700).

(4) What happens if I do not follow my WorkFirst requirements?

If you do not participate in job search, or in the activities listed in your individual responsibility plan, and you do not have a good reason, the department will impose a financial penalty (sanction, see WAC 388-310-1600).

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-0400, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-0400, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0400, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0500 WorkFirst—Individual responsibility plan. (1) What is the purpose of my individual responsibility plan?

The purpose of your individual responsibility plan is to give you a written statement that describes:

(a) What your responsibilities are; and

(b) Which WorkFirst activities you are required to participate in; and

(c) What services you will receive so you are able to participate.

(2) What is included in my individual responsibility plan?

Your individual responsibility plan includes the following:

(a) What WorkFirst activities you must be engaged in, a start and end date for each activity and how many hours a week you must spend in each activity.

(b) Any other specific requirements that are tied to the WorkFirst work activity. For example, you might be required to learn English as part of your work experience activity.

(c) What services you need to participate in the activity. For example, you may require support services (such as help with paying for transportation) or help with paying childcare.

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(d) Your statement that you recognize the need to become and remain employed as quickly as possible.

(3) How is my individual responsibility plan developed?

You and your case manager will work together to develop your individual responsibility plan and decide what activities will be included in it. Then, your case manager will assign you to specific WorkFirst activities that will help you find employment as quickly as possible.

(4) What happens after my individual responsibility plan is completed?

Once your individual responsibility plan is completed:

(a) You will sign and get a copy of your individual responsibility plan.

(b) You and your case manager will review your plan as necessary over the coming months to make sure your plan continues to meet your employment needs. You will sign and get a copy of your individual responsibility plan every time it is reviewed and changed.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-0500, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-0500, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0500, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0600 WorkFirst—Job search. (1) What is job search?

Job search is an opportunity to learn and use skills you need to find and keep a job. Job search may include:

(a) Classroom instruction; and/or

(b) Structured job search that helps you find job openings, complete applications, practice interviews and apply other skills and abilities with a job search specialist or a group of fellow job-seekers; and/or

(c) Pre-employment training.

(2) What is pre-employment training?

Pre-employment training helps you learn skills you need for an identified entry level job that pays more than average entry level wages.

(a) Pre-employment training is an acceptable job search activity when an employer or industry commits to hiring or giving hiring preference to WorkFirst participants who successfully complete pre-employment training.

(b) You can find out about current pre-employment training opportunities by asking your job service specialist, your case manager or staff at your local community and technical college.

(3) Who provides me with job search?

Your get job search from the employment security department or another organization under contract with WorkFirst to provide these services.

(4) How long do I stay in job search?

Periods of job search may last up to twelve continuous weeks. Job search specialists will monitor your progress. By the end of the first four weeks, a job search specialist will determine whether you should continue in job search. Job search will end when:

(a) You find a job; or

(b) You become exempt from WorkFirst requirements (see WAC 388-310-0300); or

(c) Your situation changes and you are temporarily deferred from continuing with job search (see WAC 388-310-0400); or

(d) Job search specialists have determined that you need additional skills and/or experience to find a job; or

(e) You have not found a job at the end of the job search period.

(5) What happens at the end of job search if I have not found a job?

At the end of each job search period, you will be referred back to your case manager for an employability evaluation if you have not found a job. You and your case manager will also modify your individual responsibility plan.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-0600, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0700 WorkFirst—Employability evaluation. (1) Why do I receive an employability evaluation?

You receive an employability evaluation from your case manager to determine:

(a) Why you are unable to look for work (if you are temporarily deferred from job search) or why you have been unable to find work in your local labor market; and

(b) Which WorkFirst activities you need to become employed in the shortest time possible.

(2) What is the employability evaluation and when will it be used?

(a) The employability evaluation is a series of questions and answers used to determine your ability to find and keep a job in your local labor market.

(b) You and your case manager and/or social worker will use the information from this evaluation to create or modify your individual responsibility plan, adding activities that will help you become employable.

(c) Your case manager will evaluate your ability to find employment when you are a mandatory WorkFirst participant and have:

(i) Gone through a period of job search without finding a job;

(ii) Been referred back early from job search; or

(iii) Been temporarily deferred from job search.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-0700, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0700, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0800 WorkFirst—Support services.

(1) Why do I receive support services?

Support services help you participate in work and WorkFirst activities that lead to financial independence. You can also get help in paying your child care expenses through the working connections child care assistance program. (Chapter 388-290 WAC describes the rules for this child care assistance program.)

(2) What support services may I receive?

You may receive support services, including but not limited to any of the following:

(a) Employment related needs such as work clothing or uniforms, tools, equipment, relocation expenses, or fees;

(b) Transportation costs such as mileage reimbursement, public transportation vouchers, and car repair;

(c) Professional services;

(d) Personal needs such as clothing appropriate for job search or other work activities;

(e) Special needs such as accommodations for employment;

(f) Identified specific needs due to location or employment if you are an American Indian;

(g) Job skills training, vocational education and/or basic education if:

(i) It is an approved activity in your individual responsibility plan; and

(ii) You do not qualify for sufficient student financial aid to meet the cost.

(3) When will I get support services?

The department or its agents will decide what support services you will receive, as follows:

(a) You need the support services to do the activities in your individual responsibility plan;

(b) It is within available funds; and

(c) It does not assist, promote, or deter religious activity.

(4) How much support services can I get?

The chart below shows the guidelines for the amount and type of support services you can get. There is a suggested limit of fifteen hundred dollars per person per calendar year for the amount of support services you can receive from the department and/or employment security.

Type of Support Service	Suggested Limit
Accommodation (reasonable)	\$1,000 per request
Books/supplies (school)	No limit
Car repair	\$500 per calendar year
Clothing-General	Participant-\$250 per request Each child-\$100 per request
Clothing/uniforms-Employment	Participant-\$200 per year
Clothing/uniforms-Training	No limit
Diapers	\$50 per child per month
Employer reimbursement	No limit
GED	No limit
Haircut	\$40 per request
License/fees	\$300 per each license or fee
Lunch	\$15 per event
Medical exams (not covered by Medicaid)	\$150 per exam
Mileage	\$0.315 per mile (not to exceed \$100 per week)
Personal hygiene	\$50 per request (up to three times per calendar year)
Professional, trade, association, union and bonds	\$300 per each due or fee
Public transportation	\$150 per month
Relocation	\$1,000 per calendar year
Rent, housing, deposits	\$500 per calendar year
Short-term lodging and meals	\$300 per request
Testing-Certification	\$100 each
Testing-Diagnostic	\$200 each
Tools (training)	No limit
Tools/equipment	\$300 per request
Tutoring	\$200 per month
Tuition and fees	No limit

(5) What if I request more support services than the guidelines allow?

If you request support services from your case manager, you can:

- (a) Ask to see a copy of these guidelines;
- (b) Ask for an exception, if you are requesting more than the guidelines allow or asking for services or goods not mentioned in the guidelines; and/or
- (c) Request a fair hearing, if your request for support services is denied.

(6) What happens to my support services if I do not participate as required?

The department will give you ten days notice, following the rules in WAC 388-418-0030, then discontinue your support services until you participate as required.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-14-043, § 388-310-0800, filed 6/30/99, effective 7/31/99; 97-20-129, § 388-310-0800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0900 WorkFirst—Basic education. (1) What is basic education?

Basic education is high school completion, classes to prepare for GED and testing to acquire GED certification. It may include families that work, workplace basics, adult basic education (ABE) or English as a second language (ESL) training if:

- (a) It is determined you need this education to become employed or get a better job; and
- (b) This activity is combined with paid or unpaid employment or job search.

(2) When do I participate in basic education as part of WorkFirst?

You may participate in basic education as part of WorkFirst under any of the following circumstances:

- (a) You may choose to participate, if you are twenty years of age or older and are working in paid or unpaid employment or in job search for a minimum of twenty hours a week (in addition to the basic education).
- (b) You may be required to participate if you are a mandatory participant, a parent eighteen or nineteen years of age, you do not have a high school diploma or GED certificate and you need this education in order to find employment.
- (c) You will be required to be in high school or a GED certification program if you are a mandatory participant, sixteen or seventeen years old and you do not have a high school diploma or GED certificate.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-0900, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0900, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1000 WorkFirst—Vocational education. (1) What is vocational education?

Vocational education is training that leads to a degree or certificate in a specific occupation and is offered by an accredited:

- (a) Public and private technical college or school;
- (b) Community college; or
- (c) Tribal college.

(2) When can vocational education be included in my individual responsibility plan?

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We may add vocational education to your individual responsibility plan if:

- (a) You are working twenty or more hours a week; or
- (b) You lack job skills that are in demand for entry level jobs in your area; and
- (c) The vocational education program is the only way that you can acquire the job skills you need to qualify for entry level jobs in your area (because there is no available work experience, pre-employment training or on-the-job training that can teach you these skills).

(3) Can I get help with paying the costs of vocational education?

WorkFirst will pay for the costs of your vocational education, such as tuition or books, if vocational education is in your individual responsibility plan and there is no other way to pay them. You can also get help with paying your child care costs through the working connections child care program. (See chapter 388-290 WAC for the working connections child care program rules.)

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1000, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1000, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1000, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1050 WorkFirst—Job skills training.

(1) What is job skills training?

Job skills training is training in specific skills directly related to employment, but not tied to a specific occupation. Job skills training programs differ in how long the course lasts, what skills are taught and who provides the training. The training may be offered by:

- (a) Community based organizations;
- (b) Businesses;
- (c) Tribal governments; or
- (d) Public and private community and technical colleges.

(2) When can job skills training be included in my individual responsibility plan?

We may add job skills training in your individual responsibility plan for the same reasons we would add vocational education. That is if:

- (a) You are working twenty or more hours a week; or
- (b) You lack job skills that are in demand for entry level jobs in your area; and
- (c) The job skills training program is the only way you can acquire the job skills you need to qualify for entry level jobs in your area (because there is no available work experience, pre-employment training, or on-the-job training that can teach you these skills).

(3) Can I get help with paying the costs of job skills training?

WorkFirst will pay your costs, such as tuition or books, if job skills training is in your individual responsibility plan and there is no other way to pay them. You can also get help with paying your child care costs through the working connections child care program. (See chapter 388-290 WAC for the working connections child care program rules.)

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1050, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1050, filed 11/10/98, effective 12/11/98.]

WAC 388-310-1100 WorkFirst—Work experience.**(1) What is work experience?**

Work experience (sometimes called WEX) is an activity for mandatory participants that will teach you the basics of holding down a job and give you a chance to practice or expand your work skills. Work experience teaches you these skills by assigning you to unpaid work with:

- (a) A private, nonprofit organization;
- (b) A community or technical college; or
- (c) A federal, state, local or tribal government or district.

(2) What happens when I am enrolled in a work experience activity?

When you are enrolled in a work experience activity:

(a) The organization, government or district that is supervising your work experience position must comply with all applicable state and federal health and safety standards while you are working there.

(b) You may be required to look for work on your own and must accept any paid employment you find that meets the criteria in WAC 388-310-1500.

(3) How long does a work experience assignment last?

Your case manager must review your work experience assignment if it lasts longer than six months. This review will determine whether you need more time to learn the skills and abilities that the work experience assignment was set up to teach you.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1100, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1200 WorkFirst—On-the-job training.**(1) What is on-the-job training?**

On-the-job training (sometimes called OJT) is skills training provided by an employer at their place of business. You are paid to both work and spend some time learning new skills to help you do your job better. You may receive the training at your job site or be sent to a classroom (using "release time" from your job) to get some of this training.

(2) When do I qualify for on-the-job training?

You may qualify for on-the-job employment if:

- (a) You lack skills which are in demand in the local labor market; and
- (b) There are employers in your area who can and will provide the training.

(3) Is my employer reimbursed for giving me on-the-job training?

Your employer may be reimbursed for giving you on-the-job training for up to fifty percent of your total gross wages for regular hours of work and pre-approved release time for training.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1200, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1200, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1300 Community jobs program.**(1) What is the community jobs program?**

The community jobs program helps you gain work skills and experience by enrolling you in a temporary, subsidized

job. You will also receive other services and support to help you move into unsubsidized employment as quickly as possible.

(a) The state department of community, trade and economic development (DCTED) administers the community jobs program.

(b) DCTED selects community jobs contractors (CJC) by using a competitive "requests for proposal" process. DCTED, based upon the successful proposals, develops contracts specific to each selected community jobs contractor.

(c) The CJs develop and manage the community jobs positions, pay the wages, provide support services and act as the "employer of record" while you are enrolled in a subsidized community job.

(d) Employers at the community jobs work sites must take actions to help participants move into unsubsidized employment. If they do not meet this requirement, they will not be considered for additional community jobs employees.

(e) The department of social and health services funds the community jobs program and reimburses your wages to the CJs.

(2) How will I be affected if I am enrolled in the community jobs program?

If you are enrolled in the community jobs program:

(a) Your case manager will assign you to a community job position for no more than nine months.

(b) You may be assigned to a community job position when:

(i) You have gone through job search without finding a job; and/or

(ii) You and your case manager decide you need a supportive work environment to help you become more employable.

(c) You may not be enrolled in any community jobs position that requires you to do work related to religious, electoral or partisan political activities.

(d) You, your case manager and the CJC will review the appropriateness of your community jobs position every ninety days during your nine-month placement, looking at:

(i) Your continued TANF/SFA eligibility;

(ii) Any earned or unearned income received by you or another member of your assistance unit (that is, you and other people in your household who are included on your cash grant); and

(iii) Whether the community jobs position is actually helping you become more employable.

(e) You may work twenty or more hours per week in the community jobs position and will be paid the federal or state minimum wage, whichever is higher.

(f) You will earn sick leave and annual leave at the rate agreed upon by DCTED and the CJC for community jobs participants.

(g) The amount of your TANF/SFA monthly grant will be determined by following the rules in WAC 388-450-0050 and 388-450-0215 (1), (3), (4), (5) and (6). WAC 388-450-0215 (2), does not apply to your community jobs wages.

(3) What kind of employers provide community jobs work sites?

The CJC may ask the following categories of employers to provide you with a community job work site:

(a) Federal, state or local governmental agencies and tribal governments; and

(b) Private and tribal nonprofit businesses, organizations and educational institutions.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-08-051, § 388-310-1300, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.08.090, 74.04.050 and 74.08A.320, 98-10-054, § 388-310-1300, filed 4/30/98, effective 5/31/98.]

WAC 388-310-1400 WorkFirst—Community service. (1) What is community service?

Community service includes two types of activities for mandatory participants:

(a) Unpaid work (such as the work performed by volunteer workers) that you perform for a charitable nonprofit organization, federal, state, local or tribal government or district; or

(b) An activity approved by your case manager which benefits you, your family, your community or your tribe. These activities may include traditional activities that perpetuate tribal culture and customs.

(2) What type of community services activities benefit me, my family, my community or my tribe and might be included in my individual responsibility plan?

The following types of community service activities benefit you, your family, your community or your tribe and might be included in your individual responsibility plan:

(a) Caring for a disabled family member;

(b) Caring for a child, if you are over fifty-five years old and receiving TANF or SFA assistance for the child as a relative (instead of as the child's parent);

(c) Providing childcare for another WorkFirst participant who is doing community service;

(d) Actively participating in a drug or alcohol assessment or treatment program which is certified or contracted by the state under chapter 70.96A RCW; and/or

(e) Participating in family violence counseling or drug or alcohol treatment that will help you become employable or keep your job (this is called "specialized services" in state law).

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1400, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1400, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1500 WorkFirst—Employment conditions. (1) If I am a mandatory participant, are there any limitations on the type of paid or unpaid employment I must accept?

If you are a mandatory participant, you must accept paid or unpaid employment (including any activity in which an employer-employee relationship exists) unless the employment:

(a) Is not covered by industrial insurance (described in state law under Title 51 RCW) unless you are employed by a tribal government or a tribal private for-profit business;

(b) Is available because of a labor dispute;

(c) Has working hours or conditions that interfere with your religious beliefs or practices (and a reasonable accommodation cannot be made);

(d) Does not meet federal, state or tribal health and safety standards; or

(e) Has unreasonable work demands or conditions, such as working for an employer who does not pay you on schedule.

(2) Are there any additional limitations on when I can be required to accept paid employment?

You must accept paid employment unless the job or the employer:

(a) Pays less than the federal, state, or tribe minimum wage, whichever is higher;

(b) Does not provide unemployment compensation coverage (described in state law under Title 50 RCW) unless you:

(i) Work for a tribal government or tribal for-profit business; or

(ii) Are a treaty fishing rights related worker (and exempt under section 7873 of the internal revenue code);

(c) Requires you to resign or refrain from joining a legitimate labor organization; or

(d) Does not provide you benefits that are equal to those provided to other workers employed in similar jobs.

(3) How many hours of unpaid employment can I be required to perform?

You can be required to work a set number of hours of unpaid employment each month. The number of hours required will not be more than your TANF, SFA or GA-S cash grant divided by the state or federal minimum wage, whichever is higher.

(4) What safeguards are in place to make sure I am not used to displace currently employed workers?

The following safeguards are in place to make sure you are not used to displace currently employed workers:

(a) You cannot be required to accept paid or unpaid employment which:

(i) Results in another employee's job loss, reduced wages, reduced hours of employment or overtime or lost employment benefits;

(ii) Impairs existing contracts for services or collective bargaining agreements;

(iii) Puts you in a job or assignment, or uses you to fill a vacancy, when:

(A) Any other person is on lay off from the same (or very similar) job within the same organizational unit; or

(B) An employer ends the job of a regular employee (or otherwise reduces its workforce) so you can be hired.

(iv) Reduces current employees' opportunities for promotions.

(b) If a regular employee believes your subsidized or unpaid work activity (such as a community jobs or work experience position) violates any of the rules described above, this employee (or his or her representative) has the right to:

(i) A grievance procedure (described in WAC 388-200-1100); and

(ii) A fair hearing (described in chapter 388-08 WAC).

(5) What other rules apply specifically to subsidized or on-the-job training positions?

If you are in a subsidized or on-the-job training position:

(a) WorkFirst state agencies must stop paying your wage or on-the-job training subsidy to your employer if your employer's worksite or operation becomes involved in a strike, lockout or bona fide labor dispute.

(b) If your wage subsidy or on-the-job training agreement is ended (and we stop paying any subsidies to your employer) because you were used to displace another employee, it will be up to you and the employer to decide whether you can (or want to) keep working there.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1500, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1500, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1600 WorkFirst—Sanctions. (1) What is a sanction and when is it used?

A sanction is a penalty that alters your grant when you refuse to:

- (a) Give the department the information we need to develop your individual responsibility plan;
- (b) Come to scheduled appointments with people who provide WorkFirst services or activities;
- (c) Do all of the activities listed on your individual responsibility plan; or
- (d) Accept paid employment that meets the criteria in WAC 388-310-1500.

(2) What happens once I do not provide information, go to an appointment, follow my individual responsibility plan or accept a job?

If you do not provide information, go to an appointment, follow up on your individual responsibility plan or accept a job, your case manager or social worker will send you a notice to set up an appointment so they can talk to you about the situation. If they are unable to contact you, they will use the information already on hand to find out why you did not follow through with the required activity. Then, your case manager will decide whether:

- (a) You were unable to do what was required; or
- (b) You were able, but refused, to do what was required.

(3) What is considered a good reason for not being able to do what WorkFirst requires?

You have a good reason if it was not possible to follow through on a required activity due to an event outside of your control. Some examples of good reasons may include:

- (a) You, your children or other family members were ill;
- (b) Your transportation or child care arrangements broke down and you could not make new arrangements in time to comply;
- (c) You could not locate child care, for your children under thirteen years, that was:

(i) Affordable (did not cost you more than your co-payment would under the working connections child care program in WAC 388-290);

(ii) Appropriate (licensed, certified or approved under federal, state or tribal law and regulations for the type of care you use and you were able to choose, within locally available options, who would provide it); and

(iii) Within a reasonable distance (within reach without traveling farther than is normally expected in your community).

(d) You could not locate other care services for an incapacitated person who lives with you and your children;

(e) You had a physical, mental or emotional condition, confirmed by a licensed health care professional, that interfered with your ability to participate;

(f) A significant person in your life died;

(g) You were threatened with or subjected to family violence;

(h) You had an immediate legal problem, such as an eviction notice; or

(i) You did not get notice telling you about our information request, an appointment or a requirement on your individual responsibility plan.

(4) What if my case manager decides that I refused to meet WorkFirst requirements without good reason?

If your case manager decides you refused to meet WorkFirst requirements without good reason, they will send you a notice that tells you:

- (a) What you refused to do;
- (b) You will be sanctioned (a penalty will be applied to your grant);
- (c) When the sanction starts;
- (d) How to request a fair hearing if you disagree with this decision; and
- (e) How to end the sanction.

(5) What are the penalties to my grant?

The following penalties are applied to your grant for anyone who is sanctioned in your household:

(a) In the first month, we calculate your family's grant and then remove the noncompliant person(s) share of the grant.

(b) In the second month, your reduced grant will be sent to a protective payee every month until the sanction is lifted. (WAC 388-460-0001 describes the protective payee rules.)

(c) In the third and following months, your grant is reduced by the person(s) share or forty percent, whichever is more.

(6) How do I stop (or end) the sanction?

To end your sanction:

- (a) You must provide the information we requested to develop your individual responsibility plan; and/or
- (b) Start and continue to do your required WorkFirst activities.

(c) Your grant will be restored after two weeks of participation, beginning with the day you began doing your required activities.

(7) What happens if I get sanctioned again after my sanction has been stopped?

If you are sanctioned again, the sanction process will start again.

(8) What if I reapply for TANF, SFA or GA-S and I was in sanction when my case closed?

You are still sanctioned at the level which was in effect when your case closed until you cure your sanction.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1600, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1600, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1700 WorkFirst—Self-employment.**(1) What is self-employment?**

When you work for yourself and do not have an employer, you are self-employed.

(2) When can I be deferred from job search to pursue self-employment?

(a) To be deferred from job search for self-employment, you must meet all the conditions below:

(i) You must be working at least twenty hours a week at your business;

(ii) Your business must generate income for you that is equal to the minimum wage (state or federal, whichever is higher) times twenty hours per week after your business expenses are subtracted.

(iii) Your case manager will refer you to a local business resource center, and they must approve your self-employment plan;

(b) If you do not meet all these conditions, you can still be self-employed, but you will also need to participate in job search or other WorkFirst activities.

(3) What self-employment services can I get?

If you are a mandatory participant and have an approved self-employment plan in your individual responsibility plan, you may get the following self-employment services:

(a) A referral to community resources for technical assistance with your business plan.

(b) Small business training courses through local community organizations or technical and community colleges.

(c) Information on affordable credit, business training and ongoing technical support.

(4) What support services may I receive?

If you have an approved self-employment plan in your individual responsibility plan all support services are available.

(5) Can I get childcare?

Childcare is available if you have an approved self-employment plan in your individual responsibility plan. (See chapter 388-290 WAC for working connections child care rules.)

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1700, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1700, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1800 WorkFirst—Post employment services. (1) What is the purpose of post employment services?

Post employment services help low-income parents who are working twenty hours or more a week keep and cope with their current jobs, look for better jobs, gain work skills for a career and become self sufficient.

(2) How do I obtain post employment services?

(a) You can obtain post employment services by:

(i) Asking for a referral from the local community service office;

(ii) Contacting community or technical colleges; or

(iii) Contacting the employment security department.

Employment security department staff may also telephone you if you got a job while you were on TANF or SFA to see if you are interested in receiving these services.

(b) You may qualify for different services (from various state or federal programs) depending on whether you:

(i) Are a mandatory participant (that is, you currently receive TANF, SFA or GA-S benefits);

(ii) Used to receive TANF or SFA benefits; or

(iii) Have never been on TANF or SFA.

(3) Who provides post employment services and what kind of services do they provide?

(a) Your WorkFirst case manager can refer you to employment retention services, that will help you develop the skills you need to keep your job. An employment retention specialist will contact you on a regular basis to:

(i) Help you resolve problems with your employer;

(ii) Help you adjust to your workplace;

(iii) Provide job coaching; and/or

(iv) Provide mentoring.

(b) The employment security department can help you increase your wages, increase your job skills or find a better job by providing you with:

(i) Employment and career counseling;

(ii) Labor market information;

(iii) Job leads for a better job (sometimes called job development);

(iv) On the job training;

(v) Help with finding a job that matches your interests, abilities and skills (sometimes called job matching); and

(vi) Help with finding a new job after job loss (sometimes called reemployment).

(c) Any Washington state technical and community college can approve a skill-training program for you that will help you advance up the career ladder. Their staff will talk to you, help you decide what training would work best for you and then help you get enrolled in these programs. The college may approve the following types of training for you at any certified institution:

(i) High school/GED,

(ii) Vocational education training,

(iii) Job skills training,

(iv) Adult basic education,

(v) English-as-a-Second language training; or

(vi) Pre-employment training.

(4) What other services are available while you receive post employment services?

While you receive post employment services, you may qualify for:

(a) Working connections childcare if you meet the criteria for this program (described in chapter 388-290 WAC). To qualify, you must also be in an approved post-employment service and your family's income cannot exceed one hundred seventy-five percent of the federal poverty level.

(b) Other support services, such as help in paying for transportation or work expenses.

(c) Other types of assistance for low-income families such as food stamps, medical assistance or help with getting child support that is due to you and your children.

(5) Who is eligible for post employment service, support services and childcare?

You may qualify for post-employment services, support services and child care if you are working twenty hours or more a week, and:

(a) You are current TANF or SFA recipient. You qualify for:

- (i) All types of post employment services, unless you are in sanction status;
- (ii) Tuition assistance from the community and technical college system;
- (iii) WorkFirst support services; and
- (iv) Working connections childcare.

(b) You are a former TANF or SFA recipient. You qualify for:

- (i) Employment retention services (help with keeping a job) for up to twelve months following TANF or SFA.
- (ii) Wage and skill progression services (help with finding a better job) for up to twenty four months after exiting TANF or SFA.
- (iii) Tuition assistance or pre-employment training from the community and technical college system;
- (iv) Working connections childcare assistance; and/or
- (v) WorkFirst support services for up to twelve months after exiting TANF or SFA.

(c) You are a low wage earner (that is, your family income does not exceed one hundred seventy-five percent of the federal poverty level) who has never received TANF or SFA benefits, and are in a community or technical college-approved skill training program. You may qualify for:

- (i) Tuition assistance or pre-employment training from the community and technical college system; or
- (ii) Working connections child care while you are in training or school for up to a total of thirty six months.

(6) What if I lose my job while I am receiving post employment services?

If you now receive or used to receive TANF or SFA, help is available to you for up to four weeks so that you can find another job and continue in your approved post employment.

(a) The employment security department will provide you with re-employment services.

(b) At the same time, your case manager can approve up to four weeks of support services and childcare for you.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1800, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1850 Re-employ Washington workers (RWW). (1) What is the re-employ Washington workers (RWW) program?

Re-employ Washington workers (RWW) is an eight-week job search program administered by the employment security department to help low-income parents connect with jobs as rapidly as possible. RWW participation satisfies unemployment insurance work search requirements while providing additional services and activities.

(2) Who can participate in RWW?

You can participate in RWW if:

(a) You worked and earned enough to establish an unemployment insurance benefit claim (see RCW 50.04.030), regardless of why your job ended; and

(b) Your family's income was not more than one hundred seventy-five percent of the federal poverty level during the time period on which your unemployment insurance claim is based; and

(c) You do not currently receive TANF or SFA cash assistance; and

(d) You have a dependent child under eighteen years of age living in your household.

(3) How do I get into RWW?

To get into RWW, you must apply for unemployment insurance and establish an unemployment insurance benefit claim. A job service specialist who has been trained to do the RWW program will screen your claim and contact you if it appears that you qualify. The RWW job service specialist will then determine your eligibility based on additional income and family information you provide.

(4) What happens when I participate in RWW?

(a) In addition to any unemployment insurance benefits you receive during your claim period, you also get:

- (i) Intensive job referral services (including a thirty-hour, job search workshop within the first four weeks of participation, and access to the resource room);
- (ii) Help with paying your child care costs under the working connections child care program (see chapter 388-290 WAC for program rules);
- (iii) Support services to help you participate in work and RWW activities, following the guidelines in WAC 388-310-0800.

(b) You may also qualify for cash incentives if you meet the following requirements:

- (i) You participate in the RWW program; and
- (ii) Go to work within six weeks; and
- (iii) Are still working twelve weeks later in a job that takes you off unemployment insurance.

(5) How much of a cash incentive can I receive?

If you return to work with earnings high enough to make you ineligible for unemployment insurance benefits, you can receive a RWW cash incentive once during the time period your unemployment insurance claim is based on. Earnings are calculated in accordance with the unemployment insurance laws in RCW 50.04.320. The cash incentives are as follows:

CASH INCENTIVES

Average gross weekly earnings	Employed within four weeks	Employed in week five or six	Employed in week seven or eight
At or above earnings from your last job*	\$300	\$100	N/A**
Below the earnings from your last job*	\$200	\$100	N/A**

*"Last job" means your most recent job that meets the definition of work in WAC 388-310-0400 (2)(a).

**Although you do not qualify for a cash incentive, you would continue to receive support services and child care assistance provided you continue to participate.

(6) What are the requirements to participate in RWW?

To be eligible for RWW program benefits, you must participate in RWW program activities, including:

- (a) Attend a thirty-hour job search workshop as soon as possible (during your first four weeks in the program);
- (b) Report to the RWW program site daily during the first four weeks and sign-in to get job leads;
- (c) Meet with fellow job seekers to support and encourage each members' job search efforts (sometimes called the RWW job club);
- (d) Report to the RWW program site at least twice a week during weeks five to eight and sign-in to receive job leads.

(7) Can I continue to participate in RWW if I don't find a job in eight weeks?

Your participation in RWW may be extended for an additional eight weeks if:

- (a) You meet the participation requirements and
- (b) RWW staff determine that an additional eight weeks of participation is likely to help you find a job.

(8) Can my RWW services be stopped once I enter the program?

If you do not follow RWW program requirements, RWW services will be stopped.

(9) What can I do if I disagree with a decision about my services or benefits?

If you disagree with the decision about your RWW services or benefits:

- (a) Ask an RWW job service specialist to take a statement from you explaining the reason you disagree.
- (b) To determine if the decision was correct, the employment security department local job service center management will review your statement.
- (c) If you disagree with the local management decision, you may request a final review by the employment security department regional office.
- (d) You may request a fair hearing under chapter 388-08 WAC if you want to appeal the decision of the employment security department regional office.

(10) Can I go back into the RWW program if there were interruptions in my participation?

RWW job search is designed to last for eight consecutive weeks. If you stopped participating but you are now able and willing to participate, you may complete the balance of your eight-week job search activities and receive the related RWW services and benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-14-044, § 388-310-1850, filed 6/30/99, effective 7/31/99.]

WAC 388-310-1900 WorkFirst—Services for American Indian tribal members and other American Indians.**(1) When might I be referred to a tribal government?**

Your case manager may refer you to a tribal government when you are an American Indian who applies for or receives TANF assistance, and:

- (a) You are in the population and service area identified in a tribal government's federally-approved tribal TANF program; or

(b) The tribal government does not operate its own TANF program, but it works with the local community service office to provide WorkFirst services and activities to meet your needs.

(2) What if I am an American Indian and am not referred to a tribal TANF program or tribal government to receive services?

WorkFirst state agencies and their community partners must give you equitable access to all WorkFirst activities and services.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1900, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1900, filed 10/1/97, effective 11/1/97.]

Chapter 388-320 WAC**PUBLIC RECORDS DISCLOSURE—
ADMINISTRATIVE PROCEDURES****WAC**

388-320-010 through 388-320-460 Repealed.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

- 388-320-010 Purpose. [Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-010, filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-010, filed 2/19/81; Order 899, § 388-320-010, filed 1/25/74.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-030 Establishment of department. [Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-030, filed 11/27/91, effective 12/28/91; Order 899, § 388-320-030, filed 1/25/74.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-100 Public records available. [Statutory Authority: RCW 74.08.090, 92-20-005 (Order 3456), § 388-320-100, filed 9/23/92, effective 10/24/92. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-100, filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-100, filed 2/19/81; Order 899, § 388-320-100, filed 1/25/74.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-110 Public records officer. [Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-110, filed 2/19/81; Order 899, § 388-320-110, filed 1/25/74.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-115 Disclosure coordinator. [Statutory Authority: RCW 74.08.090 and 42.17.260. 94-16-047 (Order 3765), § 388-320-115, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-115, filed 2/19/81; Order 899, § 388-320-115, filed 1/25/74.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-130 Request for disclosure of a public record. [Statutory Authority: RCW 74.08.090 and 42.17.260. 94-16-047 (Order 3765), § 388-320-130, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-130, filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-130, filed 2/19/81; Order 899, § 388-320-130, filed 1/25/74.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99.

- 388-320-132 Preserving requested records. [Statutory Authority: RCW 74.08.090, 92-20-005 (Order 3456), § 388-320-132, filed 9/23/92, effective 10/24/92.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-133 Approval or denial of request. [Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-133, filed 11/27/91, effective 12/28/91.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-135 Disclosure to client's representative. [Statutory Authority: RCW 74.08.090 and 42.17.260. 94-16-047 (Order 3765), § 388-320-135, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-135, filed 2/19/81.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-140 Fees—Inspection and copying. [Statutory Authority: RCW 74.08.090 and 42.17.300. 96-18-092, § 388-320-140, filed 9/4/96, effective 10/5/96. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-140, filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-140, filed 2/19/81; Order 899, § 388-320-140, filed 1/25/74.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-170 Protection of public records. [Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-170, filed 2/19/81; Order 899, § 388-320-170, filed 1/25/74.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-205 Disclosure procedure. [Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-205, filed 2/19/81.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-210 Remedy for review of denial of disclosure. [Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-210, filed 2/19/81.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-220 Exemptions to public records disclosure. [Statutory Authority: RCW 74.08.090 and 42.17.260. 94-16-047 (Order 3765), § 388-320-220, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 74.08.090, 92-20-005 (Order 3456), § 388-320-220, filed 9/23/92, effective 10/24/92. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-220, filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 34.04.020. 83-03-021 (Order 1938), § 388-320-220, filed 1/13/83. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-220, filed 2/19/81.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-225 Qualifications on nondisclosure. [Statutory Authority: RCW 74.08.090, 74.04.050, 70.04.055 and Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, § 103). 97-07-008, § 388-320-225, filed 3/10/97, effective 4/10/97. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-225, filed 2/19/81.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-235 Disclosure for program purposes. [Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-235, filed 2/19/81.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-240 Disclosure for other than program purposes. [Statutory Authority: RCW 74.08.090 and 42.17.260. 94-16-047 (Order 3765), § 388-320-240, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-240, filed 2/19/81.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-350 Declaratory orders—Forms, content, and filing. [Statutory Authority: RCW 34.05.220, 42.17.340 and chapters 17.250 and 17.260 RCW. 93-24-057 (Order 3673), § 388-320-350, filed 11/24/93, effective 12/25/93. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-350, filed 2/5/90, effective 3/1/90.] Repealed by 99-06-044, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 34.05.220, 34.05.240 and 34.05.250.
- 388-320-360 Declaratory orders—Procedural rights of persons in relation to petition. [Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-360, filed 2/5/90, effective 3/1/90.] Repealed by 99-06-044, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 34.05.220, 34.05.240 and 34.05.250.
- 388-320-370 Declaratory orders—Disposition of petition. [Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-370, filed 2/5/90, effective 3/1/90.] Repealed by 99-06-044, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 34.05.220, 34.05.240 and 34.05.250.
- 388-320-375 How do I file petitions for declaratory orders? [Statutory Authority: RCW 74.08.090, 34.05.220, 34.05.240 and 34.05.250. 99-06-044, § 388-320-375, filed 2/26/99, effective 3/29/99.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-450 Interpretive and policy statements roster and index. [Statutory Authority: RCW 34.05.220, 42.17.340 and chapters 17.250 and 17.260 RCW. 93-24-057 (Order 3673), § 388-320-450, filed 11/24/93, effective 12/25/93. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-450, filed 11/27/91, effective 12/28/91.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.
- 388-320-460 Final adjudicative and declaratory order index. [Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-460, filed 11/27/91, effective 12/28/91.] Repealed by 99-15-065, filed 7/19/99, effective 8/19/99. Statutory Authority: RCW 42.17.250 and 34.05.220.

WAC 388-320-010 through 388-320-460 Repealed.
See Disposition Table at beginning of this chapter.

**Chapter 388-400 WAC
PROGRAM SUMMARY**

WAC
388-400-0020 General assistance for pregnant women—General eligibility requirements.

WAC 388-400-0020 General assistance for pregnant women—General eligibility requirements. (1) To be eligible for general assistance for pregnant women (GA-S), a woman must:

- (a) Meet the requirements of WAC 388-462-0005; and
- (b) Meet the general assistance citizenship/alien status requirements under WAC 388-424-0005(3); and
- (c) Be in financial need according to temporary assistance for needy families (TANF) income and resource rules in chapters 388-450, 388-470 and 388-488 WAC; and
- (d) Provide a Social Security number as required under WAC 388-476-0005; and
- (e) Reside in the state of Washington as required under WAC 388-468-0005.

(2) A woman is not eligible for GA-S if she:

(a) Is eligible for or her needs are being met by the Supplemental Security Income (SSI) program TANF or state family assistance (SFA);

(b) Is under sanction for failing to comply with SSI requirements;

(c) Fails or refuses to cooperate without good cause in obtaining SSI; or

(d) Fails or refuses to cooperate in obtaining TANF or SFA. This includes disqualifications for:

(i) Convictions for misrepresenting residence to obtain assistance in two or more states as specified under chapter 388-446 WAC;

(ii) Convictions for drug-related felonies and failing to complete drug treatment as specified under chapter 388-442 WAC;

(iii) Failing to report a child's absence within five days of becoming reasonably certain the absence will exceed ninety days as specified in chapter 388-418 WAC; or

(iv) Failing to meet school attendance requirements for unmarried teen parents as specified under chapter 388-486 WAC.

(3) The assistance unit for a woman applying for or receiving GA-S will be established according to WAC 388-408-0010.

(4) Unmarried pregnant or parenting minors who are not emancipated under a court decree must meet the living arrangement requirements of WAC 388-486-0005.

(5) A pregnant woman in an institution may be eligible for GA-S as specified under WAC 388-230-0080.

(6) Effective May 1, 1999, GA-S cash benefits will count toward the sixty-month time limit as specified under WAC 388-484-0005.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-08-050, § 388-400-0020, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0020, filed 7/31/98, effective 9/1/98.]

Chapter 388-406 WAC APPLICATIONS

WAC

388-406-0015	Expedited service for food assistance.
388-406-0020	Repealed.
388-406-0021	How the department decides if you are a migrant or seasonal farmworker and if you are destitute.
388-406-0035	Time limits for processing applications.
388-406-0040	Delays in application processing.
388-406-0050	Completing the application process.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-406-0020	Destitute household definition. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0020, filed 7/31/98, effective 9/1/98.] Repealed by 99-24-008, filed 11/19/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
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WAC 388-406-0015 Expedited service for food assistance. (1) Expedited service means a client will have verification postponed and receive food assistance benefits by the end of the fifth calendar day from the day after the date the application is filed. The day after that date is day one.

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(2) The five-day period starts at a time after the date the application is filed in the following situations:

(a) The five-day period starts the date of the rescheduled interview when the client is screened as expedited service eligible and causes a delay by not showing for the initial interview;

(b) The five-day period starts the date identity is verified when the client causes a delay by not providing verification of identity at the interview; or

(c) The five-day period starts the date of the interview when the client:

(i) Waives the expedited interview and is found eligible for the service at the scheduled interview;

(ii) Is screened as ineligible for expedited service and later found eligible for the service at the scheduled interview; or

(iii) Does not request expedited service on the application and is found eligible for the service at the interview.

(3) For SSI recipients, the five-day period begins on the date the:

(a) Applicant's local office receives the application of a noninstitutionalized SSI household; or

(b) Applicant is released from a public institution.

(4) When clients request expedited service on a recertification form, the five-day period:

(a) Starts the first day of the new certification period when the recertification is made prior to the end of the current certification period;

(b) Starts the first day of the new certification period or the date of interview, whichever is later, when the client causes a delay in the recertification; or

(c) Is the same as a new application when the recertification is made after the current certification period ends.

(5) Clients are eligible for expedited service when:

(a) The household has liquid resources of one hundred dollars or less and has gross monthly income under one hundred fifty dollars; or

(b) The household has combined gross monthly income and liquid resources which are less than the household's current monthly rent and applicable utility allowance; or

(c) All household members are homeless; or

(d) The household includes a destitute migrant or seasonal farmworker, as defined in WAC 388-406-0020, whose liquid resources do not exceed one hundred dollars.

(6) A household must provide verification of:

(a) The identity of the applicant; or

(b) The identity of the authorized representative who is applying for the household; and

(c) Other eligibility factors that can be verified within the five day time period specified in subsection (1) of this section.

(7) A household is not limited to the number of times it can receive expedited service if, following the last expedited certification, the household:

(a) Completes the postponed verification requirements; or

(b) Was certified by the regular nonexpedited processing methods.

(8) Households eligible for expedited service that are not required to have an office interview will:

- (a) Have a telephone interview or home visit; and
 - (b) Still receive their benefits within the five-day expedited time period.
- (9) A household is entitled to an agency conference within two working days from the date of denial for expedited service.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-406-0015, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-406-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0020 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-406-0021 How the department decides if you are a migrant or seasonal farmworker and if you are destitute. The rules in this section apply to food assistance.

(1) A migrant is a person who travels away from home on a regular basis, usually with a group of other workers, to seek employment in an agriculturally-related activity. A migrant assistance unit is an assistance unit that travels for this purpose.

(2) A seasonal farmworker is a person who:

(a) Does agricultural work on a farm for edible crops; and

(b) Is not required to be away from their permanent place of residence overnight in order to perform this work.

(3) For seasonal farmworkers, agricultural work is field work in which the person:

(a) Plants;

(b) Cultivates; or

(c) Harvests the crop.

(4) An assistance unit is considered a seasonal farmworker assistance unit if it receives its only countable income from:

(a) Seasonal farmwork;

(b) Unemployment compensation between seasons; or

(c) Interest earned on a checking or savings account.

(5) A migrant or seasonal farmworker is considered destitute when:

(a) The assistance unit's income for the month of application was received before the date of application and was from a source no longer providing income; or

(b) The assistance unit's income of the month of application is from a new source and the assistance unit will not receive more than twenty-five dollars during the ten calendar days from the date of application.

(6) A household member changing jobs but continuing to work for the same employer is considered to be receiving income from the same source.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 99-24-008, § 388-406-0021, filed 11/19/99, effective 1/1/00.]

WAC 388-406-0035 Time limits for processing applications. (1) The application process as defined in WAC 388-406-0050(1) must be completed as quickly as possible. The time limits specified in this section cannot be used as a waiting period for determining eligibility.

(2) When applying the time limits specified in this section, day one is the date following the date:

(a) A request for benefits form is received by the department as specified under WAC 388-406-0010;

(b) A household consisting solely of persons eligible for SSI files a food assistance application at the SSADO; or

(c) An SSI recipient applying for food assistance is released from a public institution when the person filed an application with the SSADO before release.

(3) Time limits are in calendar days unless otherwise specified. Time limits for application process completion are no more than:

(a) Thirty days for TANF, SFA, RCA, consolidated emergency assistance program (CEAP), diversion cash assistance (DCA), and food assistance;

(b) Forty-five days for general assistance and alcohol and drug abuse treatment and shelter assistance (ADATSA); and

(c) Medical program benefits must be processed no more than:

(i) Sixty days when a disability decision is required;

(ii) Fifteen working days for pregnant women; and

(iii) Forty-five days for all other categories.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-406-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-406-0035, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0470.]

WAC 388-406-0040 Delays in application processing.

(1) When the department discovers that a food assistance application has not been processed within the initial thirty day time limit, and:

(a) The department has sufficient information to determine eligibility, the application will be processed without further delay; or

(b) If additional information is needed to determine eligibility, the household will be:

(i) Mailed or given a written request for the additional information needed to determine eligibility; and

(ii) Allowed an additional thirty day period to provide the information.

(2) When a household files a joint application requesting food assistance and medical or cash assistance:

(a) Approval of the food assistance application cannot be delayed pending the processing of the application for medical or cash assistance;

(b) A new application for food assistance cannot be required if the application for medical or cash assistance is denied;

(c) Approval for a medical program is not delayed pending the processing of the application for cash or food assistance.

(3) For medical and cash assistance, application processing may be delayed only when good cause exists as specified in WAC 388-406-0045.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-406-0040, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-406-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

WAC 388-406-0050 Completing the application process. (1) Application processing is completed when the department makes an eligibility decision and:

(a) Authorizes benefits and, for food assistance, mails or gives a written approval notice to the applicant; or

(b) Mails or gives a written withdrawal or denial notice to the applicant.

(2) The applicant will be notified of the department's eligibility decision in writing. A notice of denial or withdrawal must meet the adequate notice requirements in WAC 388-458-0005.

(3) For cash, medical, and food assistance, an applicant may voluntarily withdraw an application orally or in writing.

(4) For cash assistance, an application is considered withdrawn when the applicant:

(a) Fails to appear for a scheduled interview required for eligibility determination; and

(b) Does not contact the department to reschedule the interview within thirty days from the date of application.

(5) For approved applications, the date the applicant becomes eligible for assistance is established according to WAC 388-406-0055.

(6) A decision to deny an application must be made according to the requirements of WAC 388-406-0060.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0050, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0050, filed 7/31/98, effective 9/1/98. Formerly WAC 388-525-2505.]

Chapter 388-408 WAC ASSISTANCE UNITS

WAC

388-408-0010 Assistance units for general assistance programs.
388-408-0015 Assistance units for temporary assistance for needy families (TANF) or state family assistance (SFA).

WAC 388-408-0010 Assistance units for general assistance programs. (1) A GA-U assistance unit includes:

(a) An incapacitated adult; or

(b) A married couple if both persons are incapacitated and living together.

(2) A GA-H assistance unit includes only the child or children eligible for GA-H (see WAC 388-400-0015).

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-408-0010, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0015 Assistance units for temporary assistance for needy families (TANF) or state family assistance (SFA). The department must include in a TANF or SFA assistance unit certain persons who are living together, unless those person(s) must be excluded under WAC 388-408-0020 or are excluded at the option of the family under WAC 388-408-0025. An assistance unit for TANF or SFA benefits or combination of TANF and SFA benefits must include the following:

(1) The child for whom assistance is requested and:

(a) That child's full, half or adoptive sibling(s);

(b) The natural or adoptive parent(s) or stepparent(s); and

(c) The parent(s) of a pregnant or parenting minor who claims to be in need and is providing the primary care for the:

(i) Pregnant minor;

(ii) Minor parent;

(iii) Minor parent's child; or

(iv) Full, half or adoptive sibling(s) of a pregnant or parenting minor.

(2) A pregnant woman if there is no TANF or SFA eligible child in the home.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-408-0015, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0015, filed 7/31/98, effective 9/1/98.]

Chapter 388-410 WAC BENEFIT ERROR

WAC

388-410-0001 What is a cash/medical assistance overpayment?

WAC 388-410-0001 What is a cash/medical assistance overpayment? (1) An overpayment is any cash or medical assistance paid that is more than the assistance unit was eligible to receive.

(2) There are two types of cash/medical overpayments:

(a) Intentional overpayments, presumed to exist when the client willfully or knowingly:

(i) Fails to report within twenty days a change in circumstances that affects eligibility; or

(ii) Misstates or fails to reveal a fact affecting eligibility as specified in WAC 388-446-0001.

(b) Unintentional overpayments, which includes all other client-caused and all department-caused overpayments.

(3) If you request a fair hearing and the fair hearing decision is in favor of the department, then:

(a) Some or all of the continued assistance you get before the fair hearing decision must be paid back to the department (see WAC 388-418-0030); and

(b) The amount of assistance you must pay back will be limited to sixty days of assistance, starting with the day after the department receives your hearing request.

(4) If you receive child support payments directly from the noncustodial parent, you must turn these payments over to the division of child support (DCS). These payments are not cash assistance overpayments.

[Statutory Authority: RCW 74.04.510 and 7 C.F.R. 273.9 (d)(6). 99-24-131, § 388-410-0001, filed 12/1/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-412 WAC BENEFIT ISSUANCES

WAC

388-412-0005 General information about cash assistance payments.
388-412-0015 Food assistance allotments.

WAC 388-412-0005 General information about cash assistance payments. (1) Eligible clients may receive cash

assistance by electronic benefit transfer (EBT) or warrant. Each separate assistance unit receives a separate cash benefit grant, even if there are multiple assistance units in the same residence.

(2) A married couple who both receive any general assistance benefit must be considered one assistance unit. However, cash payments are made individually and will not exceed one half of the two-person GA-U standard.

(3) Grants are rounded down to the next whole dollar amount with the following exceptions:

(a) Clothing and personal incidental (CPI) allowance; and

(b) Grants with a deduction for repayment of an overpayment.

(4) Grant payments are not issued for under ten dollars except:

(a) Grants with a deduction for repayment of an overpayment;

(b) CPI allowances with income deducted; or

(c) Supplemental Social Security (SSI) interim assistance payments.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-412-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0005, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0015 Food assistance allotments. (1) A client's food assistance benefit amount is called an allotment. An allotment is the total dollar value of coupons an eligible assistance unit receives for a calendar month.

(2) Assistance units with no income receive the maximum allotment as described under the thrifty food plan (TFP) in WAC 388-478-0060. Assistance units with net income receive smaller amounts.

(3) When an assistance unit has income, the allotment is determined by:

(a) Multiplying the assistance unit's net monthly income by thirty percent and rounding up to the next whole dollar; and

(b) Subtracting the results from the thrifty food plan for the appropriate assistance unit size as specified in WAC 388-478-0060.

(4) Except for those described in WAC 388-406-0055 eligible assistance units receive benefits from the effective date of eligibility to the end of the first month. This is called proration and is based on a thirty-day month.

(5) In the first month of eligibility, assistance units do not receive an allotment when the amount is less than ten dollars.

(6) Eligible one and two person assistance units receive a minimum ten dollar allotment:

(a) After the first month of eligibility; or

(b) In the first month of eligibility when the CSO receives the assistance unit's application on the first day of the month.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-412-0015, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW

74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0015, filed 7/31/98, effective 9/1/98.]

**Chapter 388-416 WAC
CERTIFICATION PERIODS**

WAC

388-416-0005 Certification periods for food assistance.

WAC 388-416-0005 Certification periods for food assistance. A certification period is the specified amount of time the assistance unit is determined eligible. Assistance units are certified for the following periods:

(1) Not more than twenty-four months for assistance units without earned income or cash assistance when all members are elderly;

(2) Not more than twelve months for assistance units with no earned income and all household members are disabled or elderly.

(3) Not more than six months for assistance units:

(a) Receiving cash assistance;

(b) With earned income and required to report monthly;

(c) With recent work history and required to report monthly; or

(d) Not likely to have any changes.

(4) Not more than three months for assistance units:

(a) Consisting of migrant seasonal farmworkers;

(b) Containing an able-bodied adult without dependents (ABAWD);

(c) Without any income and not receiving cash assistance;

(d) With expenses that exceed income received;

(e) That are homeless or staying in an emergency or battered spouse shelter;

(f) That are staying in a non-ADATSA drug and alcohol treatment center; or

(g) Not identified in this section.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-416-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0005, filed 7/31/98, effective 9/1/98.]

**Chapter 388-418 WAC
CHANGE OF CIRCUMSTANCE**

WAC

388-418-0005 Clients must report certain changes to the department within specified time limits.

388-418-0010 Repealed.

388-418-0012 Prospective eligibility for food assistance.

388-418-0015 Repealed.

388-418-0020 How the department determines the date a change affects the benefit amount.

388-418-0025 Effect of changes on medical program eligibility.

388-418-0030 Repealed.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

388-418-0010 Requesting information or action needed. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0010, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

- 388-418-0015 Recipient fails to provide requested information or take requested action. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0015, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-418-0030 Notifying a recipient of intent to reduce, suspend or terminate assistance. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-418-0030, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0030, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2205 and 388-525-2570.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-418-0005 Clients must report certain changes to the department within specified time limits. (1) Clients who receive cash or food assistance must report the following changes about everyone in the assistance unit. The client must report these changes within ten days of when they learn about the change. Clients must report:

(a) The gross monthly amount of unearned income they receive when:

(i) They start receiving money from any new source.

(ii) The amount received from a previously reported source changes by more than twenty-five dollars.

(b) When someone, including a newborn child, moves in or out, even if the change is temporary.

(c) The marriage or divorce of any assistance unit member.

(d) A new residence, including any change in shelter expenses because of the move.

(e) Obtaining a vehicle.

(f) The end of a temporary disability when the temporary disability is the reason for excluding a vehicle.

(g) When the assistance unit's countable resources exceed the resource limits described in chapter 388-470 WAC.

(h) Any of the following changes related to employment:

(i) A new job or different employer.

(ii) A change in wage rate or pay scale.

(iii) An employment status change from part-time to full time. The employer determines when an employee has full-time employment status.

(2) Clients who receive only children or pregnant women's medical assistance must report the following changes. The client must report these changes within twenty days of when they learn about the change. Clients must report:

(a) When someone, including a newborn child, moves in or out, even if the change is temporary.

(b) When a pregnancy begins or ends.

(c) A new residence.

(3) Clients who receive any other medical assistance must report the following changes. Clients must report these changes about themselves, their spouses or any dependents. The client must report these changes within twenty days of when they learn about the change. Clients must report:

(a) When someone, including a newborn child, moves in or out, even if the change is temporary.

(b) When an assistance unit member gets married, divorced or separated.

(c) When a pregnancy begins or ends.

(d) A new residence or address.

(e) Any change in the amount of income received from any new or previously reported source.

(f) Any change in the amount of expenses paid for shelter.

(g) Any change in the amount of expenses paid for medical care.

(h) Changes in resources.

(4) For TANF/SFA, a caretaker relative must report within five days when they learn that the temporary absence of a child will exceed ninety days. When the relative fails to report timely, the relative:

(a) Is not eligible for one month; and

(b) The relative's countable income is considered available to the remaining members of the assistance unit.

(5) When a change is reported late, the client may receive the wrong amount or the wrong type of assistance. When benefits are overpaid, the client must repay the assistance as described in chapter 388-410 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-418-0005, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0010 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-418-0012 Prospective eligibility for food assistance. (1) We determine eligibility for food assistance every month for all households based on the household's expected circumstances. This is called prospective eligibility.

(2) Households must meet all eligibility requirements in WAC 388-400-0040 or 388-400-0045 in order to be eligible for food assistance unless the household meets the categorical eligibility (CE) requirements in WAC 388-414-0001.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-418-0012, filed 7/26/99, effective 9/1/99.]

WAC 388-418-0015 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-418-0020 How the department determines the date a change affects the benefit amount. (1) Unless otherwise specified, the rules in this chapter refer to cash, food and medical assistance benefits.

(2) When a change causes an increase in benefits, the client must provide proof of the change before we adjust the benefit amount.

(a) The change affects the next month after the change is reported if the client provides verification within ten days from the date we request verification.

(b) The change affects the next month after the verification is received if the client provides verification after ten days from the date we request verification.

(c) When the client is entitled to receive additional benefits, the department must send the additional amount within ten days of the day the client provides requested verification.

(3) When a change causes a decrease in benefits:

(a) If the client reports the change within the time limits in WAC 388-418-0005, the change affects the first month following the advance notice period. The advance notice period:

(i) Begins on the day we send the client a notice about the change, and

(ii) Is determined according to the rules in WAC 388-458-0010.

(b) If the client fails to report the change within the time limits in WAC 388-418-0005:

(i) The change affects the first month following the day the advance notice period would end if the client reported the change on time, allowing:

(A) Ten days for the client to report the change, and

(B) Ten days for the advance notice period to begin.

(ii) We continue assistance unchanged through the advance notice period when the advance notice period ends later than the effective date.

(iii) We establish an overpayment claim according to the rules in chapter 388-410 WAC when benefits continue beyond the effective date.

(4) Within ten days of the day we learn about a change, the department:

(a) Sends advance notice according to the rules in chapter 388-458 WAC; and

(b) Takes necessary action to correct the benefit. Action on a change is delayed when the client requests a hearing about a proposed decrease in benefits before the effective date or within the advance notice period.

(5) When the client requests a hearing and continued benefits:

(a) The department continues the same benefits received prior to the advance notice of reduction until the earliest of the following events occur:

(i) For food assistance only, the client's certification period expires;

(ii) The end of the month the fair hearing decision is mailed;

(iii) The client states in writing that the assistance unit does not want continued benefits;

(iv) The client withdraws the fair hearing request in writing; or

(v) The client abandons the fair hearing request; or

(vi) An administrative law judge issues a written order that ends continued benefits prior to the fair hearing.

(b) The department establishes an overpayment claim according to the rules in chapter 388-410 WAC when the hearing decision agrees with the department's action.

(6) Some changes have a specific effective date as follows:

(a) When cash assistance benefits increase because a person is added to the assistance unit, we use the effective date rules for applications in WAC 388-406-0055.

(b) When cash assistance benefits increase because the household becomes eligible for a higher payment standard, we use the date the change occurred.

(c) When a change in law or regulation changes the benefit amount, we use the date specified by the law or regulation.

(d) When institutional medical assistance participation changes, we calculate the new participation amount beginning with the month the income or allowable expense changes.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-418-0020, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0025 Effect of changes on medical program eligibility. (1) A client continues to receive Medicaid until the department determines the client's eligibility or ineligibility for another medical program. This applies to a client who, during a certification period, becomes ineligible for, is terminated from, or requests termination from:

(a) A Medicaid program or SFA-related medical program; or

(b) Any of the following cash grants:

(i) TANF or SFA;

(ii) SSI;

(iii) GA-H; or

(iv) GA-X. See WAC 388-434-0005 for changes reported during eligibility review.

(2) A child remains continuously eligible for medical benefits for a period of twelve months from the date of certification for medical benefits or last review, whichever is later. This applies unless the child:

(a) Moves out of state;

(b) Loses contact with the department or the department does not know the child's whereabouts;

(c) Turns eighteen years of age if receiving children's health program benefits;

(d) Turns nineteen years of age if receiving children's CN or CN scope of care program benefits; or

(e) Dies.

(3) When a client becomes ineligible for refugee cash assistance, refugee medical assistance can be continued only through the eight-month limit, as described in WAC 388-400-0035(6).

(4) A client receiving a TANF or SFA cash grant is eligible for a medical extension, as described under WAC 388-523-0100, when the client's cash grant is terminated as a result of:

(a) Earned income; or

(b) Collection of child or spousal support.

(5) A change in income during a certification period does not affect eligibility for:

(a) Pregnant women's medical programs; or

(b) The first six months of the TANF/SFA-related medical extension.

[Statutory Authority: RCW 74.04.050, 74.04.057 and Section 4731 of the BBA (Public Law 105-33). 99-10-064, § 388-418-0025, filed 5/3/99, effective 6/3/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-508-0840, 388-509-0920, 388-509-0960, 388-522-2205 and 388-522-2210.]

WAC 388-418-0030 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-424 WAC
CITIZENSHIP/ALIEN STATUS

WAC

388-424-0005	The effect of citizenship and alien status on eligibility for benefits.
388-424-0010	Alien status—Eligibility requirements for the temporary assistance for needy families program and medical benefits.

WAC 388-424-0005 The effect of citizenship and alien status on eligibility for benefits. (1) To receive benefits under the temporary assistance for needy families (TANF), Medicaid, children's health insurance program (CHIP) or federal food stamp program, a person must be a:

- (a) U.S. citizen;
- (b) U.S. national; or
- (c) Qualified alien who meets the eligibility requirements described in:
 - (i) WAC 388-424-0010 for TANF, Medicaid, and CHIP;

or

- (ii) WAC 388-424-0020 for federal food stamps.

(2) To receive benefits under the general assistance and ADATSA programs, a person must be a:

- (a) U.S. citizen;
- (b) U.S. national;
- (c) Qualified alien; or
- (d) A PRUCOL alien as defined in subsection (4) of this section.

(3) Qualified aliens are any of the following:

- (a) Lawful permanent residents under the Immigration and Nationality Act (INA);
- (b) Those granted asylum under section 208 of the INA;
- (c) Those paroled under section 212 (d)(5) of the INA for at least one year;

(d) Those admitted as refugees under section 207 of the INA;

(e) Aliens whose deportation (removal) is being withheld under section 241 (b)(3) or 243(h) of the INA;

(f) Those granted conditional entry under section 203 (a)(7) of the INA as in effect prior to April 1, 1980;

(g) Cuban and Haitian entrants as defined in section (501)(e) of the Refugee Education Assistance Act of 1980; or

(h) Amerasians admitted under section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as amended); or

(i) Aliens who are victims of domestic violence, or whose children are victims of domestic violence, when:

(i) The domestic violence was committed in the U.S. by the alien's spouse, parent, or a member of the spouse or parent's family residing in the same household as the alien;

(ii) The alien did not actively participate in the violence against his or her own children when the children are the victims of domestic violence;

(iii) The alien no longer resides with the person who committed the domestic violence;

(iv) There is a substantial connection between the domestic violence and the need for public assistance benefits; and

(v) The alien has an application with the Immigration and Naturalization Service (INS) either approved or pending for:

(A) Legal immigration status under section 204 (a)(1)(A) or section 204 (a)(1)(B) of the INA; or

(B) Cancellation of removal under section 244 (a)(3) of the INA as in effect prior to April 1, 1997 or section 240A (b)(2) of the INA.

(4) A PRUCOL alien must meet all of the following conditions:

(a) They are permanently residing in the U.S.;

(b) They do not meet a definition of a qualified alien as defined in subsection (3) of this section;

(c) The INS knows they are residing in the U.S.; and

(d) The INS is not likely to enforce their departure.

(5) During the application process, one of the following persons must indicate on the application for benefits whether each household member is a U.S. citizen or qualified alien:

(a) An adult applicant in the household; or

(b) The person applying for benefits when there are no adults in the household.

[Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-424-0005, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520, 388-518-1805 and 388-510-1020.]

WAC 388-424-0010 Alien status—Eligibility requirements for the temporary assistance for needy families program and medical benefits. (1) Qualified aliens as described in WAC 388-424-0005(3) who were residing in the U.S. before August 22, 1996 may receive temporary assistance for needy families (TANF), Medicaid, and CHIP benefits.

(2) Qualified aliens who first physically entered the U.S. after August 21, 1996 cannot receive TANF, Medicaid, or CHIP for five years after their date of entry, unless they are any of the following:

(a) An alien as described under WAC 388-424-0005 (3)(b), (d), (e), (g), or (h); or

(b) A lawful permanent resident who is:

(i) On active duty in the U.S. military, other than active duty for training;

(ii) An honorably discharged U.S. veteran;

(iii) A veteran of the military forces of the Philippines who served prior to July 1, 1946, as described in Title 38, section 107 of the U.S. code;

(iv) A Hmong or Highland Lao veteran who served in the military on behalf of the U.S. Government during the Vietnam conflict; or

(v) The spouse or unmarried dependent child(ren) of a person described in subsection (2)(f)(i) through (iv) of this section.

(3) Aliens who qualify for Medicaid benefits, but are determined ineligible because of alien status or requirements for a Social Security Number, may receive medical coverage as follows:

(a) State-funded categorically needy (CN) scope of care for:

(i) Pregnant women, as specified in WAC 388-462-0015;

(ii) Children as specified in WAC 388-505-0210;

(iii) Persons eligible for or receiving cash assistance under the state family assistance program (SFA); or

(iv) Aliens who were lawfully residing in the U.S. before August 22, 1996, including PRUCOL aliens as defined in WAC 388-424-0005(4).

(b) Alien emergency medical services as specified in WAC 388-438-0110.

(4) Alien status does not effect eligibility for the medicare indigent program described in WAC 388-438-0100.

[Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-424-0010, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520 and 388-518-1805.]

Chapter 388-426 WAC CLIENT COMPLAINTS

WAC
388-426-0005 Client complaints.

WAC 388-426-0005 Client complaints. (1) Clients who believe they have been discriminated against by the department for reason of race, color, creed, political affiliation, national origin, religion, age, gender, disability, or birthplace have the right to file a complaint. Clients can file discrimination complaints with the:

(a) DSHS, Division of Access and Equal Opportunity, PO Box 45012, Olympia, WA, 98504;

(b) Administrator, Food and Nutrition Services, 3101 Park Center Drive, Alexandria, VA, 22302; or

(c) Secretary of Agriculture, U.S. Department of Agriculture, Washington D.C., 20250.

(2) Clients with a complaint about a department decision or action have the right to present their complaint, in writing, to a supervisor.

(a) Within ten days of the receipt of the complaint:

(i) A decision will be made on the client's complaint; and

(ii) The client will be sent written notice of the decision, including information about the right to further review by the local office administrator.

(b) Clients not satisfied with the decision of a supervisor have the right to present a written complaint to the local office administrator. Within ten days of the receipt of the complaint:

(i) A decision will be made on the complaint, and

(ii) The client will be sent written notice of the decision.

(c) Written notice of the administrator's decision concludes the complaint procedure.

(d) The filing of a written complaint does not prevent a client from requesting a fair hearing under WAC 388-08-413.

(e) Clients have the right to speak to a worker's supervisor or have a decision or action reviewed by the supervisor, whether or not a formal complaint has been filed.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-426-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-426-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-434 WAC

ELIGIBILITY REVIEWS AND RECERTIFICATIONS

WAC
388-434-0005 The department reviews each client's eligibility for benefits on a regular basis.

WAC 388-434-0005 The department reviews each client's eligibility for benefits on a regular basis. (1) If you receive cash assistance, the department reviews your eligibility for assistance at least once every six months.

(2) When it is time for your eligibility review, the department requires you to complete a review form. We use the information you provide to determine your eligibility for all assistance programs.

(3) If you complete an interview for assistance with a department representative and sign the printed application for benefits (AFB) form, you do not have to complete a separate review form.

(4) For cash assistance, the eligibility review form or the AFB must be dated and signed by both husband and wife, or both parents of a child in common when the parents live together.

(5) If you receive medical assistance only, the eligibility review form or the AFB must be signed by at least one parent when the parents live together.

(6) We may move the date of your eligibility review if we decide your circumstances need to be reviewed sooner.

(7) At your review, we look at:

(a) All eligibility requirements under WAC 388-400-0005 through 388-400-0035, 388-503-0505 through 388-503-0515, and 388-505-0210 through 388-505-0220;

(b) Changes that happened since we last determined your eligibility; and

(c) Changes that are anticipated to happen during the next review period.

(8) If you receive medical assistance only, we set your eligibility review date in advance under WAC 388-416-0005 through 388-416-0035. We will start the review process before your benefits end.

(9) Clients are responsible for attending an interview if one is required under WAC 388-452-0005.

(10) If you do not complete the eligibility review for cash assistance, you are considered to be withdrawing your request for continuing assistance.

(a) Your cash assistance benefits will end.

(b) Your medical assistance will continue for twelve consecutive months from the last:

(i) Application;

(ii) Eligibility review; or

(iii) Food assistance application or recertification.

(11) We must send you written notice under WAC 388-458-0005, 388-458-0010, and 388-450-0015 before assistance can be suspended, terminated, or a benefit error is established as a result of your eligibility review.

(12) If you are currently receiving cash or medical assistance, and you are found to no longer be eligible for benefits, we will determine if you are eligible for other medical programs. Until we decide if you are eligible for other programs, your medical assistance will continue under WAC 388-418-0025 even if you request that your benefits end.

(13) When a client is determined to need necessary supplemental accommodation (NSA) under WAC 388-200-1300, we will help the client meet the requirements of this section.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 99-23-083, § 388-434-0005, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-434-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2230.]

Chapter 388-436 WAC EMERGENCY CASH ASSISTANCE

WAC

388-436-0001	Repealed.
388-436-0002	DSHS provides a cash benefit called additional requirements for emergent needs (AREN) to help families pay for short-term expenses caused by an emergency.
388-436-0005	Repealed.
388-436-0030	Eligibility for CEAP depends on other possible cash benefits.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-436-0001	Additional requirement for emergent needs (AREN). [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-436-0001, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-046, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055 and 74.08.090.
388-436-0005	AREN good cause. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-436-0005, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-046, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055 and 74.08.090.

WAC 388-436-0001 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-436-0002 DSHS provides a cash benefit called additional requirements for emergent needs (AREN) to help families pay for short-term expenses caused by an emergency. (1) Who can receive additional requirements for emergent needs (AREN) benefits?

A family may request AREN benefits if they have applied for or already get cash assistance from the temporary assistance for needy families (TANF), state family assistance (SFA) or refugee cash assistance (RCA) program. The family must meet the eligibility conditions for TANF, SFA or RCA to receive AREN benefits.

(2) Will AREN change the amount of our assistance?

When the department approves AREN benefits, the amount used to figure how much assistance the family can receive is increased for one month. This is called an 'increased payment standard.' The department uses the increased standard to:

(a) Determine initial eligibility and calculate the payment amount for families who are new applicants; or

(b) Calculate the monthly payment amount for families already receiving assistance.

(3) What kinds of things are considered AREN emergencies?

(a) The family experienced a disaster such as a theft, house fire, flood, severe weather, accident or medical emergency.

(b) The family has extra short-term expenses caused by homelessness, domestic violence, or situations that jeopardize the family's health and safety.

(c) The family's funds were used to pay for necessary expenses such as:

(i) Basic health and safety needs for shelter, food and clothing;

(ii) Medical care;

(iii) Dental care need to obtain employment or because of pain;

(iv) Emergency child care;

(v) Other reasonable and necessary expenses.

(d) The family's cash grant has been reduced or terminated in anticipation of income that will not be available to pay for the need when the payment is due.

(4) Do I need to provide proof that I have an emergency?

Families must show proof that there is a good reason they do not have sufficient funds to meet their short-term need. The proof must show:

(a) Why funds are insufficient to pay for the need; and

(b) The amount of money necessary to meet the need; and

(c) How the family will pay for the need in the future; and

(d) The expense is for a need listed in subsection (5) of this rule.

(5) What kind of expenses does the AREN benefit cover?

The department may approve AREN benefits to pay for the following kinds of expenses:

(a) Rent, security deposits, mortgage payments, taxes or fees:

(i) To prevent an eviction or foreclosure from causing the loss of housing that the family will be able to afford in the future.

(ii) To obtain housing subsidies or permanent housing the family will be able to afford in the future when:

(A) Eviction or foreclosure is not preventable.

(B) The family has no housing or has only temporary housing.

(C) The current housing puts the family's health or safety in danger due to a condition the property owner is unable or unwilling to fix.

(D) Moving is necessary to escape a domestic violence situation.

(b) Repairs, deposits, fees and services to assure the household has electricity, water, sewer or fuel for heating and cooking.

(c) Bedding, clothing, cooking utensils, and personal hygiene items when the family has lost these items due to a disaster, domestic violence, or homelessness.

(d) Food when the family has no other way to get food.

(e) Other goods and services necessary to protect the health and safety of the family.

(6) Are there any limits on the amount of AREN benefits I can get?

(a) When AREN benefits are approved, the department pays the least amount necessary to get the family through the emergency. Funds from other sources affect the amount of AREN the department pays. A representative from the department will work with your family to figure out the amount.

(b) There is no limit on how frequently a family may request or receive AREN benefits. The department makes the eligibility decision based on whether or not there is a reasonable cause for the emergent need and the lack of funds available to the family.

(7) How does the department pay the AREN benefit?

(a) The department pays the approved AREN benefit as part of the family's TANF, SFA or RCA cash grant using the income rules found in chapter 388-450 WAC.

(b) When possible, the department pays AREN benefits directly to a third party under the provisions in WAC 388-460-0001.

[Statutory Authority: RCW 74.04.050, 74.04.055, and 74.08.090. 99-14-046, § 388-436-0002, filed 6/30/99, effective 8/1/99.]

WAC 388-436-0005 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-436-0030 Eligibility for CEAP depends on other possible cash benefits. (1) Before the department approves CEAP benefits, we must determine that all household members are ineligible for benefits from any of the following programs:

- (a) Temporary assistance for needy families (TANF);
- (b) State family assistance (SFA);
- (c) Refugee cash assistance (RCA);
- (d) Diversion cash assistance (DCA).

(2) To receive CEAP, the applicant must take any required action to receive benefits from the following programs:

- (a) TANF, SFA, and RCA;
- (b) Supplemental security income (SSI);
- (c) Medical assistance for those applicants requesting help for a medical need;
- (d) Food assistance for those applicants requesting help for a food need;
- (e) Housing assistance from any available source for those applicants requesting help for a housing need;
- (f) Unemployment compensation, veteran's benefits, industrial insurance benefits, Social Security benefits, pension benefits, or any other source of financial benefits the applicant is potentially eligible to receive.

(3) The department may not authorize CEAP benefits to any household containing a member who is under a grant penalty for failure to comply with program requirements of TANF/SFA, RCA, or WorkFirst under chapter 388-310 WAC.

[Statutory Authority: RCW 74.04.660, 99-24-130, § 388-436-0030, filed 12/1/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0030, filed 7/31/98, effective 9/1/98.]

Chapter 388-438 WAC**EMERGENCY ASSISTANCE FOR MEDICAL NEEDS****WAC**

388-438-0110 The alien emergency medical (AEM) program.

WAC 388-438-0110 The alien emergency medical (AEM) program. (1) The alien emergency medical (AEM) program is a federally-funded program. It is for aliens who are ineligible for other Medicaid programs, due to citizenship or alien status requirements described in WAC 388-424-0005 and 388-424-0010.

(2) Except for the Social Security Number, citizenship, or alien status requirements, the alien must meet categorical Medicaid eligibility requirements as described in:

- (a) WAC 388-505-0110, for an SSI-related person;
- (b) WAC 388-505-0220, for family medical programs;
- (c) WAC 388-505-0210, for a child under the age of nineteen; or
- (d) WAC 388-523-0100, for medical extensions.

(3) When an alien has monthly income which exceeds the CN medical standards, the department will consider AEM medically needy coverage for children or for adults who meet SSI disability criteria. See WAC 388-519-0100.

(4) To qualify for the AEM program, the alien must have an emergency medical condition as described in WAC 388-500-0005.

(5) The alien's date of arrival in the United States is not used when determining eligibility for the AEM program.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, 42 C.F.R. 435.139 and 42 C.F.R. 440.255. 99-23-082, § 388-438-0110, filed 11/16/99, effective 12/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0110, filed 7/31/98, effective 9/1/98.]

Chapter 388-442 WAC**FELONS****WAC**

388-442-0010 Felons.

WAC 388-442-0010 Felons. (1) A person is not eligible for TANF/SFA, GA and/or food assistance if the person is:

- (a) Fleeing to avoid prosecution, custody, or confinement after conviction of a crime, or an attempt to commit a crime which is considered a felony in the place from which they were fleeing; or
- (b) Violating a condition of probation or parole as determined by an administrative body or court that has the authority to make this decision.

(2) A person is not eligible for TANF/SFA and/or food assistance if convicted of a felony committed after August 21, 1996 involving an element of possession, use, or distribution of an illegal drug, unless the person:

- (a) Was convicted only of possession or use of an illegal drug; and
- (b) Was not convicted of a felony for illegal drugs within three years of the latest conviction; and

(c) Was assessed as chemically dependent by a program certified by the division of alcohol and substance abuse (DASA); and

(d) Is taking part in or has completed a rehabilitation plan consisting of chemical dependency treatment and job services.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-442-0010, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-442-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-444 WAC

FOOD STAMP EMPLOYMENT AND TRAINING

WAC

388-444-0035	Clients who are exempt from ABAWD provisions.
388-444-0040	Work programs for ABAWDs in the food stamp employment and training program.
388-444-0045	Regaining eligibility for food assistance.
388-444-0075	Disqualifications for quitting a job without good cause.

WAC 388-444-0035 Clients who are exempt from ABAWD provisions. A client is exempt from the ABAWD rules provided in WAC 388-444-0030 when the client is:

- (1) Under eighteen or fifty years of age or older;
- (2) Physically or mentally unable to work;
- (3) A parent or other member of a household with responsibility for a dependent child under eighteen years of age or an incapacitated person;
- (4) A pregnant woman;
- (5) Living in an exempt area approved by U.S. Department of Agriculture; or
- (6) Otherwise exempt under food stamp employment and training as follows:
 - (a) Complying with the work requirements of an employment and training program under TANF;
 - (b) Applying for or receiving unemployment compensation;
 - (c) A student enrolled at least half time in any recognized school; or
 - (d) Participating in a chemical dependency treatment program; or
 - (e) Employed a minimum of thirty hours per week or receiving weekly earnings which equal the minimum hourly rate multiplied by thirty hours.
- (7) Eligible for one of the annual FNS-approved exemption slots under what is called the fifteen percent exemption rule.

[Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0035, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0040 Work programs for ABAWDs in the food stamp employment and training program. Work programs are available to clients eighteen to fifty years of age who are able to work and have no dependents.

- (1) The following are considered work programs:
 - (a) Workfare consists of:
 - (i) Thirty days of job search activities in the first month beginning with the first day of application, or sixteen hours of volunteer work with a public or private nonprofit agency; and
 - (ii) In subsequent months, sixteen hours per month of volunteer work with a public or private nonprofit agency allows the client to remain eligible for food stamps. Work-

fare is not enforced community service or for paying fines or debts due to legal problems.

(b) Work experience (WEX) is supervised, unpaid work for at least twenty hours a week. The work must be for a non-profit agency or governmental or tribal entity. This work is to improve the work skills of the client.

(c) On-the-job training (OJT) is paid employment for at least twenty hours a week. It is job training provided by an employer at the employer's place of business and may include some classroom training time.

(2) The department may not require more than thirty hours a week of Workfare and paid work combined.

(3) The department may pay for some of a client's actual expenses needed for the client to participate in work programs. Standards for paying expenses are set by the department.

[Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0040, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0045 Regaining eligibility for food assistance. (1) A client who is ineligible for food assistance because that client has exhausted the three-month limit in WAC 388-444-0030, can regain eligibility by:

- (a) Working eighty hours or more during a thirty-day period;
 - (b) Participating in and complying with a work program for eighty hours or more during a thirty-day period;
 - (c) Participating in and complying with the community service part of a Workfare program; or
 - (d) Meeting any of the work requirements in (a) through (c) of this subsection in the thirty days after an application for benefits has been filed.
- (2) A client who regains eligibility for food assistance under subsection (1) of this section is eligible from the date of application and as long as the requirements of WAC 388-444-0030 are met.

(3) If otherwise eligible, a client who regains eligibility under the provision of subsection (1) of this section, may receive an additional three consecutive months of food assistance when the client:

- (a) Loses employment; or
 - (b) Loses the opportunity to participate in a work program.
- (4) The provisions in subsection (3) of this section are allowed only once in the thirty-six month period.

[Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0045, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0075 Disqualifications for quitting a job without good cause. (1) If the client quits a job without good cause:

- (a) For applicants, the application is denied and the penalty in subsection (2) of this section is applied beginning with the day of quit; or

(b) For clients already receiving food stamps, the penalty in subsection (2) of this section begins the first of the month following the notice of adverse action.

(2) The client is disqualified for the following minimum periods of time and until the conditions in subsection (3) of this section are met:

- (a) For the first quit, one month;
- (b) For the second quit, three months; and
- (c) For the third or subsequent quit, six months.

(3) Eligibility may be established during a disqualification period, if the client is otherwise eligible and:

- (a) Secures new employment that has a salary or hours comparable to the job which was quit; or
- (b) Secures a comparable job at less hours or at a lower salary.

(4) The client may re-establish eligibility after the disqualification, if otherwise eligible by:

- (a) Getting a new job;
- (b) In nonexempt areas, participating in the FS E&T program;
- (c) Participating in Workfare as provided in WAC 388-444-0040;
- (d) Becoming exempt as provided in WAC 388-444-0015, 388-444-0020, or 388-444-0035;
- (e) Applying for or receiving unemployment compensation; or
- (f) Participating in WorkFirst.

(5) If a disqualified client moves from the assistance unit and joins another assistance unit, the client continues to be treated as an ineligible member of the new assistance unit for the remainder of the disqualification period.

[Statutory Authority: RCW 74.04.510, 99-07-024, § 388-444-0075, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-444-0075, filed 7/31/98, effective 9/1/98.]

Chapter 388-450 WAC INCOME

WAC

388-450-0005	Income—Ownership and availability.
388-450-0015	Excluded and disregarded income.
388-450-0025	Unearned income.
388-450-0030	Earned income definition.
388-450-0035	Educational benefits.
388-450-0045	Income from employment or training programs.
388-450-0050	How are your cash assistance and food assistance benefits determined when you are participating in the community jobs (CJ) program?
388-450-0060	Repealed.
388-450-0065	Gifts—Cash and noncash.
388-450-0080	Self-employment income—General rules.
388-450-0085	Self-employment income—Allowable expenses.
388-450-0100	Allocating income—Definitions.
388-450-0106	Allocating the income of a financially responsible person included in the assistance unit to household members excluded because of their alien status.
388-450-0116	Allocating the income of a financially responsible person excluded from the assistance unit because of their alien status.
388-450-0140	Income of ineligible assistance unit members—Food assistance.
388-450-0160	Sponsored alien—Food assistance.
388-450-0162	The department uses countable income to determine if you are eligible and the amount of your cash and food assistance benefits.
388-450-0180	Repealed.
388-450-0185	General information about earned income disregard and income deductions for food assistance programs.

388-450-0190	Shelter cost income deductions for food assistance.
388-450-0195	Utility allowances for food assistance programs.
388-450-0200	Medical expenses may be used as an income deduction for food assistance households containing an elderly or disabled household member.
388-450-0205	Repealed.
388-450-0215	How the department estimates income to determine your eligibility and benefits.
388-450-0220	Repealed.
388-450-0225	How the department calculates the benefit amount for the first month of eligibility for cash assistance.
388-450-0230	Treatment of income in the month of application for destitute food assistance households.
388-450-0235	Repealed.
388-450-0240	Repealed.
388-450-0245	When are my benefits suspended?
388-450-0250	Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-450-0060	Lump sum payments. [Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-450-0060, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0060, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0180	Effect of countable income on eligibility and benefit level for cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0180, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0205	Budgeting income deductions for food assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0205, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0220	Retrospective budgeting. [Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-450-0220, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0220, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0235	Discontinued income. [Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-450-0235, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0235, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0240	Effect of net lump sum payments for cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0240, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0250	Income of a new assistance unit member. [Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-450-0250, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0250, filed 7/31/98, effective 9/1/98.] Repealed by 00-01-012, filed 12/3/99, effective 1/1/00. Statutory Authority: RCW 74.04.510.

WAC 388-450-0005 Income—Ownership and availability. (1) For TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs:

(a) All available income owned or possessed by a client is considered when determining the client's eligibility and benefit level.

(b) Ownership of income is determined according to applicable state and federal laws pertaining to property own-

ership and eligibility for assistance programs. For married persons, ownership of separate and community income is determined according to chapter 26.16 RCW.

(c) Income owned by a client is considered available when it is at hand and may be used to meet the client's current need. The gross amount of available income is counted in the month it is received.

(i) If income is usually available on a specific day, it is considered available on that date.

(ii) If income is usually received monthly or semi-monthly and the pay date changes due to a reason beyond the client's control, such as a weekend or holiday, it is counted in the month it is intended to cover rather than the month it is actually received.

(iii) If income is usually received weekly or bi-weekly and the pay date changes due to a reason beyond the client's control, it is counted in the month it is received.

(d) The income of a person who is not a member of a client's assistance unit may be considered available to the client under the rules of this chapter if the person is financially responsible for the client and lives in the home with the client. For medical programs, financial responsibility is described in WAC 388-408-0055.

(e) For medical programs, the income of a financially responsible person, not living in the home is considered available to the extent it is contributed.

(f) Funds deposited into a bank account which is held jointly by a client and another are considered income possessed by and available to the client unless:

(i) The client can show that all or part of the funds belong exclusively to the other account holder and are held or used solely for the benefit of that holder; or

(ii) The funds have been considered by the Social Security Administration (SSA) when determining the other account holder's eligibility for SSI benefits.

(g) Potential income is income a client may have access to that can be used to reduce the need for assistance. For cash and medical programs, when the department determines that a potential income source exists, the client may be denied assistance when the client fails or refuses to make a reasonable effort to make the income available.

(i) A client's eligibility is not affected until the income is received as long as the client makes reasonable efforts to make potential income available; and

(ii) A client may choose whether to receive TANF/SFA or Supplemental Security Income (SSI) benefits.

(2) For TANF/SFA, RCA, GA and food assistance programs the income of an alien's sponsor is considered available to the alien under the rules of this chapter when determining the alien's eligibility and benefit level.

(3) For SSI-related medical:

(a) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the clients needs for food, clothing and shelter, except as provided in WAC 388-511-1130.

(b) Loans and certain other receipts are not defined as income for SSI-related medical purposes as described in 20 C.F.R. Sec. 416.1103.

(4) For medical programs, trusts are described in WAC 388-505-0595.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590 and 388-506-0610.]

WAC 388-450-0015 Excluded and disregarded income. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Excluded income is income that is not counted when determining a client's eligibility and benefit level. Types of excluded income include but are not limited to:

(a) Bona fide loans as defined in WAC 388-470-0025, except certain student loans as specified under WAC 388-450-0035.

(b) Federal earned income tax credit (EITC) payments;

(c) Title IV-E and state foster care maintenance payments if the foster child is not included in the assistance unit;

(d) Energy assistance payments;

(e) Educational assistance as specified in WAC 388-450-0035;

(f) Native American benefits and payments as specified in WAC 388-450-0040;

(g) Income from employment and training programs as specified in WAC 388-450-0045;

(h) Money withheld from a client's benefit to repay an overpayment from the same income source. For food assistance, this exclusion does not apply when the money is withheld to recover an intentional noncompliance overpayment from a federal, state, or local means tested program such as TANF/SFA, GA, and SSI; and

(i) Child support payments received by TANF/SFA recipients.

(2) For food assistance programs, the following income types are excluded:

(a) Emergency additional requirements authorized to TANF/SFA and RCA clients under WAC 388-436-0001 and paid directly to a third party;

(b) Cash donations based on need received directly by the household if the donations are:

(i) Made by one or more private, nonprofit, charitable organizations; and

(ii) Do not exceed three hundred dollars in any federal fiscal year quarter.

(c) Infrequent or irregular income, received during a three-month period by a prospectively budgeted assistance unit, that:

(i) Cannot be reasonably anticipated as available; and

(ii) Does not exceed thirty dollars for all household members.

(3) All income that is not excluded is considered to be part of an assistance unit's gross income.

(4) For food assistance households not containing an elderly or disabled member, the assistance unit is ineligible if its gross income exceeds one hundred thirty percent of the federal poverty level as specified in WAC 388-478-0060.

(5) Disregarded income is income that is counted when determining an assistance unit's gross income but is not used when determining an assistance unit's countable income. Types of disregarded income include but are not limited to:

(a) Earned income incentives and disregards for cash assistance; and

(b) Earned income disregard and income deductions for food assistance.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-450-0015, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

WAC 388-450-0025 Unearned income. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Unearned income is income a person receives from a source other than employment or self-employment. Examples of unearned income include but are not limited to:

- (a) Railroad Retirement;
- (b) Unemployment Compensation; or
- (c) Veteran Administration benefits.

(2) For food assistance programs, unearned income includes the amount of cash benefits due the client prior to any reductions caused by the client's failure to perform an action required under a federal, state, or local means-tested public assistance program.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-450-0025, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0030 Earned income definition. Unless specifically stated, this section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Earned income is:

(a) Income a person receives in the form of cash or in-kind, which is a gain or benefit to the person, when earned as a wage, salary, tips, gratuities, commissions, or profit from self-employment activities.

(b) Income over a period of time for which settlement is made at one time, such as sale of farm crops, livestock, or poultry.

(2) For food assistance programs only, income in-kind is excluded.

(3) Earned income from self-employment is determined as specified under WAC 388-450-0080.

(4) For TANF/SFA, RCA, GA-H, and TANF/SFA-related medical assistance, earned income includes time-loss compensation as specified in WAC 388-450-0075.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-450-0030, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0035 Educational benefits. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs. Unless otherwise stated, exclusions and disregards of educational benefits apply to clients engaged in undergraduate studies only.

(1) We exclude the educational assistance in the form of grants, loans or work study, issued from Title IV of the Higher Education Amendments (Title IV - HEA) and Bureau of Indian Affairs (BIA) education assistance programs.

Examples of Title IV - HEA and BIA educational assistance include but are not limited to:

- (a) College work study (federal and state);
- (b) Pell grants; and
- (c) BIA higher education grants.

(2) We do not count the following types of educational assistance, in the form of grants, loans, or work study when determining a student's need:

(a) Assistance under the Carl D. Perkins Vocational and Applied Technology Education Act, P.L. 101-391 for attendance costs identified by the institution as specified in subsections (3) and (4) of this section; and

(b) Educational assistance made available under any program administered by the Department of Education (DOE) to an undergraduate student. Examples of programs administered by DOE include but are not limited to:

- (i) Christa McAuliffe Fellowship Program;
- (ii) Jacob K. Javits Fellowship Program; and
- (iii) Library Career Training Program.

(3) Educational assistance under subsection (2)(a) of this section is disregarded when used for the following attendance costs when a student is attending school less than half-time:

- (a) Tuition;
- (b) Fees; and

(c) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study.

(4) Educational assistance under subsection (2)(a) of this section that is used for the following expenses is disregarded in addition to the costs specified in subsection (3) of this section when the student is attending school at least half-time:

- (a) Books;
- (b) Supplies;
- (c) Transportation;
- (d) Dependent care; and
- (e) Miscellaneous personal expenses.

(5) For TANF/SFA, RCA, GA, and TANF/SFA-related medical assistance, the amount of a student's remaining educational assistance equal to the difference between the student's appropriate need standard and payment standard is excluded.

(6) Any remaining income is unearned income and budgeted using the appropriate budgeting method for the assistance unit.

(7) When a student participates in a work study program that is not excluded by subsections (1) and (2) of this section, the income received is treated as earned income:

- (a) Applying the applicable earned income disregards;
- (b) For TANF/SFA, RCA, GA, and TANF/SFA-related medical assistance, excluding the difference between the student's appropriate need standard and payment standard; and
- (c) Budgeting remaining income using the appropriate budgeting method for the assistance unit.

(8) Budgeting remaining income using the appropriate budgeting method for the assistance unit.

(8) When a student receives Veteran's Administration Educational Assistance:

- (a) All applicable attendance costs are subtracted; and
- (b) The remaining unearned income is budgeted using the appropriate budgeting method for the assistance unit.

(9) When a student participates in graduate school studies, educational assistance made available to the student is counted as:

- (a) Assistance from another agency for cash and medical assistance;
- (b) Earned income for food assistance if there are work requirements; or
- (c) Unearned income for food assistance if there are no work requirements.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0045 Income from employment or training programs. This section applies to TANF/SFA, RCA, GA, and food assistance programs.

(1) Payments issued under the Job Training Partnership Act (JTPA) are considered as follows:

- (a) Wages paid under JTPA including wages for on-the-job training are counted as earned income.
- (b) For TANF/SFA, RCA, and GA assistance, needs based payments issued under JTPA including payments for on-the-job training are considered as follows:
 - (i) Payments which cover special needs not covered in the need standard are excluded.
 - (ii) Payments which duplicate items contained in the need standard are excluded up to the difference between the student's appropriate need standard and payment standard.

(c) For food assistance:

- (i) Living allowances and incentive payments under JTPA are excluded as income; and
- (ii) Earnings received from on-the-job training programs under JTPA are:
 - (A) Counted as earned income for persons:
 - (I) Age nineteen and older; or
 - (II) Age eighteen or younger and not under parental control.

(B) Excluded income for persons eighteen years of age or younger and under parental control.

(2) Payments issued under the National and Community Service Trust Act of 1993 (AmeriCorps) are considered as follows:

- (a) For cash assistance, living allowances or stipends paid under AmeriCorps are counted as earned income.
- (b) For food assistance, living allowances or stipends paid under AmeriCorps are excluded income.
- (3) AmeriCorps/VISTA stipends and living allowances paid to VISTA volunteers under the Domestic Volunteer Act of 1973:

(a) For TANF/SFA, RCA, and GA assistance, are disregarded as income; and

(b) For food assistance, are counted as earned income. The payments are disregarded if the client received:

- (i) Food assistance or cash assistance at the time they joined the Title I program; or
- (ii) An income disregard for the Title I program at the time of conversion to the Food Stamp Act of 1977. Disregard of Title I program income will continue through temporary interruptions in food assistance participation.

(4) For TANF/SFA, RCA, and GA assistance, needs based payments issued under AmeriCorps are considered the same way as JTPA payments as provided in subsection (1)(b) of this section.

(5) For food assistance, training allowances from vocational and rehabilitative programs are counted as earned income when:

- (a) Recognized by federal, state, or local governments; and
- (b) Not a reimbursement.
- (6) For training allowances received by GA-U clients:
 - (a) The earned income incentive and work expense deduction specified under WAC 388-450-0175 is applied when applicable; and

(b) For clients enrolled in a remedial education or vocational training course, the actual cost of uniforms or special clothing required for the course is deducted from the training allowance.

(7) Support service payments received by or made on behalf of WorkFirst participants are not considered income.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0045, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0050 How are your cash assistance and food assistance benefits determined when you are participating in the community jobs (CJ) program?

(1) The department estimates your total monthly income from your community jobs (CJ) position based on the number of hours you, your case manager and the CJ contractor expect you to work for the month multiplied by the federal or state minimum wage, whichever is higher.

(2) Once the department determines what your total monthly income is expected to be the department will not redetermine your cash benefit amount even if you do not work the number of hours you were expected to work.

(3) The department considers the total income it expects you to get each month from your CJ position as:

(a) Earned income for determining your cash assistance benefits.

(b) Unearned income for determining your food assistance benefits.

(4) When determining your benefits the department will use:

(a) One-half of your CJ income for figuring cash assistance benefits for the second and following months of your CJ participation. The department will not use any of the CJ income you receive in your first month of CJ participation to determine your cash assistance benefit amount for that month.

(b) All of your CJ income for figuring food assistance benefits.

(5) Monthly reports are not required for CJ participants.

(6) If your anticipated CJ income is more than your grant amount:

(a) Your cash grant will be suspended, see WAC 388-450-0245(1). The grant suspension can be up to a maximum of nine months; and

(b) Each month your cash grant is suspended will count toward your assistance unit's sixty month lifetime time limit, see WAC 388-484-0005.

(7) You, your case manager and the CJ contractor will review your CJ position every ninety days during your nine-month placement. During this review they will look at:

(a) Your continued TANF/SFA eligibility; and

(b) Any earned or unearned income received by you or another member of your assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-09-054, § 388-450-0050, filed 4/19/99, effective 6/1/99; 98-16-044, § 388-450-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0060 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-450-0065 Gifts—Cash and noncash. A gift is an item furnished to a client without work or cost on his or her part.

(1) A cash gift is a gift that is furnished as money, cash, checks or any other readily negotiable form.

(a) For TANF/SFA, RCA, GA-S, GA-H, and TANF/SFA-related medical programs, cash gifts totaling no more than thirty dollars per calendar quarter for each assistance unit member are disregarded as income.

(b) For GA-U, cash gifts are treated as unearned income.

(c) For food assistance programs:

(i) Cash gifts to the assistance unit are excluded if they total thirty dollars or less per quarter;

(ii) Cash gifts in excess of thirty dollars per quarter are counted in full as unearned income.

(2) For TANF/SFA, RCA, GA-S, GA-H, GA-U and TANF/SFA-related medical programs, a noncash gift is treated as a resource.

(a) If the gift is a countable resource, its value is added to the value of the client's existing countable resources and the client's eligibility is redetermined as specified in chapter 388-470 WAC.

(b) If the gift is an excluded or noncountable resource, it does not affect the client's eligibility or benefit level.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0065, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0065, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0080 Self-employment income—General rules. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Self-employment earned income is used to reduce a client's need for assistance. The income is treated as earned income as provided in WAC 388-450-0030.

(2) Self-employment earned income is defined as gross business income minus total allowable business expenses as defined in WAC 388-450-0085.

(3) In order to establish eligibility for assistance, a self-employed client must maintain and make available to the department a record clearly documenting all business expenses and income.

(4) Income from the following is treated as self-employment income:

(a) Adult family home;

(b) Farming;

(c) Roomers and boarders;

(d) Rental and lease of personal property or real estate owned by the client is counted as unearned income unless the following conditions are met:

(i) For TANF/SFA clients, the use of the property is part of an approved individual responsibility plan;

(ii) For food assistance clients, the client spends at least twenty hours per week managing the property; or

(iii) For RCA or GA clients, there are no specific requirements of a self-sufficiency plan or a set number of hours managing the property.

(e) Self-produced or supplied items.

(5) For food assistance, when two or more assistance units share a residence, the money paid from one assistance unit to the other assistance unit for shelter costs is roomer income when:

(a) One assistance unit owns or is buying the residence; or

(b) One assistance unit is renting a residence and charges the other assistance unit an amount that is in excess of the total cost of renting the residence.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0080, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0080, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0085 Self-employment income—Allowable expenses. The following self-employment expenses are allowed as deductions from gross self-employment income for TANF/SFA, RCA, GA, medical and food assistance programs unless otherwise specified:

(1) Rent or lease of business equipment or property;

(2) Utilities;

(3) Postage;

(4) Telephone;

(5) Office supplies;

(6) Advertising;

(7) Business related insurance, taxes, licenses and permits;

(8) Legal, accounting, and other professional fees;

(9) For TANF/SFA, RCA, and GA assistance programs only, the cost of goods sold, including wages paid to employees producing salable goods, raw materials, stock, and replacement or reasonable accumulation of inventory, provided inventory has been declared exempt on the basis of the individual responsibility plan or other plan approved by the department;

(10) Repairs to business equipment and property, excluding vehicles;

(11) Interest on business loans used to purchase income-producing property or equipment;

(12) Gross wages and salaries paid to employees who are not:

(a) Producing salable goods; or

(b) A member of the assistance unit

(13) Commissions paid to agents and independent contractors;

(14) Seed, fertilizer, and feed grain for a self-employed farmer;

(15) Other reasonable and necessary costs of doing business;

(16) The cost of the place of business:

(a) For TANF/SFA, RCA, GA, and medical assistance, if any portion of the client's home is used as the place of business, it must be used exclusively for business to be an allowable business expense. The percentage of the home used for business can be an allowable business expense;

(b) For food assistance, there is no requirement for a portion of the home to be used exclusively for business. The percentage of the home used for business can be an allowable business expense

(17) The following transportation expenses are allowed as a deduction from gross self-employment income:

(a) Actual, documented costs for:

(i) Gas, oil, and fluids;

(ii) Replacing worn items such as tires;

(iii) Registration and licensing fees;

(iv) Auto loan interest; and

(v) Business related parking and tolls; or

(b) A cost per mile established by the department.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0085, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0085, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0100 Allocating income—Definitions.

The following definitions apply to the allocation rules for TANF/SFA, RCA, and GA programs:

(1) "**Dependent**" means a person who:

(a) Is or could be claimed for federal income tax purposes by the financially responsible person; or

(b) The financially responsible person is legally obligated to support.

(2) "**Financially responsible person**" means a parent, stepparent, adoptive parent, spouse or caretaker relative.

(3) A "**disqualified assistance unit member**" means a person who is:

(a) An unmarried pregnant or parenting minor under age eighteen who has not completed a high school education or general education development (GED) certification and is not participating in those educational activities which would lead to the attainment of a high school diploma or GED;

(b) An unmarried pregnant or parenting minor under age eighteen who is not living in a department-approved living situation;

(c) The financially responsible person who does not report to the department within five days of the date it becomes reasonably clear that the absence of a child will exceed ninety days;

(d) A person who has been convicted in federal or state court of having made a fraudulent statement or representation about their place of residence in order to receive assistance from two or more states at the same time as defined in WAC 388-446-0010; and

(e) A person who has been convicted of unlawfully receiving public assistance as defined under WAC 388-446-0005.

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(4) "**Ineligible assistance unit member**" means an individual who is:

(a) Ineligible for cash assistance due to citizenship/alien status requirement in WAC 388-424-0005;

(b) Ineligible to receive assistance under WAC 388-442-0010 for having been convicted after August 21, 1996, under federal or state law, of possession, use or distribution of a controlled substance;

(c) Ineligible to receive assistance under WAC 388-442-0010 for fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime;

(d) Ineligible to receive assistance under WAC 388-442-0010 for violating a condition of probation or parole which was imposed under a federal or state law as determined by an administrative body or court of competent jurisdiction;

(e) The spouse of a woman who receives cash benefits from the GA-S program; or

(f) The adult parent of a minor parent's child.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0100, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0100, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0106 Allocating the income of a financially responsible person included in the assistance unit to household members excluded because of their alien status. This section applies to TANF/SFA, RCA, RMA and TANF/SFA-related medical programs.

When a financially responsible person, as defined in WAC 388-450-0100(3), is included in the assistance unit, that person's income is allocated to household members who are excluded from the assistance unit because of their alien status, as defined in WAC 388-450-0100 (4)(a), after allowing the following deductions:

(1) The fifty percent earned income incentive for TANF/SFA assistance units or the ninety dollar work expense deduction for RCA assistance units, if the income is earned;

(2) An amount equal to the difference between the payment standards:

(a) That would include the eligible assistance unit members and those individuals excluded from the assistance unit because of their alien status; and

(b) Only the eligible assistance unit members.

(3) The payment standard amount equal to the number of ineligible persons, as defined in WAC 388-450-0100 (4)(b) through (f);

(4) An amount not to exceed the need standard, as defined in WAC 388-478-0015, for court or administratively ordered current or back support paid for legal dependents; and

(5) The employment related child care expenses for which the household is liable.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0106, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.005 and 74.08.090. 98-24-037, § 388-450-0106, filed 11/24/98, effective 12/25/98.]

WAC 388-450-0116 Allocating the income of a financially responsible person excluded from the assistance unit because of their alien status. This section applies to TANF/SFA and RCA programs.

When a financially responsible person, as defined in WAC 388-450-0100(3), is excluded from the assistance unit because of their alien status, as defined in WAC 388-450-0100 (4)(a), that person's income, after allowing the following deductions, is countable income available to the assistance unit:

(1) The fifty percent earned income incentive for TANF/SFA assistance units or the ninety dollar work expense deduction for RCA assistance units, if the income is earned;

(2) An amount equal to the difference between the payment standards:

(a) That would include the eligible assistance unit members and those individuals excluded from the assistance unit because of their alien status; and

(b) Only the eligible assistance unit members.

(3) The payment standard amount equal to the number of ineligible persons, as defined in WAC 388-450-0100 (4)(b) through (f);

(4) An amount not to exceed the need standard, as defined in WAC 388-478-0015, for court or administratively ordered current or back support paid for legal dependents; and

(5) The employment related child care expenses for which the household is liable.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0116, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.005 and 74.08.090. 98-24-037, § 388-450-0116, filed 11/24/98, effective 12/25/98.]

WAC 388-450-0140 Income of ineligible assistance unit members—Food assistance. (1) When a food assistance household contains a person who is disqualified for intentional program violation or failure to meet work requirements as provided in chapter 388-444 WAC, all income of the disqualified person is included as part of the entire household's income:

(a) The standard deduction and allowable deductions for earned income, medical costs, dependent care, and excess shelter costs are applied; and

(b) The household's benefits are not increased as a result of the exclusion of the disqualified person.

(2) When a household contains a person who is ineligible due to alien status, felon status as described in WAC 388-442-0010, failure to sign the application attesting to citizenship or alien status, or who has been disqualified for refusal to obtain or provide a Social Security number:

(a) The income of the ineligible person is prorated among all household members. The ineligible person's share is excluded, and the remainder is counted as income to the eligible household members;

(b) Apply the twenty percent earned income disregard to the ineligible person's earned income attributed to the household; and

(c) Divide the portion of the household's allowable shelter expenses evenly among all members of the household, when the ineligible members have income.

(3) The ineligible or disqualified household member is not counted when determining the household's size for purposes of:

(a) Comparing the household's total monthly income to the income eligibility standards; and

(b) Computing benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0140, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0140, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0160 Sponsored alien—Food assistance. For food assistance, this section applies to aliens for whom a sponsor has signed an affidavit of support or similar statement on or after February 1, 1983:

(1) For the purpose of this rule, income of the sponsor means:

(a) Income of the sponsor; and

(b) Income of the sponsor's spouse when the spouse lives with the sponsor.

(2) Portions of the income of a sponsor is counted as unearned income and applied to the food assistance benefits of a sponsored alien. The income of an alien's sponsor is available for three years following the alien's admission for permanent residence to the U.S.

(3) The income of the alien's sponsor must be verified by the client at application or recertification for food assistance.

(4) The available income is computed as follows:

(a) Total monthly earned and unearned income of the sponsor:

(i) Minus twenty percent of the gross earned income; and

(ii) Minus the amount of the gross income eligibility standard for a household size equal to the sponsor, the sponsor's spouse, and all dependents.

(b) Plus any actual money paid to the alien by the sponsor or sponsor's spouse in excess of the amount computed in subsection (4)(a) of this section is treated as unearned income.

(5) The net income in subsection (4) of this section is available to a sponsored alien who:

(a) Applies for and receives food assistance; or

(b) Is recertified for food assistance.

(6) If the sponsored alien can show the sponsor is also sponsoring other aliens, the available income is divided by the number of sponsored aliens applying for, or receiving food assistance.

(7) If an alien changes sponsors during the certification period, available income is reviewed based on the required information about the new sponsor as soon as possible after the information is supplied and verified by the client.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0160, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0160, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0162 The department uses countable income to determine if you are eligible and the amount of

your cash and food assistance benefits. The department uses countable income to determine if the client is eligible and the amount of the cash and food assistance benefits.

(1) Countable income is all income that remains after we subtract the following:

(a) Excluded or disregarded income under WAC 388-450-0015;

(b) Deductions or earned income incentives under WAC 388-450-0170 through 388-450-0200;

(c) Allocations to someone outside of the assistance unit under WAC 388-450-0095 through 388-450-0160.

(2) Countable income includes all income that must be deemed or allocated from financially responsible persons who are not members of your assistance unit.

(3) For cash assistance:

(a) We compare your countable income to the payment standard in WAC 388-478-0020 and 388-478-0030.

(b) You are not eligible for benefits when your assistance unit's countable income is equal to or greater than the payment standard plus any authorized additional requirements.

(c) Your benefit level is the payment standard and authorized additional requirements minus your assistance unit's countable income.

(4) For food assistance:

(a) We compare your countable income to the monthly net income standard specified in WAC 388-478-0060.

(b) You are not eligible for benefits when your assistance unit's income is equal to or greater than the monthly net income standard.

(c) Your benefit level is the maximum allotment in WAC 388-478-0060 minus thirty percent of your countable income.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0162, filed 11/19/99, effective 1/1/00.]

WAC 388-450-0180 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-450-0185 General information about earned income disregard and income deductions for food assistance programs. The following amounts are deducted from a household's income to compute food assistance program benefits:

(1) One hundred thirty-four dollars per household per month (standard deduction);

(2) Twenty percent of the household's gross earned income (earned income disregard);

(3) The amount of the household's incurred or expected monthly dependent care expense:

(a) The care must be needed for an assistance unit member to seek, accept or continue employment; or

(b) The care must be needed for an assistance unit member to attend training or education in preparation for to employment;

(c) The expense must be payable to someone outside of the food assistance household; and

(d) The deduction cannot exceed:

(i) Two hundred dollars for each dependent under two years of age; or

(ii) One hundred seventy-five dollars for each dependent age two or older.

(4) Nonreimbursable monthly medical expenses over thirty-five dollars incurred or expected to be incurred by an elderly or disabled household member as specified under WAC 388-450-0200.

(5) Legally obligated child support paid for a person who is not a member of the household.

(6) Shelter costs as provided in WAC 388-450-0190.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0185, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0185, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0190 Shelter cost income deductions for food assistance. (1) Shelter costs include:

(a) Rent, lease payments and mortgage payments; and

(b) Utility costs.

(2) Shelter costs are deducted from gross income if the costs are in excess of fifty percent of the assistance unit's income after deducting the standard, earned income, medical, child support, and dependent care deductions:

(a) For an assistance unit containing an elderly or disabled member the entire amount of excess shelter costs is deducted;

(b) For all other assistance units the excess shelter cost deduction cannot exceed two hundred seventy-five dollars.

(3) Shelter costs may include:

(a) Costs for a home not occupied because of employment, training away from the home, illness, or abandonment caused by casualty loss or natural disaster if the:

(i) Assistance unit intends to return to the home;

(ii) Current occupants, if any, are not claiming shelter costs for food assistance purposes; and

(iii) The home is not being leased or rented during the assistance unit's absence.

(b) Charges for the repair of the home which was substantially damaged or destroyed due to a natural disaster.

(c) The standard utility allowance as provided in WAC 388-450-0195.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0190, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0190, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0195 Utility allowances for food assistance programs. You can use the amounts in the chart below to calculate total shelter costs. Total shelter costs are used in calculating your food assistance benefits.

If you have to pay:	Then, you can use the:
Separate heating or cooling costs	Standard utility allowance [(SUA)] [(SEA)] of \$220
Separate utility costs, but no heating or cooling costs	Limited utility allowance [(LUA)] [(L.A.)] of \$160
Separate costs for phone service only	Telephone utility allowance [(TUA)] [(TA)] of \$29

[Statutory Authority: RCW 74.040.510 [74.04.510]. 99-24-052, § 388-450-0195, filed 11/29/99, effective 12/1/99. Statutory Authority: RCW 74.04.510. 99-09-055, § 388-450-0195, filed 4/19/99, effective 5/20/99. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (d)(6). 99-01-069, §

388-450-0195, filed 12/14/98, effective 1/14/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0195, filed 7/31/98, effective 9/1/98.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-450-0200 Medical expenses may be used as an income deduction for food assistance households containing an elderly or disabled household member. (1) Food assistance households can use medical expenses in excess of thirty-five dollars monthly as an income deduction for members that are:

- (a) Age sixty or older; or
- (b) Disabled as defined in WAC 388-400-0040.
- (2) The department allows deductions for expenses to cover services, supplies, or medication prescribed by a state licensed practitioner or other state certified, qualified, health professional, such as:

- (a) Medical, psychiatric, naturopathic physician, dental, or chiropractic care;
- (b) Prescription drugs;
- (c) Over the counter drugs;
- (d) Eye glasses;
- (e) Medical supplies other than special diets;
- (f) Medical equipment.
- (g) Hospital and outpatient treatment including:
 - (i) Nursing care; or
 - (ii) Nursing home care including payments made for a person who was an assistance unit member at the time of placement.

- (h) Health insurance premiums paid by the client including:

- (i) Medicare premiums or cost sharing; and
- (ii) Insurance deductibles and co-payments.

- (i) Spenddown expenses as defined in WAC 388-519-0010. Spenddown expenses are allowed as a deduction as they are estimated to occur or as the expense become due;

- (j) Dentures, hearing aids, and prosthetics;

- (k) Cost of obtaining and caring for a seeing eye or hearing animal, including food and veterinarian bills. We do not allow the expense of guide dog food as a deduction if you receive Ongoing Additional Requirements under WAC 388-255-1050 to pay for this need;

- (l) Reasonable costs of transportation and lodging to obtain medical treatment or services;

- (m) Attendant care necessary due to age, infirmity, or illness. If your household provides most of the attendant's meals, we allow an additional deduction equal to a one-person allotment.

- (3) There are two types of deductions:

- (a) One-time expenses are expenses that cannot be estimated to occur on a regular basis. You can choose to have us:

- (i) Allow the one-time expense as a deduction when it is billed or due; or

- (ii) Average the expense through your certification period.

- (b) Recurring expenses are expenses that happen on a regular basis. We estimate your monthly expenses for the certification period.

(4) We do not allow a medical deduction if:

- (a) The expense has already been paid;

- (b) The expense is repaid by someone else;

- (c) The expense is paid or will be paid by another agency;

- (d) The expense is covered by medical insurance;

- (e) You claim the expense later than the first billing, even if:

- (i) You did not claim the expense the first time it was billed;

- (ii) The expense is included in the current billing; and

- (iii) You paid the bill.

- (f) We previously allowed the expense, and you did not pay it. We do not allow the expense again even if it is part of a repayment agreement;

- (g) You included the expense in a repayment agreement after failing to meet a previous agreement for the same expense;

- (h) You claim the expense after you have been denied for presumptive SSI; and you are not considered disabled by any other criteria; or

- (i) The provider considers the expense overdue.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-450-0200, filed 11/16/99, effective 1/1/00; 99-16-024, § 388-450-0200, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0200, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0205 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-450-0215 How the department estimates income to determine your eligibility and benefits. The department uses prospective budgeting to determine eligibility and benefits.

(1) The department determines the amount of benefits an assistance unit can receive each month based on an estimate of your income and circumstances for that month. This is known as prospective budgeting.

(2) We base this estimate on what can be reasonably expected based on your current, past and future circumstances.

(3) We determine if our estimate is reasonable by looking at documents, statements, and other verification.

(4) There are two methods of estimating a client's income:

- (a) Anticipating monthly income: We estimate the actual amount of income you expect to receive in the month; and

- (b) Averaging income: We estimate your income based on adding the total income you expect to receive for a period of time and dividing by the number of months in the time period.

(5) We must use the anticipating monthly method in the following circumstances:

- (a) If you are a destitute migrant or destitute seasonal farmworker as defined in WAC 388-406-0021;

- (b) If you are receiving SSI, Social Security, or SSI-related medical benefits;

- (c) If you have income allocated to someone receiving SSI-related medical benefits under WAC 388-450-0150; or

(d) If you have already received income in the month that you apply for benefits.

(6) When using the anticipating monthly method, we estimate the actual amount of income you expect to receive in the month. Your benefits will vary based on the income that is expected for that month.

(7) When using the averaging method, the expected changes in your income are taken into consideration so your benefits do not change as much:

(a) Clients that receive their income weekly or every other week will have their income converted to a monthly amount. If you are paid:

(i) Weekly, we multiply your expected pay by 4.3; or

(ii) Every other week, we multiply your expected pay by 2.15.

(b) Clients that receive their income other than weekly or every other week will have their monthly income estimated by:

(i) Adding the total amount of income expected to be received for the period of time; and

(ii) Dividing by the number of months in the period of time.

(8) We will not make you repay an overpayment or increase your benefits if your actual income is different than your estimated income unless:

(a) The information you provided was incomplete or false; or

(b) We made an error in calculating your benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-450-0215, filed 11/16/99, effective 1/1/00; 99-16-024, § 388-450-0215, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0215, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

WAC 388-450-0220 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-450-0225 How the department calculates the benefit amount for the first month of eligibility for cash assistance. (1) To determine the client's benefit amount for the first month of eligibility for cash assistance, the department compares the countable income to the payment standard as described in WAC 388-450-0162.

(2) Even if your countable income exceeds the payment standard, you can still receive additional requirements.

(3) When your countable income is less than the payment standard, we prorate your grant amount based on the date you are eligible.

(4) We do not prorate the approved additional requirements.

(5) We prorate your grant by:

(a) Dividing the grant amount by the number of days in the first month of eligibility; and

(b) Multiplying the figure in (5)(a) of this section by the number of days from the date of eligibility to the last day of the month.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0225, filed 11/19/99, effective 1/1/00; 99-16-024, § 388-450-0225, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0225, filed 7/31/98, effective 9/1/98.]

[2000 WAC Supp—page 1692]

WAC 388-450-0230 Treatment of income in the month of application for destitute food assistance households. (1) When a migrant or seasonal farm worker is determined destitute under WAC 388-406-0021, eligibility and benefit amount for the month of application is determined by:

(a) Counting the household's income that is received from the first of the month through the date of application; and

(b) Excluding income from a new source that the household expects to receive during the ten days after the date of application.

(2) A household member changing jobs but continuing to work for the same employer is considered to be receiving income from the same source.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0230, filed 11/19/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0230, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0235 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-450-0240 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-450-0245 When are my benefits suspended? (1) In the TANF/SFA, RCA, GA and food assistance programs, the word "suspend" means that the department stops your benefits for one month.

(2) We suspend your benefits for one month when your expected countable income as defined in WAC 388-450-0162:

(a) Exceeds the dollar limits for your household size; and

(b) Exceeds those limits for only that one month.

(3) We end your benefits when your expected countable income exceeds the limits for your household size for two or more consecutive months.

(4) If your expected income drops below the limits for your household size, you may be eligible if you reapply for benefits.

[Statutory Authority: RCW 74.04.510. 00-01-012, § 388-450-0245, filed 12/3/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0245, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0250 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-452 WAC

INTERVIEW REQUIREMENTS

WAC

388-452-0005 Interview requirements.

WAC 388-452-0005 Interview requirements. (1) When the client's application or review is for a combination of cash, food, or medical programs the department requires only a single interview.

(2) The client has an interview when they apply for or have an eligibility review for cash, food, or medical benefits.

However, the client is not required to attend an interview when the client's application or review is only for medical benefits. When the client's application for cash or food stamp eligibility is denied because the client did not appear for an interview, the department must continue to process the request for medical benefits:

- (a) For a pregnant woman;
- (b) For a child under the age of nineteen;
- (c) For a family with children under the age of nineteen;

or

(d) When the department has enough information to determine eligibility or can obtain the information by mail.

(3) The client or another person who can provide information about the assistance unit must attend the interview. The client may bring another person to the interview. The client may choose another person to attend the interview for them when:

(a) The client cannot come to the local office for a cash or medical program eligibility determination; or

(b) The client has an authorized representative as described in WAC 388-462-0005 for food assistance.

(4) The department usually holds the interview at the local office. The client may have a scheduled home visit or a telephone interview if attending an interview at the local office causes a hardship for the client or the client's representative.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 42 C.F.R. 435.907, 99-11-075, § 388-452-0005, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-452-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0420.]

Chapter 388-455 WAC LUMP SUM INCOME

WAC

388-455-0005	How lump sum payments affect benefits.
388-455-0010	How the department treats lump sum payments as a resource for cash assistance and TANF/SFA-related medical assistance.
388-455-0015	How the department treats lump sum payments as income for cash assistance and TANF/SFA-related medical assistance.

WAC 388-455-0005 How lump sum payments affect benefits. (1) For the purpose of determining benefits for cash assistance, temporary assistance for needy families (TANF)/state family assistance (SFA)-related medical assistance, and food assistance, a lump sum payment is money that the client receives but does not expect to receive on a continuing basis.

(2) For cash assistance and TANF/SFA-related medical assistance:

(a) The department counts payments awarded for wrongful death, personal injury, damage, or loss of property as resources as described in WAC 388-455-0010.

(b) We count all other lump sum payments as income as described in WAC 388-455-0015.

(3) For food assistance, all lump sum payments are counted as resources as described in WAC 388-470-0055.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 99-24-008, § 388-455-0005, filed 11/19/99, effective 1/1/00.]

WAC 388-455-0010 How the department treats lump sum payments as a resource for cash assistance and TANF/SFA-related medical assistance. This section applies to cash assistance and TANF/SFA-related medical assistance.

(1) In the month the payment is received, the department does not count any amount of a lump sum payment awarded for:

- (a) Wrongful death;
- (b) Personal injury;
- (c) Damage; or
- (d) Loss of property.

(2) In the month following the month of receipt, we count the entire amount as a resource except for the portion of the payment designated for:

- (a) Repair or replacement of damaged or lost property; or
- (b) Medical bills.

(3) We do not count the portion described in subsection (2) of this section for sixty days following the month the payment is received. At the end of the sixty-day period, we count any amount that remains as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 99-24-008, § 388-455-0010, filed 11/19/99, effective 1/1/00.]

WAC 388-455-0015 How the department treats lump sum payments as income for cash assistance and TANF/SFA-related medical assistance. For cash assistance and TANF/SFA-related medical assistance, lump sum payments not awarded for wrongful death, personal injury, damage, or loss of property are counted as income. They are budgeted against the client's benefits according to the effective dates in WAC 388-418-0020. The rules in this section describe what portion is countable and when the department counts it. For rules on how lump sum payments awarded for wrongful death, personal injury, damage, or loss of property affect benefits, see WAC 388-450-0010.

(1) To identify what portion of the lump sum the department will count as income, we take the following steps:

- (a) First, we subtract the value of your existing resources from the resource limit as described in WAC 388-470-0005;
- (b) Then, we subtract the difference in (1)(a) from the total amount of the lump sum; and

(c) The amount left over is the countable amount of the lump sum.

(2) For cash assistance, the amount of the lump sum that is countable may change if any or all of the lump sum becomes unavailable for reasons beyond your control. See WAC 388-450-0005. When the countable amount of the lump sum is:

(a) Less than your payment standard plus additional requirements, we consider it as income in the month it is received.

(b) More than one month's payment standard plus additional requirements but less than two months:

(i) We consider the portion equal to one month's payment standard plus additional requirements as income in the month it is received; and

(ii) We consider the remainder as income the following month.

(c) Equal to or greater than the total of the payment standard plus additional requirements for the month of receipt and the following month, we consider the payment as income for those months.

(3) If you are ineligible or disqualified from receiving cash benefits and you receive a one-time lump sum payment:

(a) We allocate the payment to meet your needs as specified in WAC 388-450-0105; and

(b) The remainder is treated as a lump sum payment available to the eligible assistance unit members according to the rules of this section.

(4) You can avoid having the lump sum budgeted against your benefits if you request termination of your cash assistance the month before you receive the lump sum.

(5) For TANF/SFA-related medical assistance:

(a) We consider lump sum payments as income in the month of receipt.

(b) We consider any money that remains on the first of the next month as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0015, filed 11/19/99, effective 1/1/00.]

Chapter 388-456 WAC MONTHLY REPORTING

WAC

388-456-0001 through 388-456-0015 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-456-0001 Monthly reporting. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-456-0001, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-456-0005 Processing a late report. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-456-0005, filed 7/31/98, effective 9/1/98.] Repealed by 00-02-043, filed 12/30/99, effective 1/30/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-456-0010 Recent work history. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-456-0010, filed 7/31/98, effective 9/1/98.] Repealed by 00-02-043, filed 12/30/99, effective 1/30/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-456-0015 Exceptions to monthly reporting. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-456-0015, filed 7/31/98, effective 9/1/98.] Repealed by 00-02-043, filed 12/30/99, effective 1/30/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-456-0001 through 388-456-0015 Repealed.
See Disposition Table at beginning of this chapter.

Chapter 388-458 WAC NOTICES TO CLIENTS

WAC

388-458-0001 How the department requests information or action needed when a client applies for assistance or reports a change.

388-458-0010 Adequate notice of adverse action to recipients.

WAC 388-458-0001 How the department requests information or action needed when a client applies for assistance or reports a change. (1) When the department needs additional information in order to determine the client's eligibility and benefit amount, we send a written request. The client has at least ten days from the date we send the request to respond.

(2) We send these kinds of request when:

(a) You must provide additional information, verification or participate in some activity to qualify for benefits.

(b) Additional information is necessary to determine how a change affects your benefit amount.

(c) Verification is required before we increase your benefit amount.

(3) The request must state:

(a) What information or action is needed, and

(b) The date the information or action is due, and

(c) That we may reduce or deny benefits if the client fails to provide the information or take the action.

(4) If the client fails to provide requested information or take an action within the ten days, we may deny, reduce or discontinue the client's benefits.

(5) If the client later provides the requested information or takes the requested action during the advance notice period:

(a) Assistance continues unchanged if the action or information does not result in a reduction of benefits.

(b) The information or action is treated as a newly reported change under chapter 388-418 WAC if the action or information results in a reduction of benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-458-0001, filed 11/10/99, effective 1/1/00.]

WAC 388-458-0010 Adequate notice of adverse action to recipients. (1) Before we change the benefits a client receives, we send a written notice that explains:

(a) When the benefit amount will change;

(b) If the change is an increase or decrease;

(c) The reasons for the intended action;

(d) The specific rule, regulation or law supporting the action;

(e) The recipient's right to request a fair hearing, including the circumstances under which assistance may be continued if a hearing is requested.

(2) For cash, medical and food assistance, a notice must be sent ten days in advance of an action to reduce, suspend, restrict or discontinue assistance benefits.

(a) The advance notice period begins the day we send the notice.

(b) The advance notice period ends:

(i) On the tenth day after we send the notice; or

(ii) On the next regular mail delivery day if the tenth day falls on a Sunday or holiday.

(3) For certain situations the advance notice period can be less than ten days. A shorter advance notice period is allowed when:

(a) The recipient asks the department to reduce or discontinue benefits.

(b) The department has documented information that the assistance unit has moved to another state or will move to another state before the next benefits are issued.

(c) The department has documented information that all members of the assistance unit have died.

(d) A change in law or regulation requires the department to change benefits for all clients in a certain group.

(4) When a shorter advance notice period is allowed, the notice must be mailed or given to the recipient:

(a) For cash and medical assistance, by the date of the action.

(b) For food assistance, by the date the benefits are received or should have been received.

(5) A separate adverse action notice is not required:

(a) For cash and food assistance, when:

(i) The client was notified when benefits were approved that the amount of benefits for each month varied; or

(ii) The client was already notified when a supplemental payment or increased allotment to restore lost benefits would end.

(b) For cash assistance, when the recipient was already notified that an emergent need payment was for one month only.

(6) For clients who qualify for necessary supplemental accommodation services, we provide notices as required under WAC 388-200-1300.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-458-0010, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-525-2520.]

Chapter 388-462 WAC PREGNANCY

WAC

388-462-0005	Repealed.
388-462-0010	Temporary assistance for needy families (TANF) or state family assistance (SFA) eligibility for pregnant women.
388-462-0011	Post adoption cash benefit.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-462-0005	Pregnancy requirement for GA-S. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0005, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-045, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
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WAC 388-462-0005 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-462-0010 Temporary assistance for needy families (TANF) or state family assistance (SFA) eligibility for pregnant women. (1) If you are already receiving TANF or SFA benefits, your pregnancy will not change your eligibility or benefit level.

(2) If you are not currently receiving TANF or SFA benefits, you may be eligible for these benefits if your pregnancy and expected date of delivery has been verified by a licensed medical practitioner.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-462-0010, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-462-0011 Post adoption cash benefit. (1) Under RCW 74.04.005 (6)(g) recipients of TANF or SFA who lose their eligibility solely because of the birth and relinquishment of the qualifying child may receive general assistance through the end of the month in which the period of six weeks following the birth of the child falls.

(2) The department will consider income and resources when determining eligibility and benefit amount for post adoption cash benefit in the same manner as TANF. Refer to chapters 388-450, 388-470, and 388-488 WAC.

(3) To receive the post adoption cash benefit, a client must have been receiving TANF or SFA in Washington state.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-462-0011, filed 6/30/99, effective 8/1/99.]

Chapter 388-470 WAC RESOURCES

WAC

388-470-0012	How do the resources of an ineligible or disqualified person effect eligibility for cash assistance?
388-470-0025	Excluded resources for cash assistance.
388-470-0035	Excluded resources for food assistance.
388-470-0045	Resources that are counted toward the resource limits for cash, food assistance and TANF/SFA-related medical programs.
388-470-0055	Resources that are counted for food assistance.
388-470-0075	How vehicles are counted for food assistance.
388-470-0080	Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-470-0080	Compensatory award or related settlement lump sum payments. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0080, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
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WAC 388-470-0012 How do the resources of an ineligible or disqualified person effect eligibility for cash assistance? (1) As used in this section; ineligible, disqualified and financially responsible persons are defined in WAC 388-450-0100.

(2) When determining the cash eligibility of an assistance unit, the department includes the countable resources of a financially responsible person who lives in the home even when the person is ineligible or disqualified from receiving cash assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-09-053, § 388-470-0012, filed 4/19/99, effective 5/20/99.]

WAC 388-470-0025 Excluded resources for cash assistance. The following resources do not count toward the resource limits for cash assistance:

(1) Adoption support payments when the adopted child is excluded from the assistance unit.

(2) Bona fide loans which means the loan is a debt a client owes and has an obligation to repay.

(3) Earned income tax credit and advanced earned income tax credit in the month received and the following month.

(4) Excess real property on which a client is not living:

(a) When, for a period not to exceed nine months, a client:

(i) Makes a good-faith effort to sell the excess property; and

(ii) Signs an agreement to repay the amount of benefits received or the net proceeds of the sale, whichever is less.

(b) Upon cash assistance approval, the agreement to repay is sent to office of financial recovery to file a lien without a specified amount; or

(c) Is used in a self-employment enterprise and meets the criteria in subsection (10) of this section.

(5) Food coupon allotment from the food assistance programs.

(6) Food service payments provided for children under the National School Lunch Act of 1966, PL 92-433 and 93-150.

(7) Foster care payments provided under Title IV-E and/or state foster care maintenance payments.

(8) Housing and Urban Development (HUD) community development block grant funds.

(9) Income tax refunds are excluded in the month the refund is received.

(10) A bank account jointly owned with an SSI recipient when SSA counted the funds to determine the SSI recipient's eligibility.

(11) Real and personal property used in a self-employment enterprise if:

(a) The property is necessary to restore the client's independence or will aid in rehabilitating the client or the client's dependents; and

(b) The client has an approved self-employment plan; and

(c) For WorkFirst participants, the self-employment enterprise is a component of the participant's approved individual responsibility plan (IRP).

(12) Retroactive cash benefits or TANF benefits resulting from a court order modifying a department policy.

(13) Self-employment-accounts receivable that a client bills to the client's customer but has been unable to collect.

(14) SSI recipient's income and resources.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0025, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0035 Excluded resources for food assistance. The following resources do not count toward a client's resource limit.

(1) Earned income tax credit is excluded:

(a) In the month it is received and the following month if the person was not a food assistance recipient when the credit was received; or

(b) For twelve months when the person:

(i) Was a food assistance recipient when the credit was received; and

(ii) Remains a food assistance recipient continuously during this period.

(2) Essential property needed for employment or self-employment of a household member is excluded. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing.

(3) Excluded funds that are deposited in a bank account with countable funds continue to be excluded up to six months from the date of deposit.

(4) Governmental disaster payments to repair a damaged home when the household can be sanctioned if the funds are not used for this purpose.

(5) A home a client is living in including the surrounding property that is not separated by property owned by others is excluded. Public right of ways do not affect this exclusion;

(6) A home that the household is not living in and surrounding property is excluded if the household:

(a) Is making a good faith effort to sell; or

(b) Is planning to return to the home and it is not occupied due to:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Unlivable conditions caused by a natural disaster or casualty.

(7) Any other property is excluded if the household:

(a) Has offered the property for sale through a professional real estate broker; and

(b) Has not declined an offer equivalent to fair market value.

(8) Indian lands that are held jointly by the tribe or can be sold only with the approval from the Bureau of Indian Affairs (BIA) are excluded;

(9) Installment contracts:

(a) Installment contracts or agreements for the sale of land or property are excluded when they are producing income consistent with their fair market value;

(b) Value of property sold under an installment contract or held for security is excluded if the purchase price is consistent with fair market value.

(10) Insurance policies and pension funds:

(a) Cash value of life insurance policies and pension funds, except IRAs and Keogh Plans, are excluded.

(b) Prepaid burial plans are excluded when the plan:

(i) Is death insurance as opposed to a bank account; and

(ii) Requires repayment for allowable withdrawals.

(11) Land. Where a client plans to build a permanent home or is excluded where their property is not separated by land owned by others. The land is countable if the assistance unit owns another home.

(12) A resource is excluded when it is owned by an assistance unit member who receives TANF/SFA or SSI.

(13) Resources that are owned by persons who are not members of the household are excluded.

(14) A resource is excluded when, if it is sold, would only result in a gain to the household of one-half of the applicable resource limit as defined under WAC 388-470-0005. The resource must be something other than stocks, bonds, negotiable financial instruments, or a vehicle.

(15) Prorated income for self-employed persons or ineligible students. These monies retain their exclusion for the period of time the income is prorated even when commingled with other funds.

(16) Real or personal property when:

(a) It produces yearly income that is equal to its fair market value even when used only on a seasonal basis;

(b) Secured by a lien for a business loan and the lien prevents the household from selling it; or

(c) It is directly related to the maintenance or use of a vehicle excluded in WAC 388-470-0075.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0045 Resources that are counted toward the resource limits for cash, food assistance and TANF/SFA-related medical programs. (1) The following resources are counted toward the resource limits for cash, food assistance and TANF/SFA-related medical programs:

(a) Liquid resources such as cash on hand, monies in checking or savings accounts; or

(b) Stocks or bonds minus any early withdrawal penalty.

(2) For TANF/SFA, GA, and TANF/SFA-related medical, the entire value of a motor home is counted as a resource when not used as a residence. For food assistance, a motor home is treated as a vehicle as described in WAC 388-470-0075.

(3) A resource owned with a person other than a spouse, contract vendor, mortgage or lien holder (jointly owned) is counted as follows:

(a) For cash assistance and TANF-related medical, the client's share of the equity value; or

(b) For food assistance, resources jointly owned by separate assistance units are considered available in their entirety to each assistance unit.

(4) A client may provide evidence that all or a portion of a jointly owned resource:

(a) Belongs to the other owner; and

(b) Is held for the benefit of the other owner.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0045, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0055 Resources that are counted for food assistance. The net value of the following resources are counted toward an assistance unit's resource limit:

(1) Excluded funds that are deposited in an account with countable funds (commingled) for more than six months from the date of deposit.

(2) Lump sums such as insurance settlements, refunded cleaning and damage deposits.

(3) Resources of ineligible household members, as described in WAC 388-408-0035(9).

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0055, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0075 How vehicles are counted for food assistance. (1) The entire value of a licensed vehicle even during periods of temporary unemployment is excluded if the vehicle is:

(a) Used over fifty percent of the time for income-producing purposes. An excluded vehicle used by a self-employed farmer or fisher retains its exclusion for one year from the date the household member ends this self-employment.

(b) Used to produce income annually that is consistent with its fair market value (FMV).

(c) Necessary for long-distance travel that is essential to the employment of an assistance unit member whose resources are considered available to the assistance unit. Vehicles needed for daily commuting are not excluded under this provision.

(d) Necessary for hunting or fishing to support the household.

(e) Used as the assistance unit's home.

(f) Used to carry fuel for heating or water for home use when this is the primary source of fuel or water for the assistance unit.

(g) Needed to transport a physically disabled household member.

(2) The FMV in excess of four thousand six hundred fifty dollars is counted toward the assistance unit's resource limit for the following licensed vehicles if not excluded in subsection (1) above:

(a) One per assistance unit regardless of use;

(b) Used for transportation to and from work, training, or education; or

(c) Used for seeking employment.

(3) For all other licensed vehicles, the larger value of the following is counted toward the assistance unit's resource limit:

(a) FMV in excess of four thousand six hundred fifty dollars; or

(b) Equity value.

(4) Unlicensed vehicles driven by tribal members on the reservation are treated like a licensed vehicle.

(5) For unlicensed vehicles the equity value is counted towards the assistance unit's resource limit unless the vehicle is:

(a) Used to produce income annually that is consistent with its FMV even if used on a seasonal basis; or

(b) Work-related equipment necessary for employment or self-employment of an assistance unit member.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0075, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0075, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0080 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-472 WAC

RIGHTS AND RESPONSIBILITIES

WAC

388-472-0005

Client rights and responsibilities.

WAC 388-472-0005 Client rights and responsibilities. Unless specifically stated, the following rules apply to cash, food and medical assistance programs.

(1) A person who applies for or receives public assistance has the right to:

(a) Be treated politely and fairly without regard to race, color, creed, political affiliation, national origin, religion, age, gender, disability or birthplace;

(b) File an application on the same day, during regular business hours, that the person contacts the department. A client has the right to get a receipt when leaving an application or other materials with the department;

(c) Have an application promptly accepted and promptly acted upon;

(d) Ask that the application be processed without delay if the person is pregnant, in need of immediate medical care, experiencing an emergency such as having no money for food, or facing an eviction. If a pregnant client requests an interview, she has the right to have one within five working days;

(e) Get a written decision in most cases within thirty days.

(i) Medical and some disability cases may take forty-five to sixty days. Pregnancy medical will be authorized within fifteen working days.

(ii) Food stamps will be authorized within thirty days if the person is eligible. If the person is eligible and has little or no money, food stamps will be authorized within five days;

(f) Be fully informed, in writing, of all legal rights and responsibilities in connection with public assistance;

(g) Have information kept private. The department may share some facts with other agencies for efficient management of federal and state programs;

(h) For cash and medical assistance programs, ask the department not to collect child support if the absent parent may harm the person or person's child;

(i) For cash assistance programs, ask for extra money to help in an emergency, such as an eviction or a utility shutoff;

(j) Get a written notice, in most cases, at least ten days before the department makes changes to lower or stop benefits;

(k) Ask for a fair hearing if the person does not agree with the department about a decision. Without affecting the right to a fair hearing, the person can also ask a supervisor or administrator to review an employee decision or action;

(l) Have interpreter or translator services at no cost or undue delay;

(m) Refuse to speak to a fraud early detection (FRED) investigator from the division of fraud investigations. The person does not have to let an investigator into the home. The person may ask the investigator to come back at another time. Such a request will not affect the person's eligibility for benefits;

(n) For medical assistance programs only: A person applying for or receiving medical assistance, limited casualty programs, medical care services, or children's health services has the same rights as cash assistance clients; and

(o) Receive help from the department to register to vote.

(2) A client is responsible for:

(a) Reporting any changes to the department within ten days for all cash and food assistance programs and twenty days for all medical assistance programs;

(b) Giving all the facts needed to determine eligibility;

(c) Giving the department proof of any facts for which proof is needed;

(d) For most cash or medical assistance programs related to children, cooperating with the department to get child support or medical care support unless it can be shown that harm to the person or child may occur;

(e) For cash or medical assistance programs, applying for and taking any benefits from other programs, if eligible;

(f) Completing reports and reviews when asked to do so;

(g) Seeking and taking a job or training if required; and

(h) For medical assistance programs only, showing the medical identification card or other adequate department generated notification of eligibility to the medical care provider.

(3) Clients will be screened and provided with necessary supplemental accommodation as specified under WAC 388-200-1300.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-472-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-472-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0430, 388-504-0440, 388-504-0450 and 388-505-0560.]

Chapter 388-476 WAC SOCIAL SECURITY NUMBER

WAC

388-476-0005 Social Security number requirements.

WAC 388-476-0005 Social Security number requirements. (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security number (SSN), or numbers if more than one has been issued.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;

(b) Provide proof that the SSN has been applied for; and

(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For cash, medical, and food assistance benefits, a person cannot be disqualified from receiving benefits for refusing to apply for or supply an SSN based on religious grounds.

(5) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) A newborn may receive benefits for up to six months from the date of birth if the household is unable to provide proof of application for an SSN at the time of birth.

(6) For medical programs, a newborn as described in WAC 388-505-0210(1) is eligible for categorically needy

(CN) medical without meeting the SSN requirement until the baby's first birthday.

(7) There is no SSN requirement for the following programs:

- (a) The consolidated emergency assistance program;
- (b) The refugee cash and medical assistance program;
- (c) The medically indigent program;
- (d) The alien emergency medical program;
- (e) The state-funded pregnant woman program;
- (f) The children's health program; and
- (g) Detoxification services.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-476-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-476-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0530.]

**Chapter 388-478 WAC
STANDARDS FOR PAYMENTS**

WAC

- 388-478-0010 Households with obligations to pay shelter costs.
- 388-478-0015 Need standards for cash assistance.
- 388-478-0025 Repealed.
- 388-478-0055 SSI standards.
- 388-478-0060 Income eligibility standards for food assistance.
- 388-478-0070 Monthly income and countable resource standards for medically needy (MN) and medically indigent (MI) programs.
- 388-478-0075 Medical programs—Monthly income standards based on the federal poverty level (FPL).
- 388-478-0080 SSI-related categorically needy income level (CNIL) and countable resource standards.
- 388-478-0085 Medicare cost sharing programs—Monthly income and countable resources standards.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

- 388-478-0025 TANF payment standards for recent arrivals to Washington state. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0025, filed 7/31/98, effective 9/1/98.] Repealed by 99-16-024, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.08.090 and 74.04.510.

Assistance Unit Size	Need Standard	185% of Need
1	\$ 797	\$ 1,474
2	1,008	1,864
3	1,247	2,307
4	1,467	2,714
5	1,690	3,127

(2) For assistance units with shelter provided at no cost:

Assistance Unit Size	Need Standard	185% of Need
1	\$ 480	\$ 888
2	607	1,122
3	752	1,391
4	884	1,635
5	1,019	1,885

[Statutory Authority: RCW 74.04.200. 99-04-056, § 388-478-0015, filed 1/29/99, effective 3/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0010 Households with obligations to pay shelter costs. The monthly need and payment standards for cash assistance are based on a determination of assistance unit size and whether the assistance unit has an obligation to pay shelter costs.

Eligibility and benefit level is determined using standards for assistance unit with obligations to pay shelter costs. An assistance unit has an obligation to pay shelter costs if one of the members:

(1) Owns, purchases or rents their place of residence, even if costs are limited to property taxes, fire insurance, sewer, water, or garbage;

(2) Resides in a lower income housing project which is funded under the United States Housing Act of 1937 or Section 236 of the National Housing Act, if the household either pays rent or makes a utility payment instead of a rental payment; or

(3) Is homeless. Homeless households include persons or families who:

(a) Lack a fixed, regular, and adequate nighttime residence; or

(b) Reside in a public or privately operated shelter designed to provide temporary living accommodations; or

(c) Live in temporary lodging provided through a public or privately funded emergency shelter program.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-478-0010, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0015 Need standards for cash assistance. The need standards and one hundred eighty-five percent of the need standards for cash assistance units are:

(1) For assistance units with obligation to pay shelter costs:

Assistance Unit Size	Need Standard	185% of Need
6	\$ 1,918	\$ 3,549
7	2,215	4,098
8	2,452	4,536
9	2,693	4,982
10 or more	2,926	5,413

Assistance Unit Size	Need Standard	185% of Need
6	\$ 1,156	\$ 2,138
7	1,335	2,469
8	1,478	2,734
9	1,623	3,002
10 or more	1,764	3,263

WAC 388-478-0025 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-478-0055 SSI standards. (1) Supplemental Security Income (SSI) is a cash assistance program for needy

individuals and couples who meet federal disability guidelines as aged, blind or disabled. Since the SSI program began in January 1974, the state of Washington has supplemented the federal benefit level with state funds, known as the SSI state supplement. Persons found eligible for SSI receive cash assistance based on the combined federal and state supplement benefit levels, minus countable income.

(2) Effective October 1, 1999, the federal, state and combined benefit levels for an eligible individual and couple are:

(a) Area I: King, Pierce, Snohomish, Thurston, and Kitsap Counties.

(i) Living alone (own household or alternate care, except nursing homes or medical institutions).

	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
LIVING ALONE			
Individual	\$ 500.00	\$26.00	\$ 526.00
Individual with One Essential Person ¹	\$ 750.00	\$21.00	\$ 771.00
Couple, both Eligible	\$ 751.00	\$21.00	\$ 772.00
Couple with One Essential Person ²	\$ 751.00	\$21.00	\$ 772.00
Couple includes Ineligible Spouse	\$ 500.00	\$167.20	\$ 667.20

(ii) Shared living (supplied shelter).

	Federal Benefit Level	State Supplement Benefit Level	Combined Benefit Level
SHARED LIVING			
Individual	\$ 333.34	\$4.81	\$ 338.15
Individual with One Essential Person ³	\$ 500.00	\$5.30	\$ 505.30
Couple, Both Eligible	\$ 500.67	\$5.30	\$ 505.97
Couple includes One Essential Person ⁴	\$ 500.67	\$5.30	\$ 505.97
Couple includes Ineligible Spouse	\$ 333.34	\$102.76	\$ 436.10

(b) Area II: All counties other than the above.

(i) Living alone (own household or alternate care, except nursing homes or medical institutions).

	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
LIVING ALONE			
Individual	\$ 500.00	\$ 5.55	\$ 505.55
Individual with One Essential Person ¹	\$ 750.00	\$0	\$ 750.00
Couple, Both Eligible	\$ 751.00	\$0	\$ 751.00
Couple with One Essential Person ²	\$ 751.00	\$0	\$ 751.00
Couple includes Ineligible Spouse	\$ 500.00	\$137.25	\$ 637.25

(ii) Shared living (supplied shelter).

	Federal Benefit Level	State Supplement Benefit Level	Combined Benefit Level
SHARED LIVING			
Individual	\$ 333.34	\$4.81	\$ 338.15
Individual with One Essential Person ³	\$ 500.00	\$5.30	\$ 505.30
Couple, Both Eligible	\$ 500.67	\$5.30	\$ 505.97
Couple includes One Essential Person ⁴	\$ 500.67	\$5.30	\$ 505.97
Couple includes Ineligible Spouse	\$ 333.34	\$102.76	\$ 436.10

(c) Residing in a medical institution: Area I and II

	Federal Benefit Level	State Supplement Benefit Level	Combined Benefit Level
MEDICAL INSTITUTION			
Individual	\$30.00	\$11.62	\$41.62

(d) Mandatory income level (MIL) for grandfathered claimant. "Grandfathered" refers to a person who qualified for assistance from the state as aged, blind, or disabled, was converted from the state to federal disability assistance under SSI in January 1974, and has remained continuously eligible for SSI since that date.

The combined federal/state SSI benefit level for MIL clients is the higher of the following:

(i) The state assistance standard they received in December 1973, except for those converted in a "D" living arrangement (residing in a medical institution at the time of conver-

sion), plus the federal cost-of-living adjustments (COLA) since then; or

(ii) The current standard.

¹ Eligible individual with more than one essential person living alone: \$ 500.00 for the eligible individual plus \$ 250.00 for each essential person (no state supplement).

² Eligible couple with one or more essential persons living alone: \$ 751.00 for eligible couple plus \$ 250.00 for each essential person (no state supplement).

³ Eligible individual with more than one essential person in shared living: \$ 333.34 for eligible individual plus \$ 166.66 for each essential person (no state supplement).

⁴ Eligible couple with one or more essential persons in shared living: \$ 500.67 for eligible couple plus \$ 166.66 for each essential person (no state supplement).

[Statutory Authority: RCW 74.08.090 and 74.04.057. 99-18-063, § 388-478-0055, filed 8/30/99, effective 10/1/99. Statutory Authority: RCW 74.08.090 and 74.04.630. 99-04-103, § 388-478-0055, filed 2/3/99, effective 3/6/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0055, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1115.]

WAC 388-478-0060 Income eligibility standards for food assistance. (1) When all household members receive

cash benefits (TANF, GA-U, GA-S, etc.) or Supplemental Security Income (SSI), they do not have to meet the income standard.

(2) All households, based on their size, must have income at or below the limits shown in column B to be eligible for food assistance, except as follows:

(a) Column C is to be used when a household includes a person sixty years or older, or with disabilities;

(b) Column E is to be used when determining separate household status for an elderly person and a person with permanent disability, as described in WAC 388-408-0035 (1)(d).

EFFECTIVE 10-1-99

Column A Household Size	Column B Maximum Gross Monthly Income	Column C Maximum Net Monthly Income	Column D Maximum Allotment	Column E 165% of Poverty Level
1	\$ 893	\$ 687	\$ 127	\$ 1,133
2	1,199	922	234	1,521
3	1,504	1,157	335	1,909
4	1,810	1,392	426	2,297
5	2,115	1,627	506	2,684
6	2,421	1,862	607	3,072
7	2,726	2,097	671	3,460
8	3,032	2,332	767	3,848
9	3,338	2,567	863	4,236
10	3,644	2,802	959	4,624
Each Additional Member	+306	+235	+96	+388

[Statutory Authority: RCW 74.04.510. 99-24-053, § 388-478-0060, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-478-0060, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.500, 74.04.510, 74.08.090. 99-05-074, § 388-478-0060, filed 2/17/99, effective 3/20/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0060, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0070 Monthly income and countable resource standards for medically needy (MN) and medically indigent (MI) programs. (1) Beginning January 1, 1999, the medically needy income level (MNIL) and MI monthly income standards are as follows:

(a) One person	\$527
(b) Two persons	\$592
(c) Three persons	\$667
(d) Four persons	\$742
(e) Five persons	\$858
(f) Six persons	\$975
(g) Seven persons	\$1,125
(h) Eight persons	\$1,242
(i) Nine persons	\$1,358
(j) Ten persons and more	\$1,483

(2) The MNIL standard for a person meeting institutional status requirements is in WAC 388-513-1305(2).

(3) Countable resource standards for the MN and MI programs are:

(a) One person	\$2,000
(b) A legally married couple	\$3,000

(c) For each additional family member add \$50

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. 99-11-054, § 388-478-0070, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710, 388-507-0720, 388-511-1115, 388-518-1820, 388-518-1830, 388-518-1840 and 388-518-1850.]

WAC 388-478-0075 Medical programs—Monthly income standards based on the federal poverty level (FPL). (1) The department bases the income standard upon the Federal Poverty Level (FPL) for the following medical programs:

(a) Children's health program is one hundred percent of FPL;

(b) Pregnant women's program is one hundred eighty-five percent of FPL;

(c) Children's categorically needy program is two hundred percent of FPL; and

(d) The children's health insurance program (CHIP), effective January 1, 2000, is over two hundred percent of FPL but under two hundred fifty percent of FPL.

(2) Beginning April 1, 1999, the monthly FPL standards are:

FAMILY SIZE	100% FPL	185% FPL	200% FPL	250% FPL
1	\$ 687	\$ 1271	\$ 1374	\$ 1717
2	\$ 922	\$ 1706	\$ 1844	\$ 2305
3	\$ 1157	\$ 2140	\$ 2314	\$ 2892
4	\$ 1392	\$ 2575	\$ 2784	\$ 3480

FAMILY SIZE	100% FPL	185% FPL	200% FPL	250% FPL
5	\$ 1627	\$ 3010	\$ 3254	\$ 4067
6	\$ 1862	\$ 3445	\$ 3724	\$ 4655
7	\$ 2097	\$ 3879	\$ 4194	\$ 5242
8	\$ 2332	\$ 4314	\$ 4664	\$ 5830
9	\$ 2567	\$ 4749	\$ 5134	\$ 6417
10	\$ 2802	\$ 5184	\$ 5604	\$ 7005

Add to the ten person standard for each person over ten:

\$ 235	\$ 435	\$ 470	\$ 588
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(3) There are no resource limits for the programs under this section.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530 and the poverty guidelines updated annually in the Federal Register by the United States Department of Health and Human Services under authority of Section 673(2) of the Omnibus Budget Reconciliation Act (42 U.S.C. 9902(2)). 99-19-005, § 388-478-0075, filed 9/3/99, effective 10/4/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0075, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0805, 388-508-0810, 388-509-0910, 388-509-0920, 388-509-0940 and 388-509-0960.]

WAC 388-478-0080 SSI-related categorically needy income level (CNIL) and countable resource standards.

(1) The SSI-related CNIL standard is the same as the SSI monthly payment standard based upon the area of the state where the person lives. Area 1 is defined as the following counties: King, Pierce, Snohomish, Thurston, and Kitsap. Area 2 is all other counties. Beginning January 1, 1999, the CNIL monthly income standards are as follows:

	Area 1	Area 2
(a) Single person	\$527.00	\$506.55
(b) A legally married couple who are both eligible	\$772.00	\$751.00

(2) The countable resource standards for the SSI-related CN medical program are:

(a) One person	\$2,000
(b) A legally married couple	\$3,000

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. 99-11-054, § 388-478-0080, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0080, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1110.]

WAC 388-478-0085 Medicare cost sharing programs—Monthly income and countable resources standards.

(1) The qualified Medicare beneficiary (QMB) program income standard is one hundred percent of the Federal Poverty Level (FPL). Beginning April 1, 1999, the QMB program's income standards are:

(a) One person	\$ 687
(b) Two persons	\$ 922

(2) The special low-income Medicare beneficiary (SLMB) program income standard is over one hundred percent of FPL, but under one hundred twenty percent of FPL. Beginning April 1, 1999, the SLMB program's income standards are:

	Minimum	Maximum
(a) One person	\$ 687.01	\$ 824
(b) Two persons	\$ 922.01	\$ 1106

(3) The expanded special low-income Medicare beneficiary (ESLMB) program income standard is over one hundred twenty percent of FPL, but under one hundred thirty-five percent of FPL. Beginning April 1, 1999, the ESLMB program's income standards are:

	Minimum	Maximum
(a) One person	\$ 824.01	\$ 927
(b) Two persons	\$ 1106.01	\$ 1245

(4) The qualified disabled working individual (QDWI) program income standard is standard is based upon two hundred percent of FPL. Beginning April 1, 1999, the QDWI program's income standards are:

(a) One person	\$ 1374
(b) Two persons	\$ 1844

(5) The qualified individual (QI) program income standard is over one hundred thirty-five percent of FPL, but under one hundred seventy-five percent of FPL. Beginning April 1, 1999, the QI program's income standards are:

	Minimum	Maximum
(a) One person	\$ 927.01	\$ 1202
(b) Two persons	\$ 1245.01	\$ 1613

(6) The resource standard for the Medicare cost sharing programs in this section is:

(a) One person	\$ 4000
(b) Two persons	\$ 6000

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530 and the poverty guidelines updated annually in the Federal Register by the United States Department of Health and Human Services under authority of Section 673(2) of the Omnibus Budget Reconciliation Act (42 U.S.C. 9902(2)). 99-19-005, § 388-478-0085, filed 9/3/99, effective 10/4/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0085, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1715, 388-517-1730, 388-517-1750 and 388-517-1770.]

**Chapter 388-482 WAC
STUDENT STATUS**

WAC 388-482-0005 Student status for food assistance.

WAC 388-482-0005 Student status for food assistance. (1) A food assistance client is considered a student when the client is:

- (a) Aged eighteen through forty-nine years;
- (b) Physically and mentally able to work; and
- (c) Enrolled in an institution of higher education at least half-time as defined by the institution.

- (2) An institution of higher education is:
 - (a) Any educational institution requiring a high school diploma or general education development certificate (GED);
 - (b) Business, trade or vocational schools requiring a high school diploma or GED; or
 - (c) A two-year or four-year college or university offering a degree but not requiring a high school diploma or GED.

(3) To be eligible for food assistance, a student as defined in subsection (1) of this section must meet at least one of the following requirements:

(a) Be employed for a minimum of twenty hours per week.

(b) Work and receive money from a federal or state work study program;

(c) Be responsible for the care of a dependent household member age five or younger;

(d) Be responsible for the care of a dependent household member six through eleven years of age and the department has determined that there is not adequate child care available during the school year to allow the student to:

(i) Attend class and satisfy the twenty hour work requirement; or

(ii) Take part in a work study program.

(e) Be a single parent responsible for the care of a dependent household member eleven years old or younger even if child care is available;

(f) Be an adult who has parental control of a child eleven years of age or younger and neither the adult's spouse nor the child's parents reside in the home;

(g) Participate in the WorkFirst program as required under WAC 388-310-400;

(h) Receive benefits from TANF or SFA;

(i) Attend an institution of higher education through:

(i) The job training partnership act (JTPA);

(ii) Food assistance employment and training program (FS E&T);

(iii) An approved state or local employment and training program; or

(iv) Section 236 of the Trade Act of 1974.

(4) Student status:

(a) Begins the first day of the school term; and

(b) Continues through vacations. Vacations include the summer when the student plans to return to school for the next term.

(5) If the only reason a student is eligible for food assistance is the participation in work study, the student becomes ineligible during the summer months if the student is not working and receiving money from work study. Consider other student eligibility criteria during the summer months.

(6) Student status ends when a student:

(a) Graduates;

(b) Is suspended or expelled;

(c) Drops out; or

(d) Does not intend to register for the next school term other than summer.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-482-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-482-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-484 WAC

TANF/SFA FIVE YEAR TIME LIMIT

WAC

388-484-0005 Five year (sixty-month) time limit for TANF, SFA and GA-S cash benefits.

WAC 388-484-0005 Five year (sixty-month) time limit for TANF, SFA and GA-S cash benefits. (1) What is the sixty-month time limit?

The sixty-month time limit is a lifetime limit of cash benefits for TANF, SFA, and GA-S. The time limit applies to any combination of these cash benefits.

(2) When does the sixty-month time limit start?

The sixty-month time limit starts August 1, 1997 for TANF and SFA and May 1, 1999 for GA-S.

(3) Who does this time limit apply to?

The sixty-month time limit applies to any needy caretaker relative(s) as defined in WAC 388-454-0010.

(4) Are there any exceptions to the time limit?

A month does not count towards the sixty-month time limit when:

(a) Unmarried pregnant or parenting minors live in a department approved living arrangement as defined by WAC 388-486-0005.

(b) Living in Indian country, as defined under 18 U.S.C. 1151, or an Alaskan Native village, if during the months the needy caretaker relative(s) received TANF, SFA, or GA-S cash benefits at least fifty percent of the adults living on the reservation or in the village were unemployed.

(5) What happens if a member of my assistance unit has received sixty months of TANF, SFA, and GA-S cash benefits?

The entire assistance unit becomes ineligible for TANF, SFA, or GA-S cash benefits once any member has received sixty months of these benefits.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-08-050, § 388-484-0005, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-484-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-501 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

WAC

388-501-0050	Medical services requiring approval.
388-501-0100	Subrogation.
388-501-0175	Medical care provided in bordering cities.
388-501-0200	Third-party resources.

WAC 388-501-0050 Medical services requiring approval. All medical services that are provided to clients of medical care programs are subject to review and approval for reimbursement by the medical assistance administration (MAA).

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0050, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0100 Subrogation. (1) For the purpose of this section, "liable third party" means:

(a) The tort-feasor or insurer of the tort-feasor, or both; and

(b) Any person who is liable to provide coverage for the illness or injuries for which the medical assistance administration (MAA) is providing assistance or residential care.

That liability must be based on any contract or insurance purchased by the client or any other person.

(2) As a condition of medical care eligibility, a client must assign to the state any right the client may have to receive payment from any other third party. An eligible client who receives health care items or services from the state under medical care programs under chapter 74.09 RCW and who has a right to payment from any other third party for those items or services, subrogates that right of payment to the state. This applies except as provided in subsection (3) of this section.

(3) To the extent authorized by a contract executed under RCW 74.09.522, a managed health care plan has the rights and remedies of the department as provided in RCW 43.20B.060 and 70.09.180.

(4) MAA is not responsible to pay for medical care for a client whose personal injuries are caused by the negligence or wrongdoing of another. However, MAA may provide the medical care required as a result of an injury to the client if both of the following apply:

(a) The client is otherwise eligible for medical care; and

(b) No other liable third party has been identified at the time the claim is filed.

(5) The department may pursue its right to recover the value of medical care provided to an eligible client from any liable third party as a subrogee, assignee, or by enforcement of its public assistance lien as provided under RCW 43.20B.040 through 43.20B.070.

(6) Recovery pursuant to the subrogation rights, assignment, or enforcement of the lien granted to the department is not reduced, prorated, or applied to only a portion of a judgment, award, or settlement. The secretary of the department or the secretary's designee must consent in writing to any discharge or compromise of any settlement or judgment of a lien created under RCW 42.20B.060. The department considers the compromise or discharge of a medical care lien only as authorized by federal regulation at 42 CFR 433.139.

(7) The doctrine of equitable subrogation does not apply to defeat, reduce, or prorate any recovery made by the department that is based on its assignment, lien, or subrogation rights.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0100, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0175 Medical care provided in bordering cities. (1) An eligible Washington state resident may receive medical care in a recognized out-of-state bordering city on the same basis as in-state care.

(2) The only recognized bordering cities are:

(a) Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho; and

(b) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0175, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0175, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-130.]

WAC 388-501-0200 Third-party resources. (1) MAA requires a provider to seek timely reimbursement from a third

party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) MAA pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

(a) Prenatal care;

(b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

(c) Preventive pediatric services as covered under the EPSDT program.

(3) MAA pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to MAA documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.

(5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:

(a) Third-party payment when the payment is less than MAA's maximum allowable rate; or

(b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.

(6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:

(a) Receives direct third-party reimbursement for such services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

(8) MAA considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, MAA is responsible for providing medical services as described under WAC 388-87-020.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0200, filed 12/14/99, effective 1/14/00.]

Chapter 388-502 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—PROVIDERS

WAC

388-502-0120	Payment for medical care outside the state of Washington.
388-502-0130	Interest penalties—Providers.
388-502-0220	Administrative appeal contractor/provider rate reimbursement.
388-502-0250	Decodified.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-502-0250	Interest penalties—Providers. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.] Amended and decodified by 00-01-088, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.04.050 and 74.08.090. Later promulgation, see WAC 388-502-0130.
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WAC 388-502-0120 Payment for medical care outside the state of Washington. (1) The medical assistance administration (MAA) pays the provider of service in designated bordering cities as if the care were provided within the state of Washington (see WAC 388-501-0175). MAA requires providers to meet the licensing requirements of the state in which care is rendered.

(2) MAA does not authorize payment for out-of-state medical care furnished to clients in state-only funded medical programs.

(3) MAA applies the three-month retroactive coverage as defined under WAC 388-80-005 to covered medical services that are furnished to eligible clients by out-of-state providers.

(4) MAA requires out-of-state providers to obtain a valid provider number in order to be reimbursed.

(a) MAA requires a completed core provider agreement, and furnishes the necessary billing forms, instructions, and a core provider agreement to providers.

(b) MAA issues a provider number after receiving the signed core provider agreement.

(c) The billing requirements of WAC 388-87-010 and 388-87-015 apply to out-of-state providers.

(5) For Medicare-eligible clients, providers must submit Medicare claims, on the appropriate Medicare billing form, to the intermediary or carrier in the provider's state. If the provider checks the Medicare billing form to show the state of Washington as being responsible for medical billing, the intermediary or carrier may either:

(a) Forward the claim to MAA on behalf of the provider; or

(b) Return the claim to the provider, who then submits it to MAA.

(6) For covered services for eligible clients, MAA reimburses approved out-of-state nursing facilities at the lower of:

(a) The billed amount; or
(b) The adjusted statewide average reimbursement rate for in-state nursing facility care.

(7) For covered services for eligible clients, MAA reimburses approved out-of-state hospitals at the lower of:

(a) The billed amount; or
(b) The adjusted statewide average reimbursement rate for in-state hospitals.

(8) For covered services for eligible clients, MAA reimburses other approved out-of-state providers at the lower of:

(a) The billed amount; or
(b) The rate paid by the Washington state Title XIX Medicaid program.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-502-0120, filed 12/14/99, effective 1/14/00.]

WAC 388-502-0130 Interest penalties—Providers.

(1) Providers who are enrolled as contractors with the department's medical care programs may be assessed interest on excess benefits or other inappropriate payments. Nursing home providers are governed by WAC 388-96-310 and are not subject to this section.

(2) The department assesses interest when:

(a) The excess benefits or other inappropriate payments were not the result of department error; and

(b) A provider is found liable for receipt of excess benefits or other payments under RCW 74.09.220; or

(c) A provider is notified by the department that repayment of excess benefits or other payments is due under RCW 74.09.220.

(3) The department assesses interest at the rate of one percent for each month the overpayment is not satisfied. Daily interest calculations and assessments are made for partial months.

(4) Interest is calculated beginning from the date the department receives payment from the provider. Interest ceases to be calculated and collected from the provider once the overpayment amount is received by the department.

(5) The department calculates interest and amounts, which are identified on all department collection notices and statements.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, recodified as § 388-502-0130, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.]

WAC 388-502-0220 Administrative appeal contractor/provider rate reimbursement. (1) Any enrolled contractor/provider of medical services has a right to an administrative appeal when the contractor/provider disagrees with the medical assistance administration's (MAA) reimbursement rate. The exception to this is nursing facilities governed by WAC 388-96-904.

(2) The first level of appeal. A contractor/provider who wants to contest a reimbursement rate must file a written appeal with MAA.

(a) The appeal must include all of the following:

(i) A statement of the specific issue being appealed;

(ii) Supporting documentation; and

(iii) A request for MAA to recalculate the rate.

(b) When a contractor/provider appeals a portion of a rate, MAA may review all components of the reimbursement rate.

(c) In order to complete a review of the appeal, MAA may do one or both of the following:

- (i) Request additional information; and/or
- (ii) Conduct an audit of the documentation provided.

(d) MAA issues a decision or requests additional information within sixty calendar days of receiving the rate appeal request.

(i) When MAA requests additional information, the contractor/provider has forty-five calendar days from the date of MAA's request to submit the additional information.

(ii) MAA issues a decision within thirty calendar days of receipt of the completed information.

(e) MAA may adjust rates retroactively to the effective date of a new rate or a rate change. In order for a rate increase to be retroactive, the contractor/provider must file the appeal within sixty calendar days of the date of the rate notification letter from MAA. MAA does not consider any appeal filed after the sixty day period to be eligible for retroactive adjustment.

(f) MAA may grant a time extension for the appeal period if the contractor/provider makes such a request within the sixty-day period referenced under (e) of this subsection.

(g) Any rate increase resulting from an appeal filed within the sixty-day period described in subsection (2)(e) of this section is effective retroactively to the rate effective date in the notification letter.

(h) Any rate increase resulting from an appeal filed after the sixty-day period described in subsection (2)(e) of this section is effective on the date the rate appeal is received by the department.

(i) Any rate decrease resulting from an appeal is effective on the date specified in the appeal decision letter.

(j) Any rate change that MAA grants that is the result of fraudulent practices on the part of the contractor/provider as described under RCW 74.09.210 is exempt from the appeal provisions in this chapter.

(3) The second level of appeal. When the contractor/provider disagrees with a rate review decision, it may file a request for a dispute conference with MAA. For this section "dispute conference" means an informal administrative hearing for the purpose of resolving contractor/provider disagreements with a department action as described under subsection (1) of this section, and not agreed upon at the first level of appeal. The dispute conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(a) If a contractor/provider files a request for a dispute conference, it must submit the request to MAA within thirty calendar days after the contractor/provider receives the rate review decision. MAA does not consider dispute conference requests submitted after the thirty-day period for the first level decision.

(b) MAA conducts the dispute conference within ninety calendar days of receiving the request.

(c) A department-appointed conference chairperson issues the final decision within thirty calendar days of the conference. Extensions of time for extenuating circumstances may be granted if all parties agree.

(d) Any rate increase or decrease resulting from a dispute conference decision is effective on the date specified in the dispute conference decision.

(e) The dispute conference is the final level of administrative appeal within the department and precede judicial action.

(4) MAA considers that a contractor/provider who fails to attempt to resolve disputed rates as provided in this section has abandoned the dispute.

[Statutory Authority: RCW 74.08.090 and 74.09.730, 99-16-070, § 388-502-0220, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-502-0220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-043.]

WAC 388-502-0250 Decodified. See Disposition Table at beginning of this chapter.

Chapter 388-503 WAC

PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE

WAC

388-503-0310 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-503-0310 Categorically needy eligible persons. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997, 98-15-066, § 388-503-0310, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090 and 74.04.050, 97-03-036, § 388-503-0310, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090 and SPA 95-11. 96-12-001 (Order 3981), § 388-503-0310, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090, 94-17-036 (Order 3769), § 388-503-0310, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-503-0310, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-010 and 388-82-115.] Repealed by 99-19-091, filed 9/17/99, effective 10/18/99. Statutory Authority: RCW 74.08.090.

WAC 388-503-0310 Repealed. See Disposition Table at beginning of this chapter.

Chapter 388-505 WAC FAMILY MEDICAL

WAC

388-505-0210 Children's medical eligibility.

WAC 388-505-0210 Children's medical eligibility.

(1) A child under the age of one is eligible for categorically needy (CN) medical assistance when:

(a) The child's mother was eligible for and receiving coverage under a medical program at the time of the child's birth; and

(b) The child remains with the mother and resides in the state.

(2) Children under the age of nineteen are eligible for CN medical assistance when they meet the requirements for:

(a) Citizenship or U.S. national status as described in WAC 388-424-0005(1) or immigrant status as described in WAC 388-424-0010(1) or (2);

(b) State residence as described in chapter 388-468 WAC;

(c) A social security number as described in chapter 388-476 WAC; and

(d) Family income levels as described in WAC 388-478-0075 (1)(c).

(3) Upon implementation of the children's health insurance program (CHIP) as described in chapter 388-542, WAC, children under the age of nineteen are eligible for CHIP when:

(a) They meet the requirements of subsection (2)(a) and (b) of this section;

(b) They do not have other creditable health insurance coverage; and

(c) Family income exceeds two hundred percent of the federal poverty level (FPL), but does not exceed two hundred fifty FPL as described in WAC 388-478-0075 (1)(c) and (d).

(4) Children under the age of nineteen who first physically entered the U.S. after August 21, 1996 are eligible for state-funded CN scope of care when they meet the:

(a) Eligibility requirements in subsection (2)(b), (c), and (d) of this section; and

(b) Qualified alien requirements for lawful permanent residents, parolees, conditional entrants, or domestic violence victims as described in WAC 388-424-0005 (3)(a), (c), (f), or (i).

(5) Children under the age of twenty-one are eligible for CN medical assistance when they:

(a) Meet citizenship or immigrant status, state residence, and social security number requirements as described in subsection (2)(a), (b), and (c) of this section;

(b) Meet income levels described in WAC 388-478-0075 when income is counted according to WAC 388-408-0055 (1)(c); and

(c) Meet one of the following criteria:

(i) Reside in a medical hospital, intermediate care facility for mentally retarded (ICF/MR), or nursing facility for more than thirty days;

(ii) Reside in a psychiatric or chemical dependency facility;

(iii) Are in foster care; or

(iv) Receive subsidized adoption services.

(6) Children are eligible for CN medical assistance if they:

(a) Receive Supplemental Security Income (SSI) payments based upon their own disability; or

(b) Received SSI payments for August 1996, and except for the passage of amendments to federal disability definitions, would be eligible for SSI payments.

(7) Children under the age of nineteen are eligible for Medically Needy (MN) medical assistance when they:

(a) Meet citizenship or immigrant status, state residence, and social security number requirements as described in subsection (2)(a), (b), and (c); and

(b) Have income at or above the income levels described in WAC 388-478-0075 (1)(c).

(8) A child is eligible for SSI-related MN when the child:

(a) Meets the conditions in subsection (6)(a);

(b) Meets the blind and/or disability criteria of the federal SSI program; and

(c) Has family income above the level described in WAC 388-478-0070(1).

(9) Nonimmigrant children, including visitors or students from another country and undocumented children, under the age of eighteen are eligible for the state-funded children's health program, if:

(a) The department determines the child ineligible for any CN or MN scope of care medical program;

(b) They meet family income levels described in WAC 388-478-0075 (1)(a); and

(c) They meet state residency requirements as described in chapter 388-468 WAC.

(10) There are no resource standards for the children's CN or the state-funded CN scope of care, or the children's health programs.

(11) Children may also be eligible for:

(a) Temporary assistance for needy families (TANF) or state family assistance (SFA)-related medical as described in WAC 388-505-0220; and

(b) TANF/SFA-related medical extensions as described in WAC 388-523-0100.

(12) Except for a client described in subsection (4)(c) and (d), an inmate of a public institution, as defined in WAC 388-500-0005, is not eligible for CN or MN medical coverage.

[Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-505-0210, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0210, filed 7/31/98, effective 9/1/98. Formerly WAC 388-509-0905, 388-509-0910 and 388-509-0920.]

Chapter 388-513 WAC

CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

WAC	
388-513-1300	Repealed.
388-513-1301	Definitions related to long-term care (LTC) services.
388-513-1305	Determining eligibility for noninstitutional medical assistance in an alternate living facility (ALF).
388-513-1310	Repealed.
388-513-1315	Eligibility for long-term care (institutional, waived, and hospice) services.
388-513-1320	Determining institutional status for long-term care (LTC) services.
388-513-1325	Determining available income for a single client for long-term care (LTC) services.
388-513-1330	Determining available income for legally married couples for long-term care (LTC) services.
388-513-1340	Determining excluded income for long-term care (LTC) services.
388-513-1345	Determining disregarded income for institutional or hospice services under the medically needy (MN) program.
388-513-1350	Defining the resource standard and determining available resources for long-term care (LTC) services.
388-513-1360	Determining excluded resources for long-term care (LTC) services.
388-513-1365	Evaluating the transfer of an asset made on or after March 1, 1997 for long-term care (LTC) services.
388-513-1366	Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services.
388-513-1380	Institutional—Participation—Client cost of care.
388-513-1395	Determining eligibility for institutional or hospice services and for facility care only under the medically needy (MN) program.

388-513-1396 Clients living in a fraternal, religious, or benevolent nursing facility.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-513-1300 Applicability of alternate living and institutional rules. [Statutory Authority: RCW 74.08.090, 95-06-025 (Order 3834), § 388-513-1300, filed 2/22/95, effective 3/25/95.] Repealed by 00-01-051, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act.

388-513-1310 Resource standard—Institutional. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1310, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-390.] Repealed by 00-01-051, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act.

WAC 388-513-1300 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-513-1301 Definitions related to long-term care (LTC) services. This section defines the meaning of certain terms used in chapters 388-513 and 388-515 WAC. Within these chapters, institutional, waived, and hospice services are referred to collectively as LTC services. Other terms related to LTC services that also apply to other programs are found in the sections in which they are used. Definitions of terms used in certain rules that regulate LTC programs are as follows:

"Add-on hours" means additional hours the department purchases from providers to perform medically-oriented tasks for clients who require extra help because of a handicapping condition.

"Alternate living facility (ALF)" means one of the following that are contracted with the department to provide certain services:

(1) Adult family home (AFH) is a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care.

(2) Adult residential care facility (ARC) (formally known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision.

(3) Adult residential rehabilitation center (ARRC) or Adult residential treatment facility (ARTF) is a licensed facility that provides its residents with twenty-four hour residential care for impairments related to mental illness.

(4) Assisted living facility (AL) is a licensed facility for aged and disabled low income persons with functional disabilities. COPES eligible clients are often placed in assisted living.

(5) Division of developmental disabilities (DDD) group home (GH) is a licensed facility that provides its residents with twenty-four hour supervision.

(6) Enhanced adult residential care facility (EARC) is a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs.

"Annuity" means a policy, certificate, or contract that is an agreement between two or more parties to purchase a right to receive periodic income of a specified amount for a specified period of time.

"Assets" means all the income and resources of the client and the client's spouse. This includes any income and resources they are entitled to but do not receive because of action by:

- (1) The client or the spouse;
- (2) An individual, court or administrative body, with legal authority to act in place of or on behalf of the client or the spouse; or
- (3) An individual, court or administrative body, acting at the direction or upon the request of the client or the spouse.

"Clothing and personal incidentals (CPI)" means a standard allowance intended for clothing and other personal expenses for clients who live in a medical or alternate living facility. This allowance is sometimes referred to as the client's personal needs allowance (PNA).

"Community alternatives program (CAP)" means a Medicaid-waivered program that provides home and community-based services as an alternative to an institution for the mentally retarded (ICF-MR) to persons determined eligible for services from DDD.

"Community options program entry system (COPES)" means a Medicaid-waivered program that provides an aged or disabled person assessed as needing nursing facility care with the option to remain at home or in an alternate living facility.

"Community spouse (CS)" means a person who does not receive institutional, waived, or hospice services and is legally married to an institutionalized client.

"Comprehensive assessment (CA)" means the evaluation process used by a department designated social worker to determine the client's need for long-term care services.

"Coordinated community AIDS service alternative (CASA)" means a Medicaid-waivered program that provides a person with Acquired Immune Deficiency Syndrome (AIDS) or Disabled Class IV Human Immunodeficiency Virus (HIV) and at risk of hospitalization with the option to remain at home or in an alternate living facility.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the local market at the time of transfer or assignment. A transfer of assets for love and affection is not considered a transfer for FMV.

"Federal benefit rate (FBR)" means the basic benefit amount the Social Security Administration (SSA) pays to clients who are eligible for the Supplemental Security Income (SSI) program.

"Hospice" means a Medicaid program that provides a client with a terminal illness a variety of treatment alternatives that can be received either at home or in a nursing facility.

"Institutional services" means services paid for by Medicaid or state payment and provided in a nursing facility or equivalent care provided in a medical facility.

"Institutional status" means what is described in WAC 388-513-1320.

"Institutionalized client" means a client who has attained institutional status as described in WAC 388-513-1320.

"Institutionalized spouse" means a client who has attained institutional as described in WAC 388-513-1320 and is legally married to a person who is not an institutionalized client.

"Legally married" means persons legally married to each other under provision of Washington state law. Washington recognizes other states' legal and common-law marriages. Persons are considered married if they are not divorced, even when they are physically or legally separated.

"Life estate" means an ownership interest in property limited to the owner's lifetime or, in some cases, to a lesser period. Its duration depends upon the lifetime of the owner or on the occurrence of some specific event, such as remarriage of the owner. Ordinarily, the owner of a life estate has the right: of possession, to use the property, to sell interest in the life estate, and to any income produced by the life estate. A contract establishing the life estate may restrain one or more rights of the owner.

"Likely to reside" means there is a reasonable expectation the client will remain in a medical facility for thirty consecutive days. Once made, the determination stands, even if the client does not actually remain in the facility for that length of time.

"Long-term care (LTC) services" means institutional, waived, and hospice services.

"Look-back period" means the number of months prior to the month of application for LTC services.

"Maintenance needs amount" means a monthly income amount a client keeps or that is allocated to a spouse or dependent family member who lives in the client's home.

"Medical facility" means an establishment that provides food, shelter, and medical care to four or more persons unrelated to the proprietor. (This definition does not include correctional facilities.) Medical facilities are limited to the following:

(1) A private or public medical facility licensed as a hospital and certified for Medicaid.

(2) Institution for mental disease (IMD), which is a hospital, nursing facility, or other facility of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(3) Institution for the mentally retarded (IMR), which is an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with mental retardation and related conditions. It provides, in a protected residential setting, ongoing care, twenty-four hour supervision, evaluation, and planning to help each person function at his/her greatest ability. Includes intermediate care facilities for the mentally retarded (ICF-MR).

(4) Nursing facility (NF), which is an institution or part of an institution licensed as a nursing facility or hospital which has a contract with DSHS to provide care for Medicaid clients.

(5) Residential habilitation center (RHC), which is a state-operated facility certified to provide ICF-MR and/or nursing facility level of care for persons with developmental disabilities.

"Medically intensive children (MIC)" program means a Medicaid-waivered program that enables medically fragile children under age eighteen to live in the community. The program allows them to obtain medical and support services necessary for them to remain at home or in a home setting instead of in a hospital. Eligibility is included in the OBRA program described in WAC 388-515-1510.

"Noninstitutional medical assistance" means medical benefits provided by Medicaid or state-funded programs that do not include LTC services.

"Nursing facility turnaround document (TAD)" means the billing document nursing facilities use to request payment for institutionalized clients.

"Outward bound residential alternative (OBRA)" means a Medicaid-waivered program that provides a person approved for services from DDD with the option to remain at home or in an alternate living facility.

"Penalty period" means a period of time for which a client is not eligible to receive LTC services.

"Personal needs allowance (PNA)" means a standard allowance for clothing and other personal needs for clients who live in a medical or alternate living facility. This allowance is sometimes referred to as "CPL."

"Prouty benefits" means special "age seventy-two" Social Security benefits available to persons born before 1896 who are not otherwise eligible for Social Security.

"Short stay" means a person who has entered a medical facility but is not likely to remain institutionalized for thirty consecutive days.

"Special income level (SIL)" means the monthly income standard for the categorically needy (CN) program that is three hundred percent of the SSI Federal Benefit Rate (FBR).

"SSI-related" means an aged, blind, or disabled client who meets the requirements described in WAC 388-503-0510(1).

"Swing bed" means a bed in a medical facility that is contracted as both a hospital and a nursing facility bed.

"Transfer of a resource or asset" means any act or failure to act, by a person or a nonapplying joint tenant, whereby title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person.

"Uncompensated value" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"Undue hardship" means the person is not able to meet shelter, food, clothing, or health needs.

"Value of compensation received" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(1) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and

(2) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"Veterans benefits" means different types of benefits paid by the federal Department of Veterans Affairs (VA). Some may include additional allowances for:

(1) Aid and attendance for an individual needing regular help from another person with activities of daily living;

(2) Housebound for an individual who, when without assistance from another person, is confined to the home.

(3) Improved pension is the newest type of VA disability pension. It is available to veterans and their survivors whose income from other sources (including service connected disability) is below the improved pension amount.

(4) Unusual medical expenses (UME) are determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit. The VA can use UME to reduce countable income to allow the person to receive a higher monthly VA payment, a one-time adjustment payment, or both.

"Waivered programs/services" means programs for which the federal government authorizes exceptions to Medicaid rules. Such programs provide to an eligible client a variety of services not normally covered under Medicaid. In Washington state, waived programs are CAP, CASA, COPES, MIC, and OBRA.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1301, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1305 Determining eligibility for non-institutional medical assistance in an alternate living facility (ALF). This section describes how the department defines the monthly income standard and uses it to determine eligibility for noninstitutional medical assistance for a client who lives in a department-contracted ALF. Refer to WAC 388-478-0045 for the personal needs allowance (PNA) amount that applies in this rule.

(1) Alternate living facilities include the following:

(a) An adult family home (AFH);

(b) An adult residential care facility (ARC);

(c) An adult residential rehabilitation center (ARRC);

(d) An adult residential treatment facility (ARTF);

(e) An assisted living facility (AL);

(f) A division of developmental disabilities (DDD) group home (GH); and

(g) An enhanced adult residential care facility (EARC).

(2) The monthly income standard for noninstitutional medical assistance under the categorically needy (CN) program that cannot exceed the special income level (SIL) equals the following amounts. For a client who lives in:

(a) An ARC, an ARRC, an ARTF, an AL, a DDD GH, or an EARC, the department-contracted rate based on a thirty-one day month plus the PNA; or

(b) An AFH, the department-contracted rate based on a thirty-one day month plus the PNA plus the cost of any add-on hours authorized by the department.

(3) The monthly income standard for noninstitutional medical assistance under the medically needy (MN) program equals the private facility rate based on a thirty-one-day month plus the PNA.

(4) The monthly income standard for noninstitutional medical assistance under the general assistance (GA) program equals the GA grant standard described in WAC 388-478-0030.

(5) The department determines a client's nonexcluded resources as described in chapter 388-470 WAC and WAC 388-505-0595.

(6) The department determines a client's nonexcluded income as described in chapter 388-450 WAC, WAC 388-505-0595, 388-506-0620, and 388-511-1130.

(7) The department approves CN noninstitutional medical assistance for a period of up to twelve months for a client who receives Supplemental Security Income (SSI) or who is SSI-related as described in WAC 388-503-0510(1), if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client's nonexcluded income described in subsection (6) does not exceed the CN standard described in subsection (2).

(8) The department approves MN noninstitutional medical assistance for a period of months described in chapter 388-416 WAC for an SSI-related client, if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client satisfies any spenddown liability as described in chapter 388-519 WAC.

(9) The department approves GA noninstitutional medical assistance for a period of months described in chapter 388-416 WAC for a client determined eligible for the program as described in WAC 388-400-0025.

(10) The client described in subsections (7) and (9) keeps the PNA amount and pays remaining income to the facility for board and room.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1305, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1305, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1305, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-036 and 388-99-036.]

WAC 388-513-1310 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-513-1315 Eligibility for long-term care (institutional, waived, and hospice) services. This section describes how the department determines a client's eligibility for institutional, waived, or hospice services under the categorically needy (CN) program and institutional or hospice services under the medically needy (MN) program.

Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (11) and emergency medical programs described in subsections (10) and (12).

(1) To be eligible for long-term care (LTC) services described in this section, a client must:

(a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a) through (f);

(b) Attain institutional status as described in WAC 388-513-1320; and

(c) Not be subject to a penalty period of ineligibility as described in WAC 388-513-1365 and 388-513-1366.

(2) To be eligible for institutional, waived, or hospice services under the CN program, a client must either:

(a) Be related to the Supplemental Security Income (SSI) program as described in WAC 388-503-0510(1) or be approved for the general assistance expedited Medicaid disability (GA-X) program; and

(b) Meet the following financial requirements, by having:

(i) Gross nonexcluded income described in subsection (7)(a) that does not exceed the special income level (SIL); and

(ii) Nonexcluded resources described in subsection (6) that do not exceed the resource standard described in WAC 388-513-1350(1), unless subsection (3) applies; or

(c) Be eligible for the CN children's medical program as described in WAC 388-505-0210; or

(d) Be eligible for the temporary assistance for needy families (TANF) program or state family assistance (SFA) program as described in WAC 388-505-0220.

(3) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the SIL.

(4) To be eligible for waived or hospice services, a client must also meet the program requirements described in:

(a) WAC 388-515-1505 for COPEs services;

(b) WAC 388-515-1510 for CAP and OBRA services;

(c) WAC 388-515-1530 for CASA services; or

(d) Chapter 388-551 WAC for hospice services.

(5) To be eligible for institutional or hospice services under the MN program, a client must be:

(a) Eligible for the MN children's medical program as described in WAC 388-505-0210; or

(b) Related to the SSI program as described in WAC 388-503-0510(1) and meet all requirements described in WAC 388-513-1395.

(6) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers resources available as described in WAC 388-513-1350;

(b) Excludes resources described in WAC 388-513-1360, 388-513-1365, and 388-513-1366; and

(c) Compares the nonexcluded resources to the standard described in WAC 388-513-1350(1).

(7) To determine income eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers income available as described in WAC 388-513-1325 and 388-513-1330;

(b) Excludes income for CN and MN programs as described in WAC 388-513-1340;

(c) Disregards income for the MN program as described in WAC 388-513-1345; and

(d) Follows program rules for the MN program as described in WAC 388-513-1395.

(8) A client who meets the requirements of the CN program is approved for a period of up to twelve months for:

(a) Institutional services in a medical facility;

(b) Waivered services at home or in an alternate living facility; or

(c) Hospice services at home or in a medical facility.

(9) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395 (5)(a)(ii) for:

(a) Institutional services in a medical facility; or

(b) Hospice services at home or in a medical facility.

(10) The department determines eligibility for LTC services under the alien emergency medical (AEM) program described in WAC 388-438-0110 for a client who meets all other requirements for such services but does not meet citizenship requirements.

(11) The department determines eligibility for institutional services under the GA program described in WAC 388-448-0001 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (8) through (10).

(12) The department determines eligibility for institutional services under the medically indigent program described in WAC 388-438-0100 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (8) through (11).

(13) A client is eligible for Medicaid as a resident in a psychiatric facility, if the client:

(a) Has attained institutional status as described in WAC 388-513-1320; and

(b) Is less than twenty-one years old or is at least sixty-five years old.

(14) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

(15) The department considers the parents' income and resources available as described in WAC 388-405-0055 (1)(c) for a minor who is less than eighteen years old and is receiving or is expected to receive inpatient chemical dependency and/or inpatient mental health treatment.

(16) The department considers the parents' income and resources available only as contributed for a client who is less than twenty-one years old and has attained institutional status as described in WAC 388-513-1320

(17) The department determines a client's participation in the cost of care for LTC services as described in WAC 388-513-1380.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1315, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1315,

filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.08.090 and 42 CFR 435.1005, 98-04-003, § 388-513-1315, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090, 96-11-072 (Order 3980), § 388-513-1315, filed 5/10/96, effective 6/10/96. Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48, 95-19-007 (Order 3895), § 388-513-1315, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1315, filed 5/3/94, effective 6/3/94.]

WAC 388-513-1320 Determining institutional status for long-term care (LTC) services. Institutional status is an eligibility requirement for LTC services.

(1) To attain institutional status, a client must:

(a) Be approved for and receiving waived or hospice services; or

(b) Reside or be likely to reside in a medical facility for a continuous period of:

(i) Ninety days for a child seventeen years of age or younger receiving inpatient chemical dependency and/or inpatient mental health treatment; or

(ii) Thirty days for:

(A) An SSI-related client;

(B) A child not described in subsection (1)(b)(i); or

(C) A client related to medical eligibility as described in WAC 388-513-1315 (10), (11), or (12).

(2) A client's institutional status is not affected by a:

(a) Transfer between medical facilities; or

(b) Change from one kind of long-term care services to another.

(3) A client loses institutional status when the client:

(a) Is absent from the medical facility for at least thirty consecutive days; or

(b) Does not receive waived or hospice services for at least thirty consecutive days.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1320, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500, 99-06-045, § 388-513-1320, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2), 97-15-025, § 388-513-1320, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090, 96-11-072 (Order 3980), § 388-513-1320, filed 5/10/96, effective 6/10/96; 94-10-065 (Order 3732), § 388-513-1320, filed 5/3/94, effective 6/3/94.]

WAC 388-513-1325 Determining available income for a single client for long-term care (LTC) services. This section describes income the department considers available when determining a single client's eligibility for LTC services.

(1) Refer to WAC 388-513-1330 for rules related to available income for legally married couples.

(2) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 388-450-0005 (3) and (4), Income—Ownership and availability;

(b) WAC 388-450-0085, Self-employment income—Allowable expenses;

(c) WAC 388-450-0210 (4)(b), (e), and (h), Countable income for medical programs;

(d) WAC 388-506-0620, SSI-related medical clients;

(e) WAC 388-511-1130, SSI-related income availability; and

(f) WAC 388-513-1315 (15) and (16), Eligibility for long-term care (institutional, waived, and hospice) services.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1325, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1330 Determining available income for legally married couples for long-term care (LTC) services. This section describes income the department considers available when determining a legally married client's eligibility for LTC services.

(1) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 388-450-0005 (3) and (4), Income—Ownership and availability;

(b) WAC 388-450-0085, Self-employment income—Allowable expenses;

(c) WAC 388-450-0210 (4)(b), (e), and (h), Countable income for medical programs;

(d) WAC 388-506-0620, SSI-related medical clients;

(e) WAC 388-511-1130, SSI-related income availability; and

(f) WAC 388-513-1315 (15) and (16), Eligibility for long-term care (institutional, waived, and hospice) services.

(2) For an institutionalized client married to a community spouse who is not applying or approved for LTC services, the department considers the following income available, unless subsection (4) applies:

(a) Income received in the client's name;

(b) Income paid to a representative on the client's behalf;

(c) One-half of the income received in the names of both spouses; and

(d) Income from a trust as provided by the trust.

(3) The department considers the following income unavailable to an institutionalized client:

(a) Separate or community income received in the name of the community spouse; and

(b) Income established as unavailable through a fair hearing.

(4) For the determination of eligibility only, if available income described in subsections (2)(a) through (d) minus income exclusions described in WAC 388-513-1340 exceeds the special income level (SIL), then:

(a) The department follows community property law when determining ownership of income;

(b) Presumes all income received after marriage by either or both spouses to be community income; and

(c) Considers one-half of all community income available to the institutionalized client.

(5) If both spouses are either applying or approved for LTC services, then:

(a) The department allocates one-half of all community income described in subsection (4) to each spouse; and

(b) Adds the separate income of each spouse respectively to determine available income for each of them.

(6) The department considers income generated by a transferred resource to be the separate income of the person or entity to which it is transferred.

(7) The department considers income not generated by a transferred resource available to the client, even when the client transfers or assigns the rights to the income to:

- (a) The spouse; or
- (b) A trust for the benefit of the spouse.

(8) The department evaluates the transfer of a resource described in subsection (6) according to WAC 388-513-1365 and 388-513-1366 to determine whether a penalty period of ineligibility is required.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1330, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1330, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-513-1330, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1330, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1330, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-335 and 388-95-340.]

WAC 388-513-1340 Determining excluded income for long-term care (LTC) services. This section describes income the department excludes when determining a client's eligibility and participation in the cost of care for LTC services with the exceptions described in subsections (30) and (33).

- (1) Crime victim's compensation;
- (2) Earned income tax credit (EITC);
- (3) Native American benefits excluded by federal statute (refer to WAC 388-450-0040);
- (4) Tax rebates or special payments excluded by other statutes;
- (5) Any public agency's refund of taxes paid on real property and/or on food;
- (6) Supplemental Security Income (SSI) and certain state public assistance based on financial need;
- (7) The amount a representative payee charges to provide services when the services are a requirement for the client to receive the income;
- (8) The amount of expenses necessary for a client to receive compensation, e.g., legal fees necessary to obtain settlement funds;
- (9) Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, and/or other necessary educational expenses at any educational institution;
- (10) Child support payments received from an absent parent for a minor child who is not institutionalized;
- (11) The amount of expenses related to impairments of a permanently and totally disabled client that allow the client to work;
- (12) The amount of expenses related to blindness that allow the client to work;
- (13) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);
- (14) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;

(15) Assistance (other than wages or salary) received under the Older Americans Act;

(16) Assistance (other than wages or salary) received under the foster grandparent program;

(17) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(18) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become part of the separately identified burial funds set aside;

(19) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

(20) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(21) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(22) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(23) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(24) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(25) Payments made from *Susan Walker v. Bayer Corporation, et. al.*, 95-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(26) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(27) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(28) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(29) Payments made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act;

(30) Interest earned from payments described in subsections (24) through (29) is considered available and counted as nonexcluded income;

(31) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible client, e.g., chore services;

(32) Department of Veterans Affairs benefits designated for:

- (a) The veteran's dependent;
- (b) Unusual medical expenses, aid and attendance allowance, and housebound allowance, with the exception described in subsection (33);

(33) Benefits described in subsection (32)(b) for a client who resides in a state veterans' home and has no dependents are excluded when determining eligibility, but are considered available when determining participation in the cost of care.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-513-1340, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order

3819), § 388-513-1340, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1340, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

WAC 388-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program. This section describes income the department disregards when determining a client's eligibility for institutional or hospice services under the MN program. The department considers disregarded income available when determining a client's participation in the cost of care.

(1) The department disregards the following income amounts in the following order:

(a) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

- (i) Twenty dollars per month if unearned; or
- (ii) Ten dollars per month if earned.

(b) The first twenty dollars per month of earned or unearned income, unless the income paid to a client is:

- (i) Based on need; and
- (ii) Totally or partially funded by the federal government or a private agency.

(2) For a client who is related to the Supplemental Security Income (SSI) program as described in WAC 388-503-0510(1), the first sixty-five dollars per month of earned income not excluded under WAC 388-513-1340, plus one-half of the remainder.

(3) For a TANF/SFA-related client, fifty percent of gross earned income.

(4) Department of Veterans Affairs benefits if:

(a) Those benefits are designated for:

- (i) Unusual medical expenses;
- (ii) Aid and attendance allowance; or
- (iii) Housebound allowance; and

(b) The client:

- (i) Resides in a state veterans' home; and
- (ii) Has no dependents.

(5) Income the Social Security Administration (SSA) withholds from SSA Title II benefits for the recovery of an SSI overpayment.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-513-1345, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1345, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1345, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

WAC 388-513-1350 Defining the resource standard and determining available resources for long-term care (LTC) services. This section describes how the department defines the resource standard and available resources when determining a client's eligibility for LTC services. The department uses the term "resource standard" to describe the maximum amount of resources a client can have and be resource eligible for program benefits.

(1) The resource standard used to determine eligibility for LTC services equals:

- (a) Two thousand dollars for a single client; or
- (b) Three thousand dollars for a legally married couple, unless subsection (2) applies.

(2) If the department has already established eligibility for one spouse, then it applies the standard described in subsection (1)(a) to each spouse, unless doing so would make one of the spouses ineligible.

(3) The department must apply the following rules when determining available resources for LTC services:

- (a) WAC 388-470-0005, Resource eligibility and limits;
- (b) WAC 388-470-0010, How to determine who owns a resource;

(c) WAC 388-470-0015, Availability of resources;

(d) WAC 388-470-0060(6), Resources of an alien's sponsor; and

(e) WAC 388-506-0620, SSI-related medical clients.

(4) The department determines a client's nonexcluded resources used to establish eligibility for LTC services in the following way:

(a) For an SSI-related client, the department reduces available resources by excluding resources described in WAC 388-513-1360;

(b) For an SSI-related client who has a community spouse, the department:

(i) Excludes resources described in WAC 388-513-1360; and

(ii) Adds together the available resources of both spouses according to subsection (5)(a) or (b) as appropriate;

(c) For a client not described in subsection (4)(a) or (b), the department applies the resource rules of the program used to relate the client to medical eligibility.

(5) A change in federal law that took effect on October 1, 1989 affects the way the department determines available resources of a legally married client. If the client's current period of institutional status began:

(a) On or after that date, the department adds together the total amount of nonexcluded resources held in the name of:

- (i) Either spouse; or
- (ii) Both spouses.

(b) Before that date, the department adds together one-half the total amount of nonexcluded resources held in the name of:

- (i) The institutionalized spouse; or
- (ii) Both spouses;

(6) If subsection (5)(a) applies, the department allocates the maximum amount of resources ordinarily allowed by law to the community spouse before determining nonexcluded resources used to establish eligibility for the institutionalized spouse. The maximum allocation amount is eighty-four thousand, one hundred and twenty dollars effective January 1, 2000.

(7) The amount of allocated resources described in subsection (6) can be increased, only if:

(a) A court transfers additional resources to the community spouse; or

(b) An administrative law judge establishes in a fair hearing described in chapter 388-08 WAC that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

(8) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsections (9)(a), (b), or (c) apply.

(9) A redetermination of the couples' resources as described in subsections (4)(b) or (c) is required, if:

(a) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status;

(b) The institutionalized spouse's nonexcluded resources exceed the standard described in subsection (1)(a), if subsection (5)(a) applies; or

(c) The institutionalized spouse does not transfer the amount described in subsections (6) or (7) to the community spouse or to another person for the sole benefit of the community spouse as described in WAC 388-513-1365(4) by either:

(i) The first regularly scheduled eligibility review; or

(ii) The reasonable amount of additional time necessary to obtain a court order for the support of the community spouse.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1350, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1350, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.575 and Section 1924 (42 USC 1396r-5). 98-11-033, § 388-513-1350, filed 5/14/98, effective 6/14/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. 97-09-112, § 388-513-1350, filed 4/23/97, effective 5/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1350, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1350, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-23-129 (Order 3808), § 388-513-1350, filed 11/23/94, effective 12/24/94; 94-10-065 (Order 3732), § 388-513-1350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-337 and 388-95-340.]

WAC 388-513-1360 Determining excluded resources for long-term care (LTC) services. This section describes resources the department excludes when determining a client's eligibility for LTC services.

(1) Effective July 1, 1996, if an aged, blind, or disabled client purchases a long-term care insurance policy approved by the Washington insurance commissioner under the Washington long-term care partnership program, the department reduces the client's available resources by the amount paid by the policy for LTC services. The amount the department excludes in this process is not subject to the rules described in WAC 388-513-1365 and 388-513-1366 for a transfer of assets.

(2) The amount of resources described in subsection (1) remains subject to estate recovery rules, if the client retained ownership of them.

(3) If a client has a community spouse, the value of one automobile is excluded regardless of its use or value. This is in addition to the vehicle described in WAC 388-470-0040(7), if the client's current period of institutional status began on or after October 1, 1989.

(4) For SSI-related clients, the department excludes resources described in WAC 388-470-0020 and 388-470-0040.

(5) For clients who are not SSI-related, the department excludes resources according to the rules of the program used to relate them to medical eligibility.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1360, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1360, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and 48.85.020. 96-12-002 (Order 3982), § 388-513-1360, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1360, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-380.]

WAC 388-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1366 for rules used to evaluate the transfer of an asset made before March 1, 1997.

(1) The department disregards the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC 388-513-1360 with the exception of the client's home, unless the transfer meets the conditions described in subsection (1) (d);

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department that satisfies one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(iii) A son or daughter, who:

(A) Lived in the home for at least two years immediately before the client's current period of institutional status; and

(B) Provided care that enabled the client to remain in the home; or

(iv) A brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset other than the home, if the transfer meets the conditions described in subsection (4), and the asset is transferred:

(i) To the client's spouse or to another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To the client's child who meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c) or to a trust established for the sole benefit of this child; or

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c).

(f) The transfer of an asset to a member of the client's family in exchange for care the family member provided the client before the current period of institutional status, if a written agreement that describes the terms of the exchange:

(i) Was established at the time the care began;

(ii) Defines a reasonable FMV for the care provided that reflects a time frame based on the actuarial life expectancy of the client who transfers the asset; and

(iii) States that the transferred asset is considered payment for the care provided.

(2) When the fair market value of the care described in subsection (1)(f) is less than the value of the transferred asset, the department considers the difference the transfer of an asset without adequate consideration.

(3) The department considers the transfer of an asset in exchange for care given by a family member without a written agreement as described under subsection (1)(f) as the transfer of an asset without adequate consideration.

(4) The transfer of an asset or the establishment of a trust is considered to be for the sole benefit of a person described in subsection (1)(e), if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable; and

(b) Provides for spending all funds involved for the benefit of the person for whom the transfer is made within a time frame based on the actuarial life expectancy of that person.

(5) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received on or after October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty-six months, if all or part of the assets were transferred on or after August 11, 1993; and

(b) Sixty months, if all or part of the assets were transferred into a trust as described in WAC 388-505-0595.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after March 1, 1997, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that:

(i) Begin on the latter of:

(A) The first day of the month in which the transfer is made; or

(B) The first day after any previous penalty period has ended; and

(ii) End on the last day of the whole number of months as described in subsection (6)(a)(ii).

(7) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC 388-513-1360 does not affect the client's eligibility;

(b) That remains after an acquisition described in subsection (7)(a) becomes an available resource as of the first day of the following month.

(8) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (6) through (8).

(9) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in (9)(a) is divided by the statewide average monthly private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole months found by following subsections (9)(a) and (b) is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(10) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(11) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a fair hearing as described in chapter 388-08 WAC.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1365, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1365, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090,

74.04.050, 74.04.057, 74.09.585 and § 17 of the Social Security Act. 97-05-040, § 388-513-1365, filed 2/14/97, effective 3/17/97. Statutory Authority: RCW 74.08.090, 95-02-027 (Order 3818), § 388-513-1365, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-513-1365, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-395.]

WAC 388-513-1366 Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made before March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1365 for rules used to evaluate the transfer of an asset on or after March 1, 1997.

(1) When evaluating the transfer of an asset made before March 1, 1997, the department must apply rules described in WAC 388-513-1365 (1) through (4) and (7) through (11) in addition to the rules described in this section.

(2) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received before October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty months, if the asset was transferred before August 11, 1993; or

(b) Thirty-six months, if the asset was transferred on or after August 11, 1993.

(3) If a client or the client's spouse transferred an asset without receiving adequate compensation before August 11, 1993, the department must establish a penalty period that:

(a) Runs concurrently for transfers made in more than one month in the look-back period; and

(b) Begins on the first day of the month in which the asset is transferred and ends on the last day of the month which is the lesser of:

(i) Thirty months after the month of transfer; or

(ii) The number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(4) If a client or the client's spouse transferred an asset without receiving adequate compensation on or after August 11, 1993 and before March 1, 1997, the department must establish a penalty period as follows:

(a) If the transfer is made during the look-back period, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months described in subsection (3)(b)(ii).

(b) If the transfer is made while the client is receiving LTC services or during a period of ineligibility, then the penalty period:

(i) Begins on the latter of the first day of the month:

(A) In which the transfer is made; or

(B) After a previous penalty period has ended; and

(ii) Ends on the last day of the number of whole months described in subsection (3)(b)(ii).

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.1575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1366, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1380 Institutional—Participation—Client cost of care. This section describes allocations of income and excess resources used to determine a person's participation in the cost of care for institutional services in a medical facility. Income allocations described in this section are used to reduce countable income that remains after exclusions described in WAC 388-513-1340.

(1) Allocations used to reduce excess resources are amounts for incurred medical expenses, not subject to third-party payment, for which the person is liable, including:

(a) Health insurance and Medicare premiums, deductions, and co-insurance charges; and

(b) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan.

(2) Allocations used to reduce countable income are made in the following order:

(a) Amounts described in subsection (2)(a) may not total more than the one-person medically needy income level (MNIL):

(i) A personal needs allowance (PNA) as follows:

(A) One hundred sixty dollars for a person living in a state veterans' home;

(B) Ninety dollars for a veteran or a veteran's surviving spouse, who receives an improved pension and does not live in a state veterans' home; or

(C) Forty-one dollars and sixty-two cents for all other persons in a medical facility.

(ii) Federal, state, or local income taxes:

(A) Mandatorily withheld from earned or unearned income for income tax purposes before receipt by the person; or

(B) Not covered by withholding, but are owed, become an obligation, or have been paid by the person during the time period covered by the PNA.

(iii) Wages for a person who:

(A) Is SSI-related; and

(B) Receives the wages as part of a department-approved training or rehabilitative program designed to prepare the person for a less restrictive placement. When determining this deduction employment expenses are not deducted.

(iv) Guardianship fees and administrative costs including any attorney fees paid by the guardian, after June 15, 1998, only as allowed by chapter 388-79 WAC.

(b) Income garnisheed for child support:

(i) For the time period covered by the PNA; and

(ii) Not deducted under another provision in the post-eligibility process.

(c) A monthly needs allowance for the community spouse not to exceed, effective January 1, 1999, two thousand forty-nine dollars, unless a greater amount is allocated as described in subsection (4) of this section. The monthly needs allowance:

(i) Consists of a combined total of both:

(A) An amount added to the community spouse's gross income to provide a total of one thousand three hundred fifty-eight dollars; and

(B) Excess shelter expenses as specified under subsection (3) of this section; and

(ii) Is allowed only to the extent the person's income is made available to the community spouse.

(d) A monthly maintenance needs amount for each dependent or minor child, dependent parent or dependent sibling:

(i) Residing with the community spouse, equal to one-third of the amount that one thousand three hundred fifty-seven dollars exceeds the family member's income. Child support received from an absent parent is the child's income.

(ii) Not residing with the community spouse, equal to the MNIL for the number of family members in the home less the income of the family members.

(e) Incurred medical expenses described in subsections (1)(a) and (b) not used to reduce excess resources.

(f) Maintenance of the home of a single person or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the person is likely to return to the home within the six-month period; and

(iv) When social service staff documents initial need for the income exemption and reviews the person's circumstances after ninety days.

(3) For the purposes of this section, "excess shelter expenses" equal the actual expenses under subsection (3)(a) less the standard shelter allocation under subsection (3)(b):

(a) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:

(i) Rent;

(ii) Mortgage;

(iii) Taxes and insurance;

(iv) Any maintenance care for a condominium or cooperative; and

(v) The food stamp standard utility allowance, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(b) The standard shelter allocation is four hundred seven dollars, effective April 1, 1998.

(4) The amount allocated to the community spouse may be greater than the amount in subsection (2)(c) only when:

(a) A court enters an order against the person for the support of the community spouse; or

(b) A hearing officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(5) A person receiving SSI shall continue to receive total payment under 1611 (b)(1) of the Social Security Act for the first three full calendar months of institutionalization in a public or Medicaid-approved medical institution or facility when the:

(a) Stay in the institution or facility is not expected to exceed three months; and

(b) The person plans to return to former living arrangements.

[Statutory Authority: RCW 72.36.160, 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924(g) of the Social Security Act, Section 4715 of the BBA of 1997 (Public Law 105-33, HR 2015), 99-11-017, § 388-513-1380, filed 5/10/99, effective 6/10/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 43.20B.460, 11.92.180, and Section 1924 (42 USC 396r-5), 98-08-077, § 388-513-1380, filed 3/31/98, effective 4/1/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(1)(m), 97-16-008, § 388-513-1380, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1380, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090, 95-11-045 (Order 3848), § 388-513-1380, filed 5/10/95, effective 6/10/95. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level, 95-05-022 (Order 3832), § 388-513-1380, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1380, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-360.]

WAC 388-513-1395 Determining eligibility for institutional or hospice services and for facility care only under the medically needy (MN) program. This section describes how the department determines a client's eligibility for institutional or hospice services and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for noninstitutional medical assistance under the MN program.

(1) To be eligible for institutional or hospice services under the MN program, a client must meet the financial requirements described in subsection (5)(a). In addition, a client must meet program requirements described in WAC 388-513-1315; and

(a) Be an SSI-related client with nonexcluded income as described in subsection (4)(a) that is more than the special income level (SIL); or

(b) Be a child not described in subsection (1)(a) with nonexcluded income as described in subsection (4)(b) that exceeds the categorically needy (CN) standard for the children's medical program.

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total is less than the:

(a) Private facility rate plus the amount of recurring medical expenses, for institutional services; or

(b) Private hospice rate plus the amount of recurring medical expenses, for hospice services received at home.

(3) The department determines a client's nonexcluded resources for institutional and hospice services under the MN program in the following way:

(a) For an SSI-related client, the department reduces available resources described in WAC 388-513-1350 by excluding resources described in WAC 388-513-1360;

(b) For a child not described in subsection (3)(a), no determination of resource eligibility is required.

(4) The department determines a client's nonexcluded income for institutional and hospice services under the MN program in the following way:

(a) For an SSI-related client, the department reduces available income as described in WAC 388-513-1325 and 388-513-1330 by:

- (i) Excluding income described in WAC 388-513-1340;
- (ii) Disregarding income described in WAC 388-513-1345; and
- (iii) Subtracting previously incurred medical expenses that:

- (A) Are not subject to third-party payment;
- (B) Have not been used to satisfy a previous spenddown liability; and

(C) Are amounts for which the client remains liable.

(b) For a child not described in subsection (4)(a), the department:

- (i) Follows the income rules described in WAC 388-505-0210 for the children's medical program; and
- (ii) Subtracts the medical expenses described in subsection (4)(a)(iii).

(5) If the combined total of a client's nonexcluded income, which when added to nonexcluded resources in excess of the standard described in WAC 388-513-1350(1), is:

(a) Less than the department-contracted rate plus the amount of recurring medical expenses, the client:

- (i) Is eligible for institutional and hospice services and noninstitutional medical assistance;
- (ii) Is approved for a choice of three or six months as described in chapter 388-416 WAC; and
- (iii) Participates in the cost of care as described in WAC 388-513-1380;

(b) Less than the private facility rate plus the amount of recurring medical expenses, but more than the department-contracted rate, the client:

- (i) Is eligible for facility care only that is approved for a choice of three or six months as described in chapter 388-416 WAC;
- (ii) Participates in the cost of care as described in WAC 388-513-1380; and
- (iii) Is approved for noninstitutional medical assistance for a choice of three or six months as described in chapters 388-416 and 388-519 WAC, if income and resources remaining after allocations described in WAC 388-513-1380 are used to satisfy any spenddown liability.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1395, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1395, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-513-1395, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. 95-24-017 (Order 3921, #100267), § 388-513-1395, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1395, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-400.]

WAC 388-513-1396 Clients living in a fraternal, religious, or benevolent nursing facility. This section describes how the department determines eligibility for institutional services and noninstitutional medical assistance for a client living in a fraternal, religious, or benevolent nursing facility.

(1) For a client living in a licensed nursing facility operated by a fraternal, religious, or benevolent organization who meets all other eligibility requirements, the department

approves institutional services and noninstitutional medical assistance, if:

- (a) Any contract between the client and the facility excludes such benefits on a free or prepaid basis for life; or
- (b) The facility is unable to fulfill the terms of the contract and has:

- (i) Voided the contract; and
- (ii) Refunded any of the client's existing assets to the client.

(2) For a client described in subsection (1), the department denies institutional services and noninstitutional medical assistance, if the client:

- (a) Signs a contract with the organization that includes such benefits on a free or prepaid basis for life; and
- (b) Surrenders income and/or resources to the organization in exchange for such benefits.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1396, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1396, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-310.]

Chapter 388-515 WAC

ALTERNATE LIVING—INSTITUTIONAL MEDICAL

WAC

388-515-1505	Community options program entry system (COPES).
388-515-1510	Community alternatives program (CAP) and outward bound residential alternatives (OBRA).
388-515-1530	Coordinated community AIDS services alternatives (CASA) program.

WAC 388-515-1505 Community options program entry system (COPES). This section describes the financial eligibility requirements for waived services under the COPES program and the rules used to determine a client's participation in the cost of care.

(1) The department establishes eligibility for COPES for a client who:

- (a) Is eighteen years of age or older;
- (b) Meets the disability criteria of the Supplemental Security Income (SSI) program as described in WAC 388-503-0501(1);
- (c) Requires the level of care provided in a nursing facility;

(d) Is in a medical facility, or will likely be placed in one within the next thirty days in the absence of waived services described in WAC 388-15-620;

(e) Has attained institutional status as described in WAC 388-513-1320;

(f) Has been determined to be in need of waived services and is approved for a plan of care as described in WAC 388-15-610;

(g) Is able to live at home with community support services and chooses to do so, or in a department-contracted:

- (i) Adult residential care (ARC) facility;
- (ii) Enhanced adult residential care (EARC) facility;
- (iii) Licensed adult family home (AFH); or
- (iv) Assisted living (AL) facility.

(h) Is not subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1365 and 388-513-1366; and

(i) Meets the income and resource requirements described in subsection (2).

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the special income level (SIL). Refer to WAC 388-513-1315 for rules used to determine nonexcluded income and resources. During other months, financial requirements include the following:

(a) Nonexcluded income must be at or below the SIL; and

(b) Nonexcluded resources not allocated to participation in a prior month must be at or below the resource standard.

(3) A client who is eligible for SSI does not participate SSI income in the cost of care. Such a client who is:

(a) Living at home, retains a maintenance needs amount as described in subsection (5); or

(b) Living in an ARC, EARC, AFH, or AL:

(i) Retains a personal needs allowance (PNA) of fifty-eight dollars and eighty-four cents; and

(ii) Pays remaining SSI income to the facility for the cost of board and room.

(4) A client who is eligible for the general assistance expedited Medicaid disability (GAX) program does not participate in the cost of care. Such a client who is:

(a) Living at home, retains a maintenance needs amount as described in subsection (5); or

(b) Living in an ARC, EARC, AFH, or AL:

(i) Retains a PNA of thirty-eight dollars and eighty-four cents; and

(ii) Pays remaining income and GAX grant to the facility for the cost of board and room.

(5) An SSI-related client living at home retains a maintenance needs amount equal to the following:

(a) Up to one hundred percent of the one-person Federal Poverty Level (FPL), if the client is:

(i) Single; or

(ii) Married, and is:

(A) Not living with the community spouse; or

(B) Whose spouse is receiving long-term care (LTC) services outside of the home.

(b) Up to one hundred percent of the one-person FPL for each client, if both are receiving COPEs services;

(c) Up to the one-person medically needy income level (MNIL) for a married client who is living with a community spouse who is not receiving COPEs.

(6) An SSI-related client living in an ARC, EARC, AFH, or AL receives a maintenance needs amount equal to the one-person MNIL and:

(a) Retains a PNA taken from the MNIL of fifty-eight dollars and eighty-four cents; and

(b) Pays the remainder of the MNIL to the facility for the cost of board and room.

(7) The client's income that remains:

(a) After allocations described in subsection (5) or (6) is allocated as described in WAC 388-513-1380 (1), (2)(b) through (e), (3) and (4); and

(b) After allocations described in subsection (7)(a) is the client's participation in the cost of care.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-515-1505, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-14-058 (Order 100346), § 388-515-1505, filed 6/27/96, effective 7/28/96; 95-20-030 (Order 3899), § 388-515-1505, filed 9/27/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-515-1505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-200.]

WAC 388-515-1510 Community alternatives program (CAP) and outward bound residential alternatives (OBRA). This section describes the eligibility requirements for waived services under the CAP and OBRA programs and the rules used to determine a client's participation in the cost of care.

(1) The department establishes eligibility for CAP and OBRA services for a client who:

(a) Is both Medicaid eligible under the categorically needy (CN) program and meets the requirements for services provided by the division of developmental disabilities (DDD);

(b) Has attained institutional status as described in WAC 388-513-1320;

(c) Has been assessed as requiring the level of care provided in an intermediate care facility for the mentally retarded (IMR);

(d) Has a department-approved plan of care that includes support services to be provided in the community;

(e) Is able to reside in the community according to the plan of care and chooses to do so;

(f) Meets the income and resource requirements described in subsection (2); and

(g) For the OBRA program only, the client must be a medical facility resident at the time of application.

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the special income level (SIL). Refer to WAC 388-513-1315 for rules used to determine nonexcluded income and resources. During other months, financial requirements include the following:

(a) Nonexcluded income must be at or below the SIL; and

(b) Nonexcluded resources not allocated to participation in a prior month must be at or below the resource standard.

(3) A client who is eligible for supplemental security income (SSI) does not participate in the cost of care for CAP or OBRA services.

(4) An SSI-related client retains a maintenance needs amount of up to the SIL, who is:

(a) Living at home; or

(b) Living in an alternate living facility described in WAC 388-513-1305(1).

(5) A client described in subsection (4)(b) retains the greater of:

- (a) The SSI grant standard; or
- (b) An amount equal to a total of the following:
 - (i) A personal needs allowance (PNA) of thirty-eight dollars and eighty-four cents; plus
 - (ii) The facility's monthly rate for board and room, which the client pays to the facility; plus
 - (iii) The first twenty dollars of monthly earned or unearned income; and
 - (iv) The first sixty-five dollars plus one-half of the remaining earned income not previously excluded.

(6) If a client has a spouse in the home who is not receiving CAP or OBRA services, the department allocates the client's income in excess of the amounts described in subsections (4) and (5) as an additional maintenance needs amount in the following order:

- (a) One for the spouse, as described in WAC 388-513-1380 (2)(c); and
- (b) One for any other dependent family member in the home, as described in WAC 388-513-1380 (2)(d).

(7) A client's participation in the cost of care for CAP or OBRA services is the client's income:

- (a) That exceeds the amounts described in subsections (4), (5), and (6); and
- (b) Remains after deductions for medical expenses not subject to third-party payment for which the client remains liable, included in the following:
 - (i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
 - (ii) Necessary medical care recognized under state law but not covered by Medicaid.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-515-1510, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-515-1510, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-515-1510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-210.]

WAC 388-515-1530 Coordinated community AIDS services alternatives (CASA) program. This section describes the eligibility requirements for waived services under the CASA program and the rules used to determine a client's participation in the cost of care.

(1) The department establishes eligibility for CASA services for a client who:

- (a) Meets the disability criteria of the supplemental security income (SSI) program as described in WAC 388-503-0510(1);
- (b) Has attained institutional status as described in WAC 388-513-1320;
- (c) Has been diagnosed with:
 - (i) Acquired Immune Deficiency Syndrome (AIDS) or disabling Class IV human immunodeficiency virus disease; or
 - (ii) P2 HIV/AIDS, if fourteen years old or younger;
- (d) Has been certified by the client's physician or nurse practitioner to be in the terminal state of life;

(e) Has been assessed as being medically at risk for needing inpatient care;

(f) Has a plan of care approved by the department and the department of health (DOH);

(g) Does not have private insurance, including a COBRA extension, that covers inpatient hospital care;

(h) Is able to live at home or in an alternate living facility (ALF) described in WAC 388-513-1305(1) and chooses to do so; and

(i) Meets the income and resource requirements described in subsection (2).

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or an eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the special income level (SIL). Refer to WAC 388-513-1315 for rules used to determine nonexcluded income and resources. During other months, financial requirements include the following:

- (a) Nonexcluded income must be at or below the SIL; and
- (b) Nonexcluded resources not allocated to participation in a prior month must be at or below the resource standard.

(3) A client who is eligible for SSI does not participate in the cost of care for CASA services.

(4) An SSI-related client retains a maintenance needs amount, if:

- (a) Living at home, of up to the SIL; or
- (b) Living in an ALF described in WAC 388-513-1305(1), of thirty-eight dollars and eighty-four cents.

(5) The income of a client described in subsections (4)(a) or (b) that exceeds the maintenance needs amount is allocated as described in WAC 388-513-1380 (1), (2)(b) through (e), (3), and (4).

(6) The income of a client described in subsection (4)(b) that exceeds the maintenance needs amount and the amount described in subsection (5) is paid to the facility for the cost of board and room up to an amount that is equal to the difference between the:

- (a) Amount of the SIL; and
- (b) The combined total of amounts described in subsections (4)(b) and (5).

(7) A client's participation in the cost of care for CASA services is the amount of income that remains after allocations described in subsections (4), (5), and (6).

(8) The client must meet any participation obligation, in order to remain eligible.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-515-1530, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-515-1530, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 95-18-001 (Order 3882), § 388-515-1530, filed 8/23/95, effective 9/23/95; 94-10-065 (Order 3732), § 388-515-1530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-220.]

Chapter 388-527 WAC
ESTATE RECOVERY

WAC

388-527-2700	Purpose.
388-527-2730	Estate recovery definitions.
388-527-2733	No liability for medical care.
388-527-2735	Repealed.
388-527-2737	Deferring recovery.
388-527-2740	Age when recovery applies.
388-527-2742	Services subject to recovery.
388-527-2750	Waiver of recovery if undue hardship.
388-527-2752	Repealed.
388-527-2753	Repealed.
388-527-2754	Assets not subject to recovery and other limits on recovery.
388-527-2790	Filing a lien against real property.
388-527-2795	Serving notices on office of financial recovery (OFR).

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

388-527-2735	Liability for medical care. [Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2735, filed 9/6/95, effective 10/7/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.
388-527-2752	Deferring recovery. [Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2752, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.
388-527-2753	No liability for medical care. [Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2753, filed 9/6/95, effective 10/7/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.

WAC 388-527-2700 Purpose. The department will recover from the estate of a deceased client, the cost of medical care correctly paid on the client's behalf by the department as described by this chapter.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2700, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2730 Estate recovery definitions. For estate recovery purposes:

"Estate" means all real and personal property and any other assets that pass upon the client's death under the client's will or by intestate succession pursuant to chapter 11.04 RCW or under chapter 11.62 RCW. An estate also includes:

(1) For a client who died after June 30, 1995 and before July 27, 1997, nonprobate assets as defined by RCW 11.02.005, except property passing through a community property agreement; or

(2) For a client who died after July 26, 1997, nonprobate assets as defined by RCW 11.02.005.

The value of the estate shall be reduced by any valid liability against the deceased client's property at the time of death.

"Long-term care services" means the services administered directly or through contract by the aging and adult services administration of the department, including but not limited to nursing facility care and home and community services.

"State-funded long-term care" means the long-term care services that are paid only with state funds.

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"Medical assistance" means the federal aid medical care program provided under Title XIX of the Federal Social Security Act.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2730, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2730, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2733 No liability for medical care. (1) The client's estate is not liable for services provided before July 26, 1987.

(2) The client's estate is not liable when the client died before July 1, 1994 and on the date of death there was:

- (a) A surviving spouse; or
- (b) A surviving child who was either:
 - (i) Under twenty-one years of age; or
 - (ii) Blind or disabled as defined under chapter 388-511 WAC.

(3) The estate of a frail elder or vulnerable adult under RCW 74.34.010 is not liable for the cost of adult protective services (APS) paid for only by state funds.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2733, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2735 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-527-2737 Deferring recovery. When a client died after June 30, 1994 and received services after June 30, 1994, recovery from the estate is deferred until:

- (1) The death of the surviving spouse, if any; and
- (2) There is no surviving child who is:
 - (a) Under twenty-one years of age, or
 - (b) Blind or disabled as defined under chapter 388-511 WAC.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2737, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2740 Age when recovery applies. The client's age and the date when services were received determines whether the client's estate is liable for the cost of medical care provided. Subsection (1) of this section covers liability for medical assistance and subsection (2) covers liability for state-funded long-term care services. An estate may be liable under both subsections.

(1) For a client who on July 1, 1994 was:

(a) Age sixty-five or older, the client's estate is liable for medical assistance that was subject to recovery and which was provided on and after the date the client became age sixty-five or after July 26, 1987, whichever is later;

(b) Age fifty-five through sixty-four years of age, the client's estate is liable for medical assistance that was subject to recovery and which was provided on and after July 1, 1994; or

(c) Under age fifty-five, the client's estate is liable for medical assistance subject to recovery provided on and after the date the client became age fifty-five.

(2) The client's estate is liable for state-funded long-term care services provided on and after July 1, 1995 regardless of the client's age when the services were provided.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2740, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2740, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2742 Services subject to recovery. The medical services the client received and the dates when services were provided determines whether the client's estate is liable for the medical care provided. Subsection (1) of this section covers liability for medical assistance and subsection (2) covers liability for state-funded long-term care services. An estate can be liable under both subsections.

(1) The client's estate is liable for:

(a) All medical assistance services provided from July 26, 1987 through June 30, 1994;

(b) The following medical assistance services provided after June 30, 1994 and before July 1, 1995:

(i) Nursing facility services;

(ii) Home and community-based services; and

(iii) Hospital and prescription drug services provided to a client while receiving nursing facility services or home and community-based services.

(c) The following medical assistance services provided after June 30, 1995:

(i) Nursing facility services;

(ii) Home and community-based services;

(iii) Adult day health;

(iv) Medicaid personal care;

(v) Private duty nursing administered by the aging and adult services administration of the department; and

(vi) Hospital and prescription drug services provided to a client while receiving services described under (c)(i), (ii), (iii), (iv), or (v) of this subsection.

(2) The client's estate is liable for all state-funded long-term care services and related hospital and prescription drug services provided after June 30, 1995.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2742, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2742, filed 9/6/95, effective 10/7/95.]

WAC 388-527-2750 Waiver of recovery if undue hardship. Recovery is waived under this section when recovery would cause an undue hardship, except as provided in subsection (3) of this section. This waiver is limited to the period during which undue hardship exists.

(1) Undue hardship exists when:

(a) The estate subject to adjustment or recovery is the sole income-producing asset of one or more of the heirs and income is limited; or

(b) Recovery would result in the impoverishment of one or more of the heirs; or

(c) Recovery would deprive an heir of shelter and the heir lacks the financial means to obtain and maintain alternative shelter.

(2) Undue hardship does not exist when:

(a) The adjustment or recovery of the client's cost of assistance would merely cause the client's family members inconvenience or restrict the family's lifestyle.

(b) The heir divests assets to qualify under the undue hardship provision.

(3) When a deceased client's assets were disregarded in connection with a long-term care insurance policy or contract under chapter 48.85 RCW, recovery is not waived.

(4) When a waiver is not granted, the department will provide notice to the person who requested the waiver. The denial of a waiver must state:

(a) The requirements of an application for an adjudicative proceeding to contest the department's decision to deny the waiver; and

(b) Where assistance may be obtained to make such application.

(5) A person may contest the department's decision in an adjudicative proceeding when that person requested the department waive recovery, and suffered a loss because that request was not granted.

(6) An application for an adjudicative proceeding under this section must:

(a) Be in writing;

(b) State the basis for contesting the department's denial of the request to waive recovery;

(c) Include a copy of the department's denial of the request to waive recovery;

(d) Be signed by the applicant and include the applicant's address and telephone number;

(e) Be served within twenty-eight days of the date the applicant received the department's decision denying the request for a waiver. If the applicant shows good cause, the application may be filed up to thirty days late; and

(f) Be served on the office of financial recovery (OFR) as described in WAC 388-527-2795.

(7) An adjudicative proceeding held under this section shall be governed by chapters 34.05 RCW and 388-08 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-08 WAC, the provision in this section governs.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2750, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2750, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2752 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-527-2753 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-527-2754 Assets not subject to recovery and other limits on recovery. (1) Recovery does not apply to the first fifty thousand dollars of the estate value at the time of death and is limited to thirty-five percent of the remaining value of the estate for services the client:

(a) Received before July 25, 1993; and

(b) When the client died with:

(i) No surviving spouse;

- (ii) No surviving child who is:
 - (A) Under twenty-one years of age;
 - (B) Blind; or
 - (C) Disabled.

(iii) A surviving child who is twenty-one years of age or older.

(2) For services received after July 24, 1993, all services recoverable under WAC 388-527-2742 will be recovered, even from the first fifty thousand dollars of estate value that is exempt above, except as set forth in subsection (3) of this section.

(3) For a client who received services after July 24, 1993 and before July 1, 1994, the following property, up to a fair market value of two thousand dollars, is not recovered from the estate of the client:

- (a) Family heirlooms,
- (b) Collectibles,
- (c) Antiques,
- (d) Papers,
- (e) Jewelry,
- (f) Photos, and
- (g) Other personal effects of the deceased client and to which a surviving child is entitled.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2754, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2754, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2790 Filing a lien against real property. (1) Liens are filed, adjustment sought, and other recoveries effected by the department for medical assistance or state-funded long-term care, or both, correctly paid on behalf of a client consistent with 42 U.S.C. 1396p and chapters 43.20B RCW and 388-527 WAC.

(2) When the department seeks to recover from a client's estate the cost of medical assistance or state-funded long-term care, or both, provided to the client, prior to filing a lien against the deceased client's real property, notice shall be given to:

- (a) The probate estate's personal representative, if any; or
- (b) Any other person known to have title to the affected property.

(3) Prior to filing a lien against any of the deceased client's real property, a person known to have title to the property shall be notified and have an opportunity for an adjudicative proceeding as follows:

(a) Any person known to have title to the property shall be served with a notice of intent to file lien, which shall state:

(i) The deceased client's name, social security number, if known, date of birth, and date of death;

(ii) The amount of medical assistance, or state-funded long-term care, or both, correctly paid on behalf of the deceased client the department seeks to recover;

(iii) The department's intent to file a lien against the deceased client's real property to recover the medical assistance or state-funded long-term care, or both, correctly paid on behalf of the deceased client;

(iv) The county in which the real property is located; and

(v) The right of the person known to have title to the property to contest the department's decision to file a lien by applying for an adjudicative proceeding with the office of financial recovery (OFR).

(b) An adjudicative proceeding can determine whether:

(i) The amount of medical assistance or state-funded long-term care, or both, correctly paid on behalf of the deceased client alleged by the department's notice of intent to file a lien is correct; and

(ii) The deceased client had legal title to the real property at the time of the client's death.

(4) An application for an adjudicative proceeding must:

(a) Be in writing;

(b) State the basis for contesting the department's notice of intent to file the lien;

(c) Be signed by the applicant and state the applicant's address and telephone number;

(d) Be served on (OFR) within twenty-eight days of the date the applicant received the department's notice of intent to file the lien. An application filed up to thirty days late may be treated as timely filed if the applicant shows good cause for filing late; and

(e) Be served on OFR as described in WAC 388-527-2795.

(5) Persons known to have title to the property shall be notified of the time and place of the adjudicative proceeding by the department when it receives an application for the same.

(6) An adjudicative proceeding under this section shall be governed by chapters 34.05 RCW and 388-08 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-08 WAC, the provision in this section governs.

(7) If no known title holder requests an adjudicative proceeding, a lien shall be filed by the department twenty-eight days after the date that the notice of intent to file the lien letter was mailed. The lien will be filed against the deceased client's real property in the amount of the correctly paid medical assistance or state-funded long-term care, or both.

(8) If an adjudicative proceeding is conducted in accordance with this regulation, when the final agency decision is issued, the department will file a lien against the deceased client's real property for the amount of the correctly paid medical assistance or state-funded long-term care, or both, as established by that final agency decision.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2790, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2790, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2795 Serving notices on office of financial recovery (OFR). (1) Legal service must be by personal service or certified mail, return receipt requested, to OFR at the address described in this section.

(2) The mailing address of the office of financial recovery is:

Office of Financial Recovery
P.O. Box 9501
Olympia, WA 98507-9501.

(3) The physical location of the office of financial recovery is:

Blake Office Park
4450 10th Avenue Southeast
Lacey, Washington.

[Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2795, filed 5/18/99, effective 6/18/99.]

Chapter 388-530 WAC PHARMACY SERVICES

WAC

388-530-1800 Requirements for pharmacy claim payment.
388-530-2050 Reimbursement of out-of-state prescriptions.

WAC 388-530-1800 Requirements for pharmacy claim payment. (1) When billing for pharmacy services, providers must:

(a) Use the appropriate department claim form or electronic billing specifications; and

(b) Include the actual eleven-digit NDC number of the product dispensed.

(2) When billing drugs requiring authorization, providers must insert the authorization number in the appropriate data field on the drug claim.

(3) When billing drugs under the expedited authorization process, providers must insert the authorization number which includes the corresponding criteria code in the appropriate data field on the drug claim.

(4) Pharmacy services for clients on restriction under WAC 388-501-0135 must be prescribed by the client's primary care provider and are paid only to the client's primary pharmacy, except in cases of:

(a) Emergency;

(b) Family planning services; or

(c) Services properly referred from the client's assigned pharmacy or physician/ARNP.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-530-1800, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1800, filed 10/9/96, effective 11/9/96.]

WAC 388-530-2050 Reimbursement of out-of-state prescriptions. (1) The department reimburses out-of-state pharmacies for drugs provided to eligible MAA clients who are:

(a) Washington state residents; and

(b) Located temporarily outside the state subject to the provisions of WAC 388-501-0180.

(2) Border areas, as described under WAC 388-501-0175, are considered in-state and not subject to out-of-state rules. Pharmacies in border areas are eligible to apply to the department to be enrolled as providers of medical services in the state of Washington.

(3) Out-of-state pharmacies must meet the same criteria as in-state pharmacies.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-530-2050, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-2050, filed 10/9/96, effective 11/9/96.]

Chapter 388-535 WAC DENTAL-RELATED SERVICES

WAC

388-535-1000 Repealed.
388-535-1010 Dental-related program introduction.
388-535-1050 Dental-related definitions.
388-535-1060 Eligible dental-related clients.
388-535-1080 Covered dental-related services.
388-535-1100 Dental-related services not covered.
388-535-1150 Becoming a DSHS dental provider.
388-535-1200 Dental services requiring prior authorization.
388-535-1220 Obtaining prior authorization for dental services.
388-535-1230 Crowns.
388-535-1240 Dentures.
388-535-1250 Orthodontic coverage for DSHS children.
388-535-1260 Dental-related limits of state-only funded programs.
388-535-1300 Access to baby and child dentistry (ABCD) program.
388-535-1350 Dental-related services—Payment methodology.
388-535-1400 Dental payment limits.
388-535-1450 Denture laboratory services—Payment.
388-535-1500 Dental-related hospital services—Payment.
388-535-1550 Dental care provided out-of-state—Payment.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-535-1000 Dental-related services—Scope of coverage. [Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1000, filed 12/6/95, effective 1/6/96.] Repealed by 99-07-023, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225.

WAC 388-535-1000 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-535-1010 Dental-related program introduction. This chapter describes:

(1) The dental-related services that the medical assistance administration (MAA) offers to its eligible clients;

(2) Limitations to those services;

(3) Provider requirements, including prior authorizations; and

(4) MAA's methods for paying providers for dental-related services.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1010, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1050 Dental-related definitions. This section contains definitions of words and phrases in bold that the department uses in this chapter. See also chapter 388-500 WAC for other definitions and abbreviations. Further dental definitions used by the department may be found in the Current Dental Terminology (CDT-2) and the Current Procedural Terminology (CPT). Where there is any discrepancy between the CDT-2 or CPT and this section, this section prevails.

"Access to baby and child dentistry (ABCD)" is a demonstration project to increase access to dental services in targeted areas for Medicaid eligible infants, toddlers, and preschoolers up through the age of five. See WAC 388-535-1300 for specific information.

"Adult" means a client nineteen years of age or older.

"**Anterior**" means teeth in the front of the mouth. In relation to crowns, only these permanent teeth are considered anterior for laboratory processed crowns:

- (1) "**Lower anterior**," teeth twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven; and
- (2) "**Upper anterior**," teeth six, seven, eight, nine, ten, and eleven.

"**Arch**" means the curving structure formed by the crowns of the teeth in their normal position, or by the residual ridge after loss of the teeth.

"**Asymptomatic**" means having no symptoms.

"**Banding**" means the application of **orthodontic** brackets to the teeth for the purpose of correcting dentofacial abnormalities.

"**Base metal**" means dental alloy containing little or no precious metals.

"**Behavior management**" means managing the behavior of a client during treatment using the assistance of additional professional staff, and professionally accepted restraints or sedative agent, to protect the client from self-injury.

"**Bicuspid**" means teeth four, five, twelve, thirteen, twenty, twenty-one, twenty-eight, and twenty-nine.

"**By report**" - a method of payment for a covered service, supply, or equipment which:

- (1) Has no maximum allowable established by MAA,
- (2) Is a variation on a standard practice, or
- (3) Is rarely provided.

"**Caries**" means tooth decay.

"**Child**" means a client eighteen years of age or younger.

"**Cleft**" means an opening or fissure involving significant dental processes, especially one occurring in the embryo. These can be:

- (1) Cleft lip,
- (2) Cleft palate (at the roof of the mouth), or
- (3) Transverse facial cleft (macrostomia).

"**Comprehensive oral evaluation**" means a thorough evaluation and recording of the hard and soft tissues in and around the mouth, including the evaluation and recording of the patient's dental and medical history and a general health assessment.

"**Corona**" is the portion of a tooth that is covered by **enamel**, and is separated from the root or roots by a slightly constricted region, known as the cemento-**enamel** junction.

"**Craniofacial anomalies**" means abnormalities of the head and face, either congenital or acquired, involving significant dental processes.

"**Craniofacial team**" means a department of health and MAA recognized cleft palate/maxillofacial team which is: Responsible for management (review, evaluation, and approval) of patients with cleft palate craniofacial anomalies to provide integrated case management, promote parent-professional partnership, making appropriate referrals to implement and coordinate treatment plans.

"**Current dental terminology (CDT), second edition (CDT-2)**," a systematic listing of descriptive terms and identifying codes for reporting dental services and procedures

performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

"**Current procedural terminology (CPT)**," means a description of medical procedures and is available from the American Medical Association of Chicago, Illinois.

"**Dental general anesthesia**" means the use of agents to induce loss of feeling or sensation, a controlled state of unconsciousness, in order to allow dental services to be rendered to the client.

"**Dentally necessary**" means diagnostic, preventive, or corrective services that are accepted dental procedures appropriate for the age and development of the client to prevent the incidence or worsening of conditions that endanger teeth or periodontium (tissues around the teeth) or cause significant malfunction or impede reasonable development or homeostatis (health) in the stomatognathic (mouth and jaw) system:

- (1) Which may include simple observation with no treatment, if appropriate; and
- (2) Includes use of less costly, equally effective services.

"**Dentin**" is the mineralized tissue of the teeth, which surrounds the tooth pulp and is covered by **enamel** on the crown and by cementum on the roots of the teeth.

"**Dentures**" are a set of prosthetic artificial teeth. See WAC 388-535-1240 for specific information.

"**Dysplasia**" means an abnormality in the development of the teeth.

"**Enamel**" is the white, compact, and very hard substance that covers and protects the dentin of the crown of a tooth.

"**Endodontic**" means a root canal treatment and related follow-up.

"**EPSDT/healthy kids**" means the department's early periodic screening, diagnosis, and treatment program for clients twenty years of age and younger as described in WAC 388-86-027.

"**Fluoride varnish**" means a substance containing dental fluoride, for painting onto teeth. When painted onto teeth, it sticks to tooth surfaces.

"**Gingiva**" means the gums.

"**Hemifacial microsomia**" means half or part of the face is smaller-sized.

"**High noble metal**" means dental alloy containing at least sixty percent pure gold.

"**High risk child**" means any **child** who has been identified through an oral evaluation or assessment as being at a high risk for developing dental disease because of **caries** in the **child's** dentin; or a **child** identified by the department as developmentally disabled.

"**Hypoplasia**" means the incomplete or defective development of the **enamel** of the teeth.

"**Low risk child**" means any **child** who has been identified through an oral evaluation or assessment as being at a low risk for dental disease because of the absence of white spots or **caries** in the **enamel** or **dentin**. This category includes **children** with restorations who are otherwise without disease.

"Major bone grafts" means a transplant of solid bone tissue(s), such as buttons or plugs.

"Malocclusion" means the contact between the upper and lower teeth that interferes with the highest efficiency during the movements of the jaw that are essential to chewing. The abnormality is categorized into four classes, graded by Angle's classification. For coverage, see WAC 388-535-1250.

"Maxillofacial" means relating to the jaws and face.

"Minor bone grafts" means a transplant of nonsolid bone tissue(s), such as powdered bone.

"Moderate risk child" means a **child** who has been identified through an **oral evaluation or assessment** as being at a moderate risk for dental disease, based on presence of white spots, **enamel caries** or **hypoplasia**.

"Molars" means:

(1) Permanent teeth one, two, three, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, thirty, thirty-one, and thirty-two; and

(2) Primary teeth A, B, I, J, K, L, S and T.

"Noble metal" means a dental alloy containing at least twenty-five percent but less than sixty percent pure gold.

"Occlusion" means the relation of the upper and lower teeth when in functional contact during jaw movement.

"Oral evaluation" is a comprehensive oral health and developmental history; an assessment of physical and oral health development and nutritional status; and health education, including anticipatory guidance.

"Oral health assessment or screening" means a screening of the hard and soft tissues in the mouth.

"Oral health status" refers to the client's risk or susceptibility to dental disease at the time an oral evaluation is done by a dental practitioner. This risk is designated as low, moderate or high based on the presence or absence of certain indicators.

"Orthodontic" is a treatment involving the use of any appliance, in or out of the mouth, removable or fixed, or any surgical procedure designed to redirect teeth and surrounding tissues.

"Partials" means a prosthetic appliance replacing one or more missing teeth in one jaw, and receiving its support and retention from both the underlying tissues and some or all of the remaining teeth. See WAC 388-535-1240 for specific information.

"Posterior" means teeth and tissue towards the back of the mouth. Specifically, only these permanent teeth: One, two, three, four, five, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, thirty-one, and thirty-two.

"Prophylaxis" means intervention which includes the **scaling** and **polishing** of teeth to remove **coronal** plaque, calculus, and stains.

"Reline" means to resurface the tissue side of a denture with new base material in order to achieve a more accurate fit.

"Root planing" is a procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased

cementum or **dentin** from the teeth's root surfaces and pockets.

"Scaling" means the removal of calculus material from the exposed tooth surfaces and that part of the teeth covered by the marginal gingiva.

"Sealant" is a material applied to teeth to prevent dental caries.

"Sequestrectomy" means removal of dead or dying bone that has separated from healthy bone.

"Therapeutic pulpotomy" means the surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

"Usual and customary" means the fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill MAA.

"Wisdom teeth" means teeth one, sixteen, seventeen, and thirty-two.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1050, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1050, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1060 Eligible dental-related clients.

(1) Subject to the specific limitations described in WAC 388-535-1080, Covered services, clients of the following MAA programs are eligible for the dental-related services described in this chapter:

(a) Categorically needy (CN or CNP), including:

- (i) Children's health; and
 - (ii) Pregnant undocumented aliens.
- (b) Medically needy (MN).

(2) Clients with the following state-only funded eligibility programs receive the coverage described in WAC 388-535-1260:

(a) General assistance unemployable (GAU); and

(b) Alcohol and drug abuse treatment and support act (ADATSA).

(3) Clients of the medically indigent (MI) program are limited to emergency hospital-based services only.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1060, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1080 Covered dental-related services.

(1) MAA pays only for covered dental and dental-related services, equipment, and supplies listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) **Dentally necessary**;

(c) Within accepted dental or medical practice standards and are:

(i) Consistent with a diagnosis of dental disease or condition; and

(ii) Reasonable in amount and duration of care, treatment, or service.

(2) The following dental-related services are covered:

(a) Oral health evaluations and assessments.

(i) Oral health evaluations no more than once every six months.

(ii) The evaluation services must be documented in the client's dental file.

(iii) These evaluations must include:

(A) A comprehensive oral health and developmental history;

(B) An assessment of physical and oral health development status;

(C) Health education, including anticipatory guidance; and

(D) **Oral health status.**

(b) Dentally necessary services for the identification of dental problems or the prevention of dental disease subject to limitations of this chapter;

(c) Prophylaxis treatment is allowed:

(i) Once every twelve months for **adults** including nursing facility clients.

(ii) Once every six months for **children.**

(iii) Three times a calendar year for clients of the division of developmental disabilities.

(d) Dental services or treatment necessary for the relief of pain and infections, including removal of symptomatic **wisdom teeth.** Routine removal of **asymptomatic wisdom teeth** without justifiable medical indications is not covered;

(e) Restoration of teeth and maintenance of dental health subject to limitations of WAC 388-535-1100, Dental services not covered;

(f) Complex **orthodontic** treatment for severe handicapping dental needs as specified in WAC 388-535-1250, Orthodontic coverage for DSHS clients;

(g) Complete and partial dentures, and necessary modifications, repairs, rebasing, **relining** and adjustments of dentures subject to the limitations of WAC 388-535-1240, Dentures;

(h) **Dentally necessary** oral surgery when coordinated with the client's managed care plan (if any);

(i) **Endodontic** (root canal) therapies for permanent teeth except for **wisdom teeth**;

(j) Nitrous oxide only when medically justified and a component of **behavior management**;

(k) Crowns as described in WAC 388-535-1230, Crowns;

(l) **Therapeutic pulpotomies**, once per tooth; and

(m) Sealants for:

(i) Occlusal surfaces of only these:

(A) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty and thirty-one; and

(B) Primary teeth A, B, I, J, K, L, S and T.

(ii) Lingual pits of teeth seven and ten;

(iii) Teeth with no decay;

(iv) **Children** only; and

(v) Once per tooth in a three-year period.

(3) For clients identified by the department as developmentally disabled, the following preventive services may be allowed more frequently than the limits listed in (3) of this section:

(a) **Fluoride** application, **varnish** or gel;

(b) **Root planing**; and

(c) **Prophylaxis scaling** and **coronal** polishing.

(4) Panoramic radiographs are allowed only for oral surgical or **orthodontic** purposes.

(5) The department covers **dentally necessary** services provided in a hospital under the direction of a physician or dentist for:

(a) The care or treatment of teeth, jaws, or structures directly supporting the teeth if the procedure requires hospitalization; and

(b) Short stays when the procedure cannot be done in an office setting. See WAC 388-550-1100(4), Hospital coverage.

(6) For clients residing in nursing facilities or group homes:

(a) Dental services must be requested by the client or a referral for services made by the attending physician, facility nursing supervisor, or the client's legal guardian;

(b) Mass screening for dental services of clients residing in a facility is not permitted; and

(c) Nursing facilities must provide dental-related necessary services per WAC 388-97-225, Nursing facility care.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1080, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1100 Dental-related services not covered. (1) Dental-related services described in subsection (2) of this section are not covered unless:

(a) Required by a physician as a result of an **EPSDT/Healthy Kids** screen:

(i) Except that all of the orthodontic limitations of WAC 388-535-1250, Orthodontic coverage for DSHS clients, still apply; and

(ii) Such services must be **dentally necessary**

(b) Included in a waived program; or

(c) Part of one of the Medicare programs for qualified Medicare beneficiaries (QMB) except for QMB-only which is not covered.

(2) MAA does not cover:

(a) Services, procedures, treatment, devices, drugs, or application of associated services which MAA or the Health Care Financing Administration (HCFA) consider investigative or experimental on the date the services are provided;

(b) Cosmetic treatment or surgery, except for medically or **dentally necessary** reconstructive surgery to correct defects attributable to an accident, birth defect, or illness;

(c) Teeth whitening;

(d) **Orthodontic** care for **adults**;

(e) **Orthodontic** care for cosmetic reasons and for **children** who do not meet the criteria in WAC 388-535-1250, Orthodontic coverage for DSHS clients;

(f) Any service specifically excluded by statute;

(g) More costly services when less costly equally effective services as determined by the department are available;

(h) Nonmedical equipment, supplies, personal or comfort items and/or services;

(i) **Root planing** for **children** unless clients of the division of developmental disabilities;

(j) Root canal services for primary teeth;

(k) Routine fluoride treatments for **adults**, unless clients of the division of developmental disabilities;

(l) Extraction of **asymptomatic** teeth:

(i) Except as a necessary part of orthodontic treatment, or

(ii) Unless their removal is the most cost effective dental procedure related to dentures;

(m) Crowns for **wisdom teeth**; and

(n) Amalgam or acrylic build-up for **wisdom teeth**.

(3) MAA does not pay for the following services/supplies:

(a) Missed or canceled appointments;

(b) Provider mileage or travel costs;

(c) Take-home drugs;

(d) Dental supplies such as toothbrushes (manual, automatic, or electric), toothpaste, floss, or whiteners;

(e) Educational supplies;

(f) Reports, client charts, insurance forms, copying expenses;

(g) Service charges/delinquent payment fees;

(h) Dentist's time writing prescriptions or calling in prescriptions or prescription refills to a pharmacy;

(i) Supplies used in conjunction with an office visit;

(j) Transitional/immediate dentures;

(k) Teeth implants including follow up and maintenance;

(l) Bridges;

(m) Nonemergent oral surgery for **adults** performed in an inpatient setting;

(n) **Minor bone grafts**; or

(o) Temporary crowns.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1100, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1100, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1150 Becoming a DSHS dental provider. (1) The following providers are eligible for enrollment to provide and be paid for dental-related services to eligible clients:

(a) Persons currently licensed by the state of Washington to:

(i) Practice dentistry or specialties of dentistry;

(ii) Practice medicine and osteopathy for:

(A) Oral surgery procedures; or

(B) **Fluoride varnish** under **EPSDT/Healthy Kids**.

(iii) Practice as dental hygienists;

(iv) Provide denture services;

(v) Practice anesthesiology; or

(vi) Provide conscious sedation, when providing that service in dental offices for dental treatments and when certified by the department of health.

(b) Facilities which are:

(i) Hospitals currently licensed by the department of health;

(ii) Federally-qualified health centers;

(iii) Medicare-certified ambulatory surgical centers;

(iv) Medicare-certified rural health clinics; or

(v) Community health centers.

(c) Participating local health jurisdictions; and

(d) Border area or out-of-state providers of dental-related services qualified in their states to provide these services.

(2) Licensed providers participating in the MAA dental program may be paid only for those services that are within their scope of practice.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1150, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1150, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1200 Dental services requiring prior authorization. The following services require prior approval:

(1) Nonemergent inpatient hospital dental admissions as described under WAC 388-550-1100(1) Hospital coverage;

(2) **Orthodontic** treatment as described under WAC 388-535-1250;

(3) Dentures as described in WAC 388-535-1240;

(4) Crowns as described in WAC 388-535-1230; and

(5) Selected procedures identified by MAA, published in its current dental billing instructions, available from MAA at Olympia, Washington.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1200, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1200, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1220 Obtaining prior authorization for dental services. Authorization by MAA only indicates that the specific treatment is **dentally necessary**. Authorization for dental services does not guarantee payment.

(1) When requesting prior authorization, the dental provider must submit to MAA, in writing, sufficient objective clinical information to establish dental necessity including, but not limited to:

(a) Physiological description of the disease, injury, impairment, or other ailment;

(b) X-ray(s);

(c) Treatment plan;

(d) Study model, if requested; and

(e) Photographs, if requested.

(2) When the requested service meets the criteria in WAC 388-535-1080, Covered services, it will be authorized.

(3) A request for dental services will be denied when the requested service is:

(a) Not **dentally necessary**; or

(b) A service, procedure, treatment, device, drug, or application of associated service which MAA or the Health Care Financing Administration (HCFA) consider investigative or experimental on the date the service is provided.

(4) Second opinions and/or consultations may be required before the authorization of any elective procedure.

(5) Authorization is valid only if the client is eligible for the date of service.

(6) Miscellaneous or unspecified procedures may require prior authorization at MAA's discretion.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1220, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1230 Crowns. (1) The following crowns do not need authorization and are covered:

- (a) Stainless steel, and
- (b) Nonlaboratory resin for primary anterior teeth.

(2) The following crowns are limited to single restorations for permanent **anterior** (upper and lower) teeth and require prior authorization by MAA:

- (a) Porcelain fused to a **high noble metal**;
- (b) Porcelain fused to a predominately **base metal**;
- (c) Porcelain fused to a **noble metal**;
- (d) Porcelain with ceramic substrate;
- (e) Full cast **high noble metal**;
- (f) Full cast predominately **base metal**;
- (g) Full cast **noble metal**; and
- (h) Resin (laboratory).

(3) Criteria for crowns:

(a) Crowns may be authorized when the tooth meets the criteria of **dentally necessary**.

(b) Coverage is based upon a supportable five year prognosis that the client will retain the tooth if crowned. The provider must submit the following information:

- (i) The overall condition of the mouth;
- (ii) **Oral health status**;
- (iii) Patient maintenance of good oral health status;
- (iv) **Arch integrity**; and
- (v) Prognosis of remaining teeth (that is, no more involved than periodontal case type II).

(c) **Anterior** teeth must show traumatic or pathological destruction to loss of at least one incisal angle.

(4) The laboratory processed crowns described in subsection (2):

(a) Are covered only once per permanent tooth in a five year period;

(b) Are covered for **endodontically** treated **anterior** teeth only after satisfactory completion of the root canal therapy. Post-**endodontic** treatment X-rays must be submitted for prior authorization of these crowns; and

(c) Including tooth and soft tissue preparation, amalgam or acrylic build-ups, temporary restoration, cement base, insulating bases, impressions, and local anesthesia; and

(d) Are covered when a lesser service will not suffice because of extensive **coronal** destruction, and treatment is beyond **intracoronal** restoration.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1230, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1240 Dentures. (1) Initial dentures do not require prior authorization except as described in subsection (4).

(2) Partial dentures are covered under these limits:

(a) Cast base partials only when replacing three or more teeth per **arch** excluding **wisdom teeth**; and

(b) No partials are covered when they replace **wisdom teeth** only.

(3) Prior authorization for replacement dentures or partials is not required when:

(a) The client's existing dentures or partials are:

(i) No longer serviceable and cannot be **relined** or rebased;

(ii) Are lost; or

(iii) Are damaged beyond repair.

(b) The client's health would be adversely affected by absence of dentures;

(c) The client has been able to wear dentures successfully; and

(d) The denture meets the criteria of **dentally necessary**.

(4) Payment (which may be partial) for laboratory and professional fees for dentures and partials requires prior authorization when the client:

(a) Dies;

(b) Moves from the state;

(c) Cannot be located; or

(d) Does not participate in completing the dentures.

(5) The provider must document in the client's medical or dental record:

(a) Justification for replacement of dentures; and

(b) Charts of missing teeth, for replacement of partials.

(6) The impression date may be used as the service date for dentures including partials only when:

(a) Related dental services including laboratory services were provided during a client's eligible period; and

(b) The client is not eligible at the time of delivery.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1240, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1250 Orthodontic coverage for DSHS children. Complex **orthodontic** treatment for severe hand-capping dental needs is covered only for categorically needy children subject to the limits of this section.

(1) Prior authorization is not required for **cleft lip**, **cleft palate**, or **craniofacial anomalies** when the client is:

(a) Being treated by a department-recognized **cleft lip**, **cleft palate** or **craniofacial anomaly team**; and

(b) Eligible per WAC 388-535-1060.

(2) **Orthodontic** care must be prior authorized for children with severe **malocclusions**.

(3) A client must meet one of the following categories to be eligible for **orthodontic** care:

(a) A child with **clefths** (lip or palate) **craniofacial anomalies** and severe **malocclusions** when followed by an MAA-recognized cleft lip, cleft palate, or **craniofacial team** for:

(i) **Cleft lip** and palate, **cleft palate**, or **cleft lip** with alveolar process involvement;

(ii) **Craniofacial anomalies**, including but not limited to:

(A) Hemifacial microsomia;

(B) Craniosynostosis syndromes;

(C) Cleidocranial dysplasia;

(D) Arthrogyposis;

(E) Marfans syndrome; or

(F) Other syndromes by MAA review;

(iii) Other diseases/**dysplasia** with significant facial growth impact, e.g., juvenile rheumatoid arthritis (JRA); or
 (iv) Post traumatic, post radiation, or post burn jaw deformity.

(b) A child with severe **malocclusions** which include one or more of the following:

(i) A severe skeletal disharmony;
 (ii) A severe overjet resulting in functional impairment;
 (iii) A severe vertical overbite resulting in palatal impingement and/or damage to the mandibular labial tissues.

(c) A child with other dental malformations resulting in severe dental functional impairment. MAA reviews each of these cases for **dental necessity**.

(4) Interceptive **orthodontic** treatment is covered once per client's lifetime for clients with **clef**t palate, **craniofacial anomaly**, or severe **malocclusions**.

(5) Limited transitional **orthodontic** care is covered for a maximum of one year from original placement. Follow up treatment is allowed in three-month increments after the initial placement.

(6) Full **orthodontic** care is limited to a maximum of two years from original **banding**. Six follow up treatments are allowed in three month increments, beginning six months after original banding.

(7) Lost or broken **orthodontics** appliances are not covered.

(8) Orthodontic removal is covered for a client whose appliance was placed by a provider not participating with MAA, or whose payment was not covered by MAA.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1250, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1250, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1260 Dental-related limits of state-only funded programs. (1) Clients with the following state-funded only eligibility programs receive only the limited coverage described in this section:

(a) General assistance unemployable (GAU); and
 (b) Alcohol and drug abuse treatment and support act (ADATSA) (GAU-W).

(2) The dental services described and limited in this chapter are covered for clients eligible for GAU or GAU-W only when provided as part of a medical treatment for:

(a) Apical abscess verified by clinical examination, and treated by:

(i) Open and drain palliative treatment;
 (ii) Tooth extraction; or
 (iii) Root canal;
 (b) Radiation therapy for cancer of the mouth, only for a total dental extraction performed prior to and because of that radiation therapy;

(c) Tooth fractures (limited to extraction);
 (d) **Maxillofacial** fracture;
 (e) Systemic or presystemic cancer, only for oral hygiene related to those conditions;
 (f) Cysts or tumor therapies; or
 (g) Sequestrectomies.

(3) MAA may require prior authorization for any dental treatment provided to a GAU or GAU-W client.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1260, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1300 Access to baby and child dentistry (ABCD) program. (1) The access to baby and child dentistry (ABCD) program is a demonstration project established to increase access to dental services in targeted areas for Medicaid eligible infants, toddlers, and preschoolers.

(2) **Children** eligible for the **ABCD** program must be five years of age or younger and residing in targeted areas selected by MAA.

(3) MAA pays enhanced fees to **ABCD**-certified participating providers for the targeted services. The University of Washington continuing education program certifies dental providers for **ABCD** services.

(4) In addition to services provided under the MAA dental care program, the following services are provided:

(a) Family oral health education; and
 (b) Case management services.

(5) Clients who do not comply with program requirements may be disqualified from the **ABCD** program. The client remains eligible for regular MAA dental coverage.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1300, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1300, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1350 Dental-related services—Payment methodology. The department uses the dental services described in the Current Dental Terminology, 2nd edition (**CDT-2**), and the Current Procedure Terminology (**CPT**). The department uses state-assigned procedure codes to identify services not fully described in the **CDT-2** or **CPT** descriptions.

(1) For covered services provided to eligible clients, MAA pays dentists and related providers on a fee-for-service or contractual basis, subject to the exceptions and restrictions listed under WAC 388-535-1100, Dental services not covered, and WAC 388-535-1400, Dental payment limits.

(2) MAA may pay providers a higher reimbursement rate for selected dental services provided to **children** in order to increase **children's** access to dental services.

(3) Maximum allowable fees for dental services provided to **children** are set as follows:

(a) The department's historical reimbursement rates for various procedures are compared to usual and customary charges.

(b) The department consults with and seeks input from representatives of the provider community to identify program areas and concerns that need to be addressed.

(c) The department consults with dental experts and public health professionals to identify and prioritize dental services and procedures in terms of their effectiveness in improving or promoting **children's** dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for **children's** dental services are allocated to specific procedures based on this priority list and considerations of access to services.

(e) Larger percentage increases may be given to those procedures which have been identified as most effective in improving or promoting **children's** dental health.

(f) Budget-neutral rate adjustments are made as appropriate based on the department's evaluation of utilization trends, effectiveness of interventions, and access issues.

(4) **Dental general anesthesia** services for all eligible clients are reimbursed on the basis of base anesthesia units plus time. Payment for **dental general anesthesia** is calculated as follows:

(a) Dental procedures are assigned an anesthesia base unit of five;

(b) Twelve minutes constitute one unit of time. When a dental procedure requiring **dental general anesthesia** results in multiple time units and a remainder (less than twelve minutes), the remainder or fraction is considered as one time unit;

(c) Time units are added to the anesthesia base unit of five and multiplied by the anesthesia conversion factor;

(d) The formula for determining payment for **dental general anesthesia** is: (5.0 base anesthesia units + time units) x conversion factor = payment.

(5) Anesthesiologists may be paid for **general dental anesthesia** provided in dental offices. Only anesthesiologists specially contracted by MAA will be paid an additional fee for that service.

(6) Dental hygienists are paid at the same rate as dentists for services allowed under The Dental Hygienist Practice Act available from the department of health, Olympia, Washington.

(7) Licensed denturists or dental laboratories billing independently are paid at MAA's allowance for prosthetics (dentures and partials) services.

(8) Fee schedule changes are made whenever vendor rate increases or decreases are authorized by the legislature.

(9) The department may adjust maximum allowable fees to reflect changes in the services or procedure code descriptions.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1350, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1350, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1400 Dental payment limits. (1) Provision of covered dental services to an eligible client constitutes acceptance by the provider of the department's rules and fees.

(2) Participating providers must bill the department their usual and customary fees.

(3) Payment for dental services is based on the department's schedule of maximum allowances. Fees listed in the MAA fee schedule are the maximum allowable fees.

(4) Payment to the provider will be the lesser of the billed charge (**usual and customary fee**) or the department's maximum allowable fee.

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(5) If a covered service is performed for which no fee is listed, the service is paid "**by report**" on a case-by-case basis as determined by MAA

(6) If eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility.

The client is responsible for payment of any dental treatment or service received during any period of ineligibility with the exception described in WAC 388-535-1240(4) even if the treatment was started when the client was eligible.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1400, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1400, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1450 Denture laboratory services—Payment. A dentist using the services of an independent denture laboratory must bill MAA for the services of the laboratory.

No payment will be made to a dentist for services performed and billed by an independent denturist.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1450, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1450, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1500 Dental-related hospital services—Payment. MAA pays for dentally necessary hospital inpatient and outpatient services in accord with WAC 388-550-1100.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1500, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1500, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1550 Dental care provided out-of-state—Payment. (1) Clients, except those receiving medical care services (state-only funding), who are temporarily outside the state receive the same dental care services as clients in the state, subject to the same exceptions and limitations.

(2) Out-of-state dental care received by clients receiving medical care services (state-only funding) is not covered.

(3) Eligible clients in MAA-designated border areas may receive the same dental services as if provided in state.

(4) Dental providers who are out-of-state must meet the same criteria for payment as in-state providers, including the requirements to contract with MAA.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1550, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1550, filed 12/6/95, effective 1/6/96.]

Chapter 388-537 WAC SCHOOL SERVICES

WAC

388-537-0100

School medical services for students in special education programs.

WAC 388-537-0100 School medical services for students in special education programs. (1) The medical assistance administration (MAA) pays school districts or educational service districts (ESD) for qualifying medical services provided to an eligible student. To be covered under this section, the student must be eligible for Title XIX (i.e., either the categorically needy or medically needy programs).

(2) To qualify for payment under this section, the medical services must be provided:

(a) By the school district or the ESD; and

(b) To the eligible special education student as part of the student's individualized education program (IEP) or individualized family service plan (IFSP).

(3) To qualify for payment under this section, the medical services must be provided by one of the following service providers:

(a) A qualified Medicaid provider as described under WAC 388-87-005;

(b) A psychologist, licensed by the state of Washington or granted an educational staff associate (ESA) certificate by the state board of education;

(c) A school guidance counselor, or a school social worker, who has been granted an ESA certificate by the state board of education; or

(d) A person trained and supervised by any of the following:

(i) A licensed registered nurse;

(ii) A licensed physical therapist or physiatrist;

(iii) A licensed occupational therapist; or

(iv) A speech pathologist or audiologist who:

(A) Has been granted a certificate of clinical competence by the American speech, hearing, and language association;

(B) Is a person who completed the equivalent educational and work experience necessary for such a certificate; or

(C) Is a person who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(4) Student service recommendations and referrals must be updated at least annually.

(5) The student does not need a provider prescription to receive services described under this section.

(6) MAA pays for school-based medical services according to the department-established rate or the billed amount, whichever is lower.

(7) MAA does not pay individual school practitioners who provide school-based medical services.

(8) For medical services billed to Medicaid, school districts or ESD, must pursue third-party resources.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-537-0100, filed 12/14/99, effective 1/14/00.]

Chapter 388-540 WAC KIDNEY CENTERS

WAC

388-540-001	Purpose.
388-540-005	Definitions.
388-540-010	Services.
388-540-020	Reimbursement.
388-540-030	KDP eligibility requirements.
388-540-040	Transfer of resources without adequate consideration.
388-540-050	Fiscal information.

388-540-060 KDP eligibility determination.

WAC 388-540-001 Purpose. The department administers state funds to assist eligible clients with medical care costs associated with **end stage renal disease (ESRD)**.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-001, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-001, filed 7/28/93, effective 8/28/93.]

WAC 388-540-005 Definitions. The following definitions and those found in WAC 388-500-0005, Medical definitions, apply to this chapter. Defined words and phrases are bolded in the text.

"Adequate consideration" means that the reasonable value of goods or services received in exchange for transferred property approximates the reasonable value of the property transferred;

"Affiliate" means a facility, hospital, unit, business, or person having an agreement with a **kidney center** to provide specified services to **ESRD** patients;

"Application for kidney disease program (KDP) eligibility" means the form provided by MAA, which the client completes and submits to the contracted **kidney center** to determine **KDP** eligibility;

"Assets" means income, resources, or any real or personal property that a person or the person's spouse owns and could convert to cash to be used for support or maintenance;

"Certification" means the **kidney center** has determined a client eligible for the **KDP** for a defined period of time;

"End stage renal disease (ESRD)" means that stage of renal impairment which is irreversible and permanent, and requires dialysis or kidney transplantation to ameliorate uremic symptoms and maintain life;

"KDP application period" means the time between the date of application and **certification**;

"KDP client" means a resident of the state who has a diagnosis of **ESRD** and meets the financial and medical criteria to be determined eligible by a contracted **kidney center**;

"KDP contract manual" is a set of policies and procedures for contracting **kidney centers**;

"Kidney center" means a facility as defined and certified by the federal government to:

(1) Provide **ESRD** services;

(2) Provide the services specified in this chapter; and

(3) Promote and encourage home dialysis for a client when medically indicated;

"Kidney disease program (KDP)" is a public state program that helps eligible clients with the costs of **ESRD**-related medical care;

"Recertifying client" means a **KDP client** who was determined eligible the previous year for the **KDP** and will continue to qualify under this chapter;

"Substantial financial change" means:

(1) The elimination of a client's required annual deductible amount; or

(2) The increase or decrease of income or **assets** by five hundred dollars.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-005, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-005, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-005, filed 7/28/93, effective 8/28/93.]

WAC 388-540-010 Services. The **kidney center** must provide, directly or through an **affiliate**, all physical facilities, professional consultation, personal instructions, medical treatment and care, drug products, and all supplies necessary for carrying out a medically-sound **ESRD** treatment program, including all of the following:

- (1) Dialysis for clients with **ESRD** when medically indicated;
- (2) Kidney transplantation treatment, either directly or by referral, for clients with **ESRD** when medically indicated;
- (3) Treatment for conditions directly related to **ESRD**;
- (4) Training and supervision of supporting personnel and clients for home dialysis, medical care, and treatment; and
- (5) Supplies and equipment for home dialysis.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-010, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-010, filed 7/28/93, effective 8/28/93.]

WAC 388-540-020 Reimbursement. MAA reimburses **kidney centers** for services according to this chapter and the **kidney center's** contract with the department to the extent the legislature has appropriated funds.

(1) To request reimbursement, the **kidney center** must submit documented evidence, satisfactory to MAA, showing:

- (a) The services for which reimbursement is requested; and
- (b) The client's financial eligibility for the state **KDP** under this chapter.

(2) MAA limits reimbursement for services provided to a client while visiting out of state to fourteen days per calendar year.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-020, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-020, filed 7/28/93, effective 8/28/93.]

WAC 388-540-030 KDP eligibility requirements. (1) The **kidney center** determines clients' eligibility annually on a case-by-case basis, according to this chapter and the **KDP contract manual**. To be eligible for the **KDP**, a client must:

- (a) Be a Washington state resident;
- (b) Have countable resources, not exempted under subsection (2) of this section, which are equal to or lower than fifteen thousand dollars;
- (c) Have countable income as defined in WAC 388-500-0005, which is equal to or lower than three hundred percent of the federal poverty level (FPL); and
- (d) Exhaust or be ineligible for all other resources providing similar benefits to meet the cost of **ESRD**-related medical care, such as:

- (i) Government or private disability programs; or

(ii) Local funds raised for the purpose of providing financial support for a specified **ESRD** client.

(2) The following resources are exempt:

- (a) A home, defined as real property owned by a client as a principal place of residence, together with surrounding and contiguous property not to exceed five acres;
- (b) Household furnishings; and
- (c) An automobile.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-030, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-030, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-030, filed 7/28/93, effective 8/28/93.]

WAC 388-540-040 Transfer of resources without adequate consideration. A person may be ineligible for the **KDP** if the person knowingly and willfully assigns or transfers nonexempt resources at less than fair market value within two years preceding the date of application, for the purpose of qualifying or continuing to qualify for the program.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-040, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-040, filed 7/28/93, effective 8/28/93.]

WAC 388-540-050 Fiscal information. The **kidney center** must provide fiscal information upon request by the department, including:

- (1) Accounting information and documentation sufficient to establish the basis for fees for services and/or charges;
- (2) Sources and amounts of resources allowing an individual client to verify financial eligibility;
- (3) Evidence that all other available resources have been depleted before requests for reimbursement from the **KDP** are submitted to MAA; and
- (4) Other information as MAA may require.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-050, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-050, filed 7/28/93, effective 8/28/93.]

WAC 388-540-060 KDP eligibility determination. The **kidney center** and client must comply with the following rules to determine **KDP** eligibility:

- (1) The **kidney center** must:
 - (a) Inform the client of the requirements for **KDP** eligibility as defined in this chapter;
 - (b) Provide the client with necessary department forms and instructions in a timely manner;
 - (c) Review the **KDP application** and documentation;
 - (d) Determine client eligibility using department policies, rules, and instructions; and
 - (e) Forward the **KDP application** and documentation to the medical assistance administration (MAA). If necessary, MAA may amend or terminate a client's **certification** period within thirty days of receipt.
- (2) A person applying for **KDP** must:

(a) Complete the **KDP application** and submit any documentation necessary to determine eligibility to the **kidney center**; and

(b) Apply for Medicaid, obtain a written Medicaid eligibility determination, and submit a copy to the **kidney center**.

(3) A client applying for recertification must:

(a) Apply for Medicaid forty-five days before the end of the **KDP certification** period, obtain a written Medicaid eligibility determination, and submit a copy to the **kidney center**; or

(b) Have applied for Medicaid within the previous five years and continue to be ineligible because the client:

(i) Was denied Medicaid due to:

(A) Failure to meet Medicaid categorical requirements;

(B) **Assets** which exceed Medicaid resource standards;

or

(C) Income which exceeds the categorically needy income standards; or

(ii) Does not meet the medically needy spenddown amount because the cost of medical care is:

(A) Less than the spenddown amount; or

(B) Covered by third-party insurance.

(4) The **KDP application period** is:

(a) One hundred and twenty days for a new client; and

(b) Forty-five days prior to the end of a **certification** period for a client requesting recertification.

(5) The **kidney center** may request an extension of application time limits from MAA when extenuating circumstances prevent the client from completing the application or recertification process within the specified time limits.

(6) The **kidney center** certifies the client as **KDP** eligible for a period of one year from the first day of the month of application, unless the client:

(a) Needs medical coverage for less than one year; or

(b) Has a **substantial financial change**, in which case the client must complete a new **application for KDP eligibility**;

(7) The effective date of **KDP** eligibility is the first day of the month of **KDP** application if the client was eligible at any time during that month. The effective date of **KDP** eligibility may be a maximum of four months before the month of **KDP** application if the:

(a) Medical services received were covered; and

(b) Client would have been eligible had the client applied.

[Statutory Authority: RCW 74.04.050 and 74.08.090, 00-01-088, § 388-540-060, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025, 98-06-025, § 388-540-060, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090, 93-16-039 (Order 3600), § 388-540-060, filed 7/28/93, effective 8/28/93.]

Chapter 388-545 WAC

THERAPIES

WAC

388-545-300

Occupational therapy.

388-545-700

Speech/audiology services.

WAC 388-545-300 Occupational therapy. (1) The following providers are eligible to enroll with medical assistance administration (MAA) to provide occupational therapy services:

(a) A licensed occupational therapist;

(b) A licensed occupational therapy assistant supervised by a licensed occupational therapist; and

(c) An occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist.

(2) Clients in the following MAA programs are eligible to receive occupational therapy services described in this chapter:

(a) Categorically needy;

(b) Children's health;

(c) General assistance unemployable (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program for emergency hospital-based services only; or

(f) Medically needy program only when the client is either:

(i) Twenty years of age or younger and referred by a screening provider under the early and periodic screening, diagnosis and treatment program (healthy kids program) as described in WAC 388-86-027; or

(ii) Receiving home health care services as described in WAC 388-86-045.

(3) Occupational therapy services received by MAA eligible clients must be provided:

(a) As part of an outpatient treatment program for adults and children;

(b) By a home health agency as described under WAC 388-86-045;

(c) As part of the physical medicine and rehabilitation (PM&R) program as described in WAC 388-86-112;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education program or individualized family service plan as described in WAC 388-86-022; or

(f) When prescribed by a provider for clients age twenty-one or older. The therapy must:

(i) Prevent the need for hospitalization or nursing home care;

(ii) Assist a client in becoming employable;

(iii) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(iv) Be a part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(4) MAA pays only for covered occupational therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary, when prescribed by a provider; and

(c) Begun within thirty days of the date prescribed.

(5) MAA covers the following occupational therapy services per client, per calendar year:

(a) Unlimited occupational therapy program visits for clients twenty years of age or younger;

(b) One occupational therapy evaluation. The evaluation is in addition to the twelve program visits allowed per year;

(c) Two durable medical equipment needs assessments. The assessments are in addition to the twelve program visits allowed per year;

(d) Twelve occupational therapy program visits;

(e) Twenty-four additional outpatient occupational therapy program visits when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement;

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(f) Twenty-four additional occupational therapy program visits following a completed and approved inpatient PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of function due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quads only;

(ix) Bilateral limb loss; or

(x) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(g) Additional medically necessary occupational therapy services, regardless of the diagnosis, must be approved by MAA.

(6) MAA will pay for one visit to instruct in the application of transcutaneous neurostimulator (TENS), per client, per lifetime.

(7) MAA does not cover occupational therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-16-068, § 388-545-300, filed 8/2/99, effective 9/2/99.]

WAC 388-545-700 Speech/audiology services. (1)

The following providers are eligible to enroll with medical assistance administration (MAA) to provide, and be reimbursed for, speech/audiology services:

(a) A speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Hearing and Language Association;

(b) A speech-language pathologist who has completed the equivalent educational and work experience necessary for such a certificate;

(c) An audiologist who is appropriately licensed or registered to perform audiology services within their state of residence; and

(d) School districts or educational service districts. Services must be noted in the client's individual educational program or individualized family service plan as described under WAC 388-86-022.

(2) Clients in the following MAA programs are eligible to receive speech/audiology services described in this chapter:

(a) Categorically needy, children's health, general assistance unemployable, and alcoholism and drug addiction treatment and support act (ADATSA) programs within Washington state or border areas only; or

(b) Medically needy program only when the client is either:

(i) Twenty years of age or under; or

(ii) Receiving home health care services as described under WAC 388-86-045;

(c) Medically indigent program only for emergency hospital-based services.

(3) MAA pays only for covered speech/audiology services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) For conditions which are the result of medically recognized diseases and defects; and

(c) Medically necessary, as determined by a health professional.

(4) The following speech/audiology services are covered per client, per calendar year, per provider:

(a) Unlimited speech/audiology program visits for clients twenty years of age and younger;

(b) One medical diagnostic evaluation for clients twenty-one years of age and older. The medical diagnostic evaluation is in addition to the twelve program visits allowed per year;

(c) One second medical diagnostic evaluation at the time of discharge for any of the following:

(i) Anoxic brain damage;

(ii) Acute, ill-defined, cerebrovascular disease;

(iii) Subarachnoid, subdural, and extradural hemorrhage following injury; or

(iv) Intracranial injury of other and unspecified nature;

(d) Twelve speech/audiology program visits for clients twenty-one years of age and older;

(e) Twenty-four additional speech/audiology visits if the speech/audiology service is for any of the following:

(i) Medically necessary conditions for developmentally delayed clients;

(ii) Neurofibromatosis;

(iii) Severe oral or motor dyspraxia;

(iv) Amyotrophic lateral sclerosis (ALS);

(v) Multiple sclerosis;

(vi) Cerebral palsy;

(vii) Quadriplegia;

- (viii) Acute, infective polyneuritis (Guillain-Barre' syndrome);
- (ix) Acute, but ill-defined, cerebrovascular disease;
- (x) Meningomyelocele;
- (xi) Cleft palate and cleft lip;
- (xii) Down's syndrome;
- (xiii) Lack of coordination;
- (xiv) Severe aphasia;
- (xv) Severe dysphagia;
- (xvi) Fracture of the:
 - (A) Vault or base of the skull;
 - (B) Multiple fracture involving skull or face with other bones;
- (C) Cervical column;
- (D) Larynx and trachea; or
- (E) Other and unqualified skull fractures;
- (xvii) Head injuries as follows:
 - (A) Cerebral laceration and contusion;
 - (B) Subarachnoid, subdural, and extradural hemorrhage following injury;
 - (C) Other and unspecified intracranial hemorrhage following injury;
 - (D) Injury to blood vessels of the head and neck; or
 - (E) Intracranial injury of other second unspecified nature;
- (xviii) Burns of:
 - (A) The face, head, and neck, when severe;
 - (B) Multiple, specified sites; or
 - (C) Internal organs;
- (xix) Cervical spinal cord injury without evidence of spinal bone injury; or
- (xx) Other speech disturbances (e.g., severe dysarthria).

(f) Additional medically necessary speech/audiology program visits beyond the initial twelve visits and additional twenty-four visits for clients twenty-one years of age and older if approved by MAA.

- (5) MAA limits:
 - (a) Caloric vestibular testing to four units for each ear, and
 - (b) Sinusoidal vertical axis rotational testing to three units for each direction.
- (6) MAA does not cover speech/audiology services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090 and 74.09.520, 99-16-071, § 388-545-700, filed 8/2/99, effective 9/2/99.]

**Chapter 388-550 WAC
HOSPITAL SERVICES**

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388-550-1200	Limitations on hospital coverage.
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388-550-2501	Acute physical medicine and rehabilitation (acute PM&R) program—General.
388-550-2511	Acute PM&R definitions.
388-550-2521	Client eligibility requirements for acute PM&R services.
388-550-2531	Requirements for becoming an MAA Level A or B acute PM&R provider.

388-550-2541	Quality of care for acute PM&R clients through audits and reviews.
388-550-2551	How MAA determines client placement in Level A or B acute PM&R.
388-550-2561	MAA's requirements for authorizing acute PM&R services.
388-550-2800	Inpatient payment methods and limits.
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388-550-5600	Administrative appeal for hospital rate reimbursement.
388-550-6000	Payment—Outpatient hospital services.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

388-550-2300	Payment—PM&R. [Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2300, filed 12/18/97, effective 1/18/98.] Repealed by 99-17-111, filed 8/18/99, effective 9/18/99. Statutory Authority: RCW 74.08.090 and 74.09.520.
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WAC 388-550-1050 Definitions. See also chapter 388-500 WAC for other definitions and abbreviations used by MAA. Unless otherwise specified, the terms used in this chapter have the following meaning:

"Accommodation costs" means the expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made, such as, but not limited to, a regular hospital room, special care hospital room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain hospital equipment and facilities.

"Acute" means a medical condition of severe intensity with sudden onset.

"Acute care" means care provided by an agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional in order to maintain their health status (WAC 248-27-015).

"Acute physical medicine and rehabilitation (Acute PM&R)" means a comprehensive inpatient rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for a diagnostic category for which the client shows significant potential functional improvement.

"ADATSA/DASA assessment center" means an agency contracted by the division of alcohol and substance

- (viii) Acute, infective polyneuritis (Guillain-Barre' syndrome);
- (ix) Acute, but ill-defined, cerebrovascular disease;
- (x) Meningomyelocele;
- (xi) Cleft palate and cleft lip;
- (xii) Down's syndrome;
- (xiii) Lack of coordination;
- (xiv) Severe aphasia;
- (xv) Severe dysphagia;
- (xvi) Fracture of the:
 - (A) Vault or base of the skull;
 - (B) Multiple fracture involving skull or face with other bones;
- (C) Cervical column;
- (D) Larynx and trachea; or
- (E) Other and unqualified skull fractures;
- (xvii) Head injuries as follows:
 - (A) Cerebral laceration and contusion;
 - (B) Subarachnoid, subdural, and extradural hemorrhage following injury;
 - (C) Other and unspecified intracranial hemorrhage following injury;
 - (D) Injury to blood vessels of the head and neck; or
 - (E) Intracranial injury of other second unspecified nature;
- (xviii) Burns of:
 - (A) The face, head, and neck, when severe;
 - (B) Multiple, specified sites; or
 - (C) Internal organs;
- (xix) Cervical spinal cord injury without evidence of spinal bone injury; or
- (xx) Other speech disturbances (e.g., severe dysarthria).

(f) Additional medically necessary speech/audiology program visits beyond the initial twelve visits and additional twenty-four visits for clients twenty-one years of age and older if approved by MAA.

- (5) MAA limits:
 - (a) Caloric vestibular testing to four units for each ear, and
 - (b) Sinusoidal vertical axis rotational testing to three units for each direction.
- (6) MAA does not cover speech/audiology services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090 and 74.09.520, 99-16-071, § 388-545-700, filed 8/2/99, effective 9/2/99.]

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388-550-2521	Client eligibility requirements for acute PM&R services.
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388-550-2561	MAA's requirements for authorizing acute PM&R services.
388-550-2800	Inpatient payment methods and limits.
388-550-2900	Payment limits—Inpatient hospital services.
388-550-3000	DRG payment system.
388-550-3100	Calculating DRG relative weights.
388-550-3381	How MAA pays acute PM&R facilities for Level A services.
388-550-3401	How MAA pays acute PM&R facilities for Level B services.
388-550-3450	Payment method for calculating CBCF rates.
388-550-3500	Hospital inflation adjustment determinations.
388-550-3700	DRG outliers and administrative day rates.
388-550-3900	Payment method—Border area hospitals.
388-550-4100	Payment method—New hospitals.
388-550-4500	Payment method—RCC.
388-550-4700	Payment—Non-SCA participating hospitals.
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388-550-5000	Payment method—LIDSH.
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388-550-5200	Payment method—SRHAPDSH.
388-550-5250	Payment method—THAPDSH.
388-550-5300	Payment method—STHFPDSH.
388-550-5350	Payment method—CTHFPDSH.
388-550-5400	Payment method—PHDDSH.
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WAC 388-550-1050 Definitions. See also chapter 388-500 WAC for other definitions and abbreviations used by MAA. Unless otherwise specified, the terms used in this chapter have the following meaning:

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"Acute" means a medical condition of severe intensity with sudden onset.

"Acute care" means care provided by an agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional in order to maintain their health status (WAC 248-27-015).

"Acute physical medicine and rehabilitation (Acute PM&R)" means a comprehensive inpatient rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for a diagnostic category for which the client shows significant potential functional improvement.

"ADATSA/DASA assessment center" means an agency contracted by the division of alcohol and substance

abuse (DASA) to provide chemical dependency assessment for clients and pregnant women in accordance with the alcohol and drug addiction treatment and support act (ADATSA). Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

"Add-on procedure" means a secondary procedure that is performed in addition to another procedure.

"Administrative day" means a day of a hospital stay in which an acute inpatient level of care is no longer necessary, and noninpatient hospital placement is appropriate.

"Admitting diagnosis" means the diagnosis, coded according to the International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM), indicating the medical condition which precipitated the client's admission to an inpatient hospital facility.

"Advance directive" means a document, such as a living will, executed by a client, that tells the client's health care providers and others the client's decisions regarding his or her medical care, particularly whether the client wishes to accept or refuse extraordinary measures to prolong his or her life.

"Aggregate capital cost" means the total cost or the sum of all capital costs.

"Aggregate cost" means the total cost or the sum of all constituent costs.

"Aggregate operating cost" means the total cost or the sum of all operating costs.

"Alcohol and drug addiction treatment and support act (ADATSA)" means the law and the state-funded program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

"Alcoholism and/or alcohol abuse treatment" means the provision of medical social services to an eligible client designed to mitigate or reverse the effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by the provision of a combination of alcohol education sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and their families.

"All-patient grouper (AP-DRG)" means a computer program that determines the diagnosis-related group (DRG) assignments.

"Allowed charges" means the maximum amount for any procedure that the department will recognize.

"Ancillary hospital costs" means the expenses incurred by a hospital to provide additional or supporting services to its patients during their hospital stay. See **"ancillary services."**

"Ancillary services" means additional or supporting services, such as, but not limited to, laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services, provided by a hospital to a patient during his or her hospital stay.

"Approved treatment facility" means a treatment facility, either public or private, profit or nonprofit, approved by DSHS.

"Audit" means an assessment, evaluation, examination, or investigation of a health care provider's accounts, books and records, including:

(1) Medical, financial and billing records pertaining to billed services paid by the department through Medicaid or other state programs, by a person not employed or affiliated with the provider, for the purpose of verifying the service was provided as billed and was allowable under program regulations; and

(2) Financial, statistical and medical records, including mathematical computations and special studies conducted supporting Medicare cost reports HCFA Form 2552, submitted to the department for the purpose of establishing program rates of reimbursement to hospital providers.

"Audit claims sample" means a subset of the universe of paid claims from which the sample is drawn, whether based upon judgmental factors or random selection. The sample may consist of any number of claims in the population up to one hundred percent. See also **"random claims sample"** and **"stratified random sample."**

"Authorization number" means a nine-digit number assigned by MAA that identifies individual requests for approval of services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

"Authorization requirement" means MAA's requirement that a provider present proof of medical necessity to MAA, prior to providing certain medical services or equipment to a client. This takes the form of a request for authorization of the service(s) and/or equipment, including a complete, detailed description of the client's diagnosis and/or any disabling conditions, justifying the need for the equipment or the level of service being requested.

"Average hospital rate" means the average of hospital rates for any particular type of rate that MAA uses.

"Bad debt" means an operating expense or loss incurred by a hospital because of uncollectible accounts receivables.

"Beneficiary" means a recipient of Social Security benefits, or a person designated by an insuring organization as eligible to receive benefits.

"Billed charge" - See **"usual and customary charge."**

"Blended rate" means a mathematically weighted average rate.

"Border area hospital" means a hospital located in an area defined by state law as:

(1) Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, or The Dalles; and

(2) Idaho - Coeur d'Alene, Lewiston, Moscow, Priest River or Sandpoint.

"Bundled services" mean interventions which are incidental to the major procedure and are not separately reimbursable.

"Buy-in premium" means a monthly premium the state pays so a client is enrolled in part A and/or part B Medicare.

"By report" means a method of reimbursement in which MAA determines the amount it will pay for a service

that is not included in MAA's published fee schedules by requiring the provider to submit a "report" describing the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Callback" means keeping physician staff on duty beyond their regularly scheduled hours, or having them return to the facility after hours to provide unscheduled services; usually associated with hospital emergency room, surgery, laboratory and radiology services.

"Capital-related costs" mean the component of operating costs related to capital assets, including, but not limited to:

- (1) Net adjusted depreciation expenses;
- (2) Lease and rentals for the use of depreciable assets;
- (3) The costs for betterment and improvements;
- (4) The cost of minor equipment;
- (5) Insurance expenses on depreciable assets;
- (6) Interest expense; and
- (7) Capital-related costs of related organizations that provide services to the hospital.

It excludes capital costs due solely to changes in ownership of the provider's capital assets.

"Case mix complexity" means, from the clinical perspective, the condition of the treated patients and the difficulty associated with providing care. Administratively, it means the resource intensity demands that patients place on an institution.

"Case mix index" means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using diagnosis-related group weights as a measure of relative cost.

"Charity care" means necessary hospital health care rendered to indigent persons, as defined in this section, to the extent that these persons are unable to pay for the care or to pay the deductibles or coinsurance amounts required by a third-party payer, as determined by the department.

"Chemical dependency" means an alcohol or drug addiction; or dependence on alcohol and one or more other psychoactive chemicals.

"Children's hospital" means a hospital primarily serving children.

"Comorbidity" means of, relating to, or caused by a disease other than the principal disease.

"Complication" means a disease or condition occurring subsequent to or concurrent with another condition and aggravating it.

"Comprehensive hospital abstract reporting system (CHARS)" means the department of health's hospital data collection, tracking and reporting system.

"Contract hospital" means a licensed hospital located in a selective contracting area, which is awarded a contract to participate in the department's selective contracting hospital program.

"Contractual adjustment" means the difference between the amount billed at established charges for the services provided and the amount received or due from a third-party payer under a contract agreement. A contractual adjustment is similar to a trade discount.

"Conversion factor" means a hospital-specific dollar amount that reflects the average cost of treating Medicaid clients in a given hospital. See **"cost-based conversion factor (CBCF)"** and **"negotiated conversion factor (NCF)."**

"Cost proxy" means an average ratio of costs to charges for ancillary charges or per diem for accommodation cost centers used to determine a hospital's cost for the services where the hospital has Medicaid claim charges for the services, but does not report costs in corresponding centers in its Medicare cost report.

"Cost report" means the HCFA Form 2552, Hospital and Hospital Health Care Complex Cost Report, completed and submitted annually by a provider:

- (1) To Medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and
- (2) To Medicaid to establish appropriate DRG and RCC reimbursement.

"Costs" mean MAA-approved operating, medical education, and capital-related costs as reported and identified on the HCFA 2552 form.

"Cost-based conversion factor (CBCF)" means a hospital-specific dollar amount that reflects the average cost of treating Medicaid clients in a given hospital. It is calculated from the hospital's cost report by dividing the hospital's costs for treating Medicaid clients during a base period by the number of Medicaid discharges during that same period and adjusting for the hospital's case mix. See also **"conversion factor"** and **"negotiated conversion factor."**

"County hospital" means a hospital established under the provisions of chapter 36.62 RCW.

"Covered service" means a service that is included in the Medicaid program and is within the scope of the eligible client's medical care program.

"Critical care services" mean services for critically ill or injured patients in a variety of medical emergencies that require the constant attendance of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications). For Medicaid reimbursement purposes, critical care services must be provided in a Medicare qualified critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility, to qualify for reimbursement as a special care level of service.

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians; it is published annually by the American Medical Association (AMA).

"Customary charge payment limit" means the limit placed on aggregate diagnosis-related group (DRG) payments to a hospital during a given year to assure that DRG payments do not exceed the hospital's charges to the general public for the same services.

"Day outlier" means a case that requires MAA to make additional payment to the hospital provider but which does not qualify as a high-cost outlier. See **"day outlier payment"** and **"day outlier threshold."**

"Day outlier payment" means the additional amount paid to a disproportionate share hospital for a client five years old or younger who has a prolonged inpatient stay which exceeds the day outlier threshold but whose charges for care fall short of the high cost outlier threshold. The amount is determined by multiplying the number of days in excess of the day outlier threshold and the administrative day rate.

"Day outlier threshold" means the average number of days a client stays in the hospital for an applicable DRG before being discharged, plus twenty days.

"Deductible" means the amount a beneficiary is responsible for, before Medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible.

"Detoxification" means treatment provided to persons who are recovering from the effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

"Diabetic education program" means a comprehensive, multidisciplinary program of instruction offered by an MAA-approved facility to diabetic clients on dealing with diabetes, including instruction on nutrition, foot care, medication and insulin administration, skin care, glucose monitoring, and recognition of signs/symptoms of diabetes with appropriate treatment of problems or complications.

"Diagnosis code" means a set of alphabetic, numeric, or alpha-numeric characters assigned by the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as a shorthand symbol to represent the nature of a disease.

"Diagnosis-related group (DRG)" means a classification system which categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant co-morbidities or complications, and other relevant criteria.

"Direct medical education costs" means the direct costs of providing an approved medical residency program as recognized by Medicare.

"Discharging hospital" means the institution releasing a client from the acute care hospital setting.

"Disproportionate share payment" means additional payment(s) made by the department to a hospital which serves a disproportionate number of Medicaid and other low-income clients and which qualifies for one or more of the disproportionate share hospital programs identified in the state plan.

"Disproportionate share program" means a program that provides additional payments to hospitals which serve a disproportionate number of Medicaid and other low-income clients.

"Dispute conference" means a hospital rate appeal meeting for deliberation during a provider administrative appeal.

(1) At the first level of appeal it is usually a meeting between auditors and the audited provider and/or staff to resolve disputed audit findings, clarify interpretation of regu-

lations and policies, provide additional supporting information and/or documentation.

(2) At the second level of appeal the dispute conference is an informal administrative hearing conducted by an MAA administrator for the purpose of resolving contractor/provider rate disagreements with any of the department's action at the first level of appeal. The dispute conference in this regard is not a formal adjudicative process held in accordance with the Administrative Procedure Act, chapter 34.05 RCW.

"Distinct unit" means a Medicare-certified distinct area for rehabilitation services within a general acute care hospital or a department-designated unit in a children's hospital.

"DRG" - See **"diagnosis-related group."**

"DRG-exempt services" mean services which are paid for through other methodologies than those using cost-based or negotiated conversion factors.

"DRG payment" means the payment made by MAA for a client's inpatient hospital stay; it is calculated by multiplying the hospital-specific conversion factor by the DRG relative weight for the client's medical diagnosis.

"DRG relative weight" means the average cost or charge of a certain DRG divided by the average cost or charge, respectively, for all cases in the entire data base for all DRGs.

"Drug addiction and/or drug abuse treatment" means the provision of medical and rehabilitative social services to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by the provision of a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities to detoxified addicts and their families.

"Elective procedure or surgery" means a nonemergent procedure or surgery that can be scheduled at convenience.

"Emergency room" or **"emergency facility"** means an organized, distinct hospital-based facility available twenty-four hours a day for the provision of unscheduled episodic services to patients who present for immediate medical attention, and capable of providing emergency services including trauma.

"Emergency services" mean medical services, including maternity services, required by and provided to a patient after the sudden onset of a medical condition 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 placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are treated as emergency services.

"Equivalency factor" means a conversion factor used, in conjunction with two other factors (cost-based conversion factor and the ratable factor), to determine the level of state-only program payment.

"Exempt hospital" means a hospital that is either not located in a selective contracting area or is exempted by the department and is reimbursed for services to MAA clients

through methodologies other than those using cost-based or negotiated conversion factors.

"Experimental treatment" means a course of treatment or procedure that:

- (1) Is not generally accepted by the medical profession as effective and proven;
- (2) Is not recognized by professional medical organizations as conforming to accepted medical practice;
- (3) Has not been approved by the federal Food and Drug Administration (FDA) or other requisite government body;
- (4) Is still in clinical trials, or has been judged to need further study;
- (5) Is covered by the federal law requiring provider institutional review of patient consent forms, and such review did not occur; or
- (6) Is rarely used, novel, or relatively unknown, and lacks authoritative evidence of safety and effectiveness.

"Facility triage fee" means the amount the medical assistance administration will pay a hospital for a medical evaluation or medical screening examination, performed in the hospital's emergency department, of a nonemergent condition of a *healthy options* client covered under the primary care case management (PCCM) program. This amount corresponds to the professional care level A or level B service.

"Fee for service" means the general payment method MAA uses to reimburse for medical services provided to clients other than for those services provided through MAA's per capita *healthy options* program.

"Fiscal intermediary" means Medicare's designated fiscal intermediary for a region and/or category of service.

"Fixed per diem rate" means a contracted nonnegotiated daily amount, used to determine payment to a hospital for specific services.

"Global surgery days" means the number of preoperative and follow-up days that are included in the reimbursement to the physician for the major surgical procedure.

"Graduate medical education costs" means the direct and indirect costs of providing medical education in teaching hospitals.

"Grouper" - See **"all-patient grouper (AP-DRG)."**

"HCFA 2552" - See **"cost report."**

"Health care team" means a team of professionals and/or paraprofessionals involved in the care of a client.

"High-cost outlier" means a case with extraordinarily high costs when compared to other cases in the same DRG, in which the allowed charges prior to July 1, 1999, exceed three times the applicable DRG payment or twenty-eight thousand dollars, whichever is greater. On and after July 1, 1999, to qualify as a high-cost outlier, the allowed charges must exceed three times the applicable DRG payment or thirty-three thousand dollars, whichever is greater.

"Hospice" means a medically-directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington state-licensed and Title XVIII-certified Washington state hospice for terminally ill clients and the clients' families.

"Hospital" means an entity which is licensed as an acute care hospital in accordance with applicable state laws

and regulations, and which is certified under Title XVIII of the federal Social Security Act.

"Hospital admission" means admission as an inpatient to a hospital, for a stay of twenty-four hours or longer.

"Hospital base period" means, for purposes of establishing a provider rate, a specific period or timespan used as a reference point or basis for comparison.

"Hospital base period costs" mean costs incurred in or associated with a specified base period.

"Hospital cost report" - See **"cost report."**

"Hospital facility fee" - See **"facility triage fee."**

"Hospital market basket index" means a measure, expressed as a percentage, of the annual inflationary costs for hospital services, as measured by Data Resources, Inc., (DRI).

"Hospital peer group" means the peer group categories adopted by the former Washington state hospital commission for rate-setting purposes:

- (1) Group A - rural hospitals paid under a ratio-of-costs-to-charges (RCC) methodology;
- (2) Group B - urban hospitals without medical education programs;
- (3) Group C - urban hospitals with medical education programs; and
- (4) Group D - specialty hospitals and/or hospitals not easily assignable to the other three peer groups.

"Indigent patient" means a patient who has exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below two hundred percent of the federal poverty standards (adjusted for family size), or is otherwise not sufficient to enable the individual to pay for his or her care, or to pay deductibles or coinsurance amounts required by a third-party payor.

"Indirect medical education costs" means the indirect costs of providing an approved medical residency program as recognized by Medicare.

"Inflation adjustment" means, for cost inflation, the hospital inflation adjustment. This adjustment is determined by using the inflation factor method and guidance indicated by the legislature in the budget notes to the biennium appropriations bill. For charge inflation, it means the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the comprehensive hospital abstract reporting system (CHARS) standard reports three and four.

"Inpatient hospital" means a hospital authorized by the department of health to provide inpatient services.

"Inpatient services" means all services provided directly or indirectly by the hospital to a patient subsequent to admission and prior to discharge, and includes, but is not limited to, the following services: Bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and services provided by

the hospital within twenty-four hours of the patient's admission as an inpatient.

"Interdisciplinary group (IDG)" means the team, including a physician, a registered nurse, a social worker, and a pastoral or other counselor, which is primarily responsible for the provision or supervision of care and services for a Medicaid client.

"Intermediary" - See **"fiscal intermediary."**

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Edition" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into alpha-numerical designations (coding).

"Intervention" means any medical or dental service provided to a client that modifies the medical or dental outcome for that client.

"Length of stay (LOS)" means the number of days of inpatient hospitalization. The phrase more commonly means the average length of hospital stay for patients based on diagnosis and age, as determined by the Commission of Professional and Hospital Activities and published in a book entitled *Length of Stay by Diagnosis, Western Region*. See also **"professional activity study (PAS)."**

"Length of stay extension request" means a request from a hospital provider for MAA to approve a client's hospital stay exceeding the average length of stay for the client's diagnosis and age.

"Lifetime hospitalization reserve" means, under the Medicare Part A benefit, the nonrenewable sixty hospital days that a beneficiary is entitled to use during his or her lifetime for hospital stays extending beyond ninety days per benefit period. See also **"reserve days."**

"Low-cost outlier" means a case with extraordinarily low costs when compared to other cases in the same DRG, in which the allowed charges for the case prior to July 1, 1999, is less than or equal to ten percent of the applicable DRG payment or four hundred dollars, whichever is greater. On and after July 1, 1999, to qualify as a low-cost outlier, the allowed charges must be less than or equal to ten percent of the applicable DRG payment or four hundred and fifty dollars, whichever is greater. Reimbursement in such cases is determined by multiplying the case's allowed charges by the hospital's RCC ratio.

"Low income utilization rate" means a formula represented as $(A/B)+(C/D)$ in which:

(1) The numerator A is the hospital's total patient services revenue under the state plan, plus the amount of cash subsidies for patient services received directly from state and local governments in a period;

(2) The denominator B is the hospital's total patient services revenue (including the amount of such cash subsidies) in the same period as the numerator;

(3) The numerator C is the hospital's total inpatient service charge attributable to charity care in a period, less the portion of cash subsidies described in (1) of this definition in the period reasonably attributable to inpatient hospital services. The amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the state plan); and

(4) The denominator D is the hospital's total charge for inpatient hospital services in the same period as the numerator.

"Major diagnostic category (MDC)" means one of the twenty-five mutually exclusive groupings of principal diagnosis areas in the DRG system. The diagnoses in each MDC correspond to a single major organ system or etiology and, in general, are associated with a particular medical specialty.

"Market basket index" - See **"hospital market basket index."**

"Medicaid cost proxy" means a figure developed to approximate or represent a missing cost figure.

"Medicaid inpatient utilization rate" means a formula represented as X/Y in which:

(1) The numerator X is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the state plan in a period.

(2) The denominator Y is the hospital's total number of inpatient days in the same period as the numerator's. Inpatient day includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

"Medical assistance program" means Medicaid and medical care services.

"Medical education costs" means the expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program.

"Medical screening evaluation" means the service(s) provided by a physician or other practitioner to determine whether an emergent medical condition exists. See also **"facility triage fee."**

"Medical stabilization" means a return to a state of constant and steady function. It is commonly used to mean the client is adequately supported to prevent further deterioration.

"Medically indigent person" means a person certified by the department of social and health services as eligible for the limited casualty program-medically indigent (LCP-MI) program. See also **"indigent patient."**

"Medicare cost report" means the annual cost data reported by a hospital to Medicare on the HCFA form 2552.

"Medicare crossover" means a claim involving a client who is eligible for both Medicare benefits and Medicaid.

"Medicare fee schedule (MFS)" means the official HCFA publication of Medicare policies and relative value units for the resource based relative value scale (RBRVS) reimbursement program.

"Medicare Part A" means that part of the Medicare program that helps pay for inpatient hospital services, which may include, but are not limited to:

- (1) A semi-private room;
- (2) Meals;
- (3) Regular nursing services;
- (4) Operating room;
- (5) Special care units;
- (6) Drugs and medical supplies;
- (7) Laboratory services;

- (8) X-ray and other imaging services; and
- (9) Rehabilitation services.

Medicare hospital insurance also helps pay for post-hospital skilled nursing facility care, some specified home health care, and hospice care for certain terminally ill beneficiaries.

"Medicare part B" means that part of the Medicare program that helps pay for, but is not limited to:

- (1) Physician services;
- (2) Outpatient hospital services;
- (3) Diagnostic tests and imaging services;
- (4) Outpatient physical therapy;
- (5) Speech pathology services;
- (6) Medical equipment and supplies;
- (7) Ambulance;
- (8) Mental health services; and
- (9) Home health services.

"Medicare buy-in premium" - See **"buy-in premium."**

"Medicare payment principles" means the rules published in the federal register regarding reimbursement for services provided to Medicare clients.

"Mentally incompetent" means a client who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the client has been declared competent for purposes which include the ability to consent to sterilization.

"Multiple occupancy rate" means the rate customarily charged for a hospital room with two or more patient beds.

"Negotiated conversion factor (NCF)" means a negotiated hospital-specific dollar amount which is used in lieu of the cost-based conversion factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital. See also **"conversion factor"** and **"cost-based conversion factor."**

"Nonallowed service or charge" means a service or charge that cannot be billed to the department or client.

"Noncontract hospital" means a licensed hospital located in a selective contracting area (SCA) but which does not have a contract to participate in the selective contracting hospital program.

"Noncovered service or charge" means a service or charge that is not covered by medical assistance, including, but not limited to, such services or charges as a private room, circumcision, and video recording of the procedure.

"Nonemergent hospital admission" means any inpatient hospitalization of a client who does not have an emergent condition, as defined in WAC 388-500-0005, Emergency services.

"Nonparticipating hospital" means a noncontract hospital, as defined in this section.

"Operating costs" means all expenses incurred in providing accommodation and ancillary services, excluding capital and medical education costs.

"Orthotic device" means a fitted surgical apparatus designed to activate or supplement a weakened or atrophied limb or bodily function.

"Out-of-state hospital" means any hospital located outside the state of Washington or outside the designated border areas in Oregon and Idaho.

"Outlier set-aside factor" means the amount by which a hospital's cost-based conversion factor is reduced for payments of high cost outlier cases.

"Outlier set-aside pool" means the total amount of payments for high cost outliers which are funded annually based on payments for high cost outliers during the year.

"Outliers" means cases with extraordinarily high or low costs when compared to other cases in the same DRG.

"Outpatient" means a client who is receiving medical services in other than an inpatient hospital setting.

"Outpatient care" means medical care provided other than inpatient services in a hospital setting.

"Outpatient hospital" means a hospital authorized by the department of health to provide outpatient services.

"Outpatient stay" means a hospital stay of less than or approximating twenty-four hours, except that cases involving the death of a client, delivery or initial care of a newborn, or transfer to another acute care facility are not deemed outpatient stays.

"Pain treatment facility" means an MAA-approved inpatient facility for pain management, in which a multidisciplinary approach is used to teach clients various techniques to live with chronic pain.

"Participating hospital" means a licensed hospital that accepts MAA clients.

"PAS length of stay (LOS)" means the average length of hospital stay for patients based on diagnosis and age, as determined by the Commission of Professional and Hospital Activities and published in a book entitled *Length of Stay by Diagnosis, Western Region*. See also **"professional activity study (PAS)"** and **"length of stay."**

"Patient consent" means the informed consent of the client and/or the client's guardian to the procedure(s) to be performed upon or the treatment provided to the client, evidenced by the client's or guardian's signature on a consent form.

"Peer group" - See **"hospital peer group."**

"Peer group cap" means the reimbursement limit set for hospital peer groups B and C, established at the seventieth percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs.

"Per diem charge" means the daily charge per client that a facility may bill or is allowed to receive as payment for its services.

"Personal comfort items" means items and services which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member.

"PM&R"-See **"Acute PM&R."**

"Physician standby" means physician attendance without direct face-to-face patient contact and does not involve provision of care or services.

"Physician's current procedural terminology (CPT)" - See **"CPT."**

"Plan of treatment" or **"plan of care"** means the written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.

"Pregnant and postpartum women (PPW)" means eligible female clients who are pregnant or within the first one hundred sixty days following delivery.

"Principal diagnosis" means the medical condition determined after study of the patient's medical records to be the principal cause of the patient's hospital stay.

"Principal procedure" means a procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.

"Private room rate" means the rate customarily charged by a hospital for a one-bed room.

"Professional activity study (PAS)" means the compilation of inpatient hospital data by diagnosis and age, conducted by the Commission of Professional and Hospital Activities, which resulted in the determination of an average length of stay for patients. The data are published in a book entitled *Length of Stay by Diagnosis, Western Region*.

"Professional component" means the part of a procedure or service that relies on the physician's professional skill or training, or the part of a reimbursement that recognizes the physician's cognitive skill.

"Profitability factor" means a factor used to calculate a hospital's low income disproportionate share (LIDSH) payment. The methods used to determine the profitability factor are:

(1) Determine the net revenue of each LIDSH qualified hospital. The net revenue amount will be the "net revenue" figure identified on the MAA hospital disproportionate share application submitted by the hospital. (Net revenue may be calculated using a three year average net revenue using "net revenue" figures from the most recent three years' MAA hospital disproportionate share applications.);

(2) Add the net revenue figures for all hospitals together to determine one total net revenue figure for all hospitals together to determine one total net revenue figure for all LIDSH qualified hospitals;

(3) Divide the hospital specific net revenue figure by the net revenue total for all hospitals; and

(4) Subtract the resulting amount from 1.00. The outcome is the profitability factor.

"Prognosis" means the probable outcome of a patient's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the patient's probable life span as a result of the illness.

"Prolonged service" means direct face-to-face patient services provided by a physician, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services.

"Prospective payment system (PPS)" means a system that sets payment rates for a pre-determined period for defined services, before the services are provided. The payment rates are based on economic forecasts and the projected cost of services for the pre-determined period.

"Psychiatric hospitals" means designated psychiatric facilities, state psychiatric hospitals, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals.

"Public hospital district" means a hospital district established under chapter 70.44 RCW.

"Random claims sample" means a sample in which all of the items are selected randomly, using a random number table or computer program, based on a scientific method of assuring that each item has an equal chance of being included in the sample. See also **"audit claims sample"** and **"stratified random sample."**

"Ratable" means a hospital-specific adjustment factor applied to the cost-based conversion factor (CBCF) to determine state-only program payment rates to hospitals.

"Ratio of costs to charges (RCC)" means the methodology used to pay hospitals for services exempt from the DRG payment method. It also refers to the factor applied to a hospital's allowed charges for medically necessary services to determine payment to the hospital for these DRG-exempt services.

"Readmission" means the situation in which a client who was admitted as an inpatient and discharged from the hospital is back as an inpatient within seven days as a result of one or more of the following: A new flair of illness, complication(s) from the first admission, a therapeutic admission following a diagnostic admission, a planned readmission following discharge, or a premature hospital discharge.

"Rebasing" means the process of recalculating the hospital cost-based conversion factors using more current data.

"Recalibration" means the process of recalculating DRG relative weights using more current data.

"Regional support network (RSN)" means a county authority or a group of county authorities recognized and certified by the department, that contracts with the department per chapters 38.52, 71.05, 71.24, 71.34, and 74.09 RCW and chapters 275-54, 275-55, and 275-57 WAC.

"Rehabilitation units" means specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals that meet Medicare criteria for distinct part rehabilitation units.

"Relative weights" - See **"DRG relative weights."**

"Remote hospitals" means hospitals located outside selective contracting areas (SCAs), or which:

(1) Are more than ten miles from the nearest contract hospital in the SCA; and

(2) Have fewer than seventy five beds; and

(3) Have fewer than five hundred Medicaid admissions in a two-year period.

"Reserve days" means the days beyond the ninetieth day of hospitalization of a Medicare patient for a benefit period or spell of illness. See also **"lifetime hospitalization reserve."**

"Retrospective payment system" means a system that sets payment rates for defined services according to historic costs. The payment rates reflect economic conditions experienced in the past.

"Revenue code" means a nationally-used three-digit coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

"Room and board" means services provided in a nursing facility, including:

- (1) Assistance in the activities of daily living.
- (2) Socialization activities.
- (3) Administration of medication.
- (4) Maintenance of the resident's room.
- (5) Supervision and assistance in the use of durable medical equipment and prescribed therapies.

See **"accommodation costs"** for services included in the hospital room and board category.

"Rural health clinic" means a clinic that is located in a rural area designated as a shortage area, and is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

"Rural hospital" means a rural health care facility capable of providing or assuring availability of health services in a rural area.

"Secondary diagnosis" means a diagnosis other than the principal diagnosis for which an inpatient is admitted to a hospital.

"Selective contracting area (SCA)" means an area in which hospitals participate in competitive bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by Medicaid patients.

"Selective hospital contracting program" or **"selective contracting"** means a competitive bidding program for hospitals within a specified geographic area to provide inpatient hospital services to medical assistance clients.

"Semi-private room rate" means a rate customarily charged for a hospital room with two to four beds; this charge is generally lower than a private room rate and higher than a ward room. See also **"multiple occupancy rate."**

"Short stay" means a hospital stay of less than or approximating twenty-four hours where an inpatient admission was not appropriate.

"Special care unit" means a Medicare-certified hospital unit where intensive care, coronary care, psychiatric intensive care, burn treatment or other specialized care is provided.

"Specialty hospitals" means children's hospitals, psychiatric hospitals, cancer research centers or other hospitals which specialize in treating a particular group of clients or diseases.

"Spendedown" means the amount of excess income MAA has determined that a client has available to meet his or her medical expenses. The client becomes eligible for Medicaid coverage only after he or she meets the spenddown requirement.

"Stat laboratory charges" means the charges by a laboratory for performing a test or tests immediately. "Stat." is the abbreviation for the Latin word "statim" meaning immediately.

"State plan" means the plan filed by the department with the Health Care Financing Administration (HCFA),

Department of Health and Human Services (DHHS), outlining how the state will administer the hospital program.

"Stratified random sample" means a sample consisting of claims drawn randomly, using statistical formulas, from each stratum of a universe of paid claims stratified according to the dollar value of the claims. See also **"audit claims sample"** and **"random claims sample."**

"Subacute care" means care to a patient which is less intrusive than that given at an acute care hospital. Skilled nursing, nursing care facilities and other facilities provide subacute care services.

"Surgery" means the medical diagnosis and treatment of injury, deformity or disease by manual and instrumental operations. For reimbursement purposes, surgical procedures are those designated in CPT as procedure codes 10000 to 69999.

"Swing-bed days" means a bed day on which an inpatient is receiving skilled nursing services in a swing bed at the hospital's census hour. The hospital bed must be certified by the health care financing administration for both acute care and skilled nursing services.

"Teaching hospital" means, for purposes of the teaching hospital assistance program disproportionate share hospital (THAPDSH), the University of Washington Medical Center and Harborview Medical Center.

"Technical component" means the part of a procedure or service that relates to the equipment set-up and technician's time, or the part of a reimbursement that recognizes the equipment cost and technician time.

"Tertiary care hospital" means a specialty care hospital providing highly specialized services to clients with more complex medical needs than acute care services.

"Total patient days" means all patient days in a hospital for a given reporting period, excluding days for skilled nursing, nursing care, and observation days.

"Transfer" means to move a client from one acute care facility to another.

"Transferring hospital" means the hospital transferring a client to another acute care facility.

"Trauma care facility" means a facility certified by the department of health as a level I, II, III, IV or V facility.

"Trauma care service" - See department of health's WAC 246-976-935.

"UB-92" means the uniform billing document intended for use nationally by hospitals, hospital-based skilled nursing facilities, home health, and hospice agencies in billing third party payers for services provided to clients.

"Unbundled services" means services which are excluded from the DRG payment to a hospital, including but not limited to, physician professional services and certain nursing services.

"Uncompensated care" - See **"charity care."**

"Uniform cost reporting requirements" means a standard accounting and reporting format as defined by Medicare.

"Uninsured indigent patient" means an individual who receives hospital inpatient and/or outpatient services and who cannot meet the cost of services provided because the

individual has no or insufficient health insurance or other resources to cover the cost.

"Usual and customary charge (UCC)" means the charge customarily made to the general public for a procedure or service, or the rate charged other contractors for the service if the general public is not served.

"Vendor rate increase" means an inflation adjustment determined by the legislature, used to periodically increase reimbursement to vendors, including health care providers, that do business with the state.

[Statutory Authority: RCW 74.08.090, 74.09.730, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, .11303 and .2652. 99-14-039, § 388-550-1050, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-1050, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1050, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1200 Limitations on hospital coverage. Hospital coverage under the medical assistance fee for service program is limited for certain eligible clients. This coverage includes, but is not limited to the following:

(1) Medical care clients enrolled with the department's healthy options carriers are subject to the respective carrier's policies and procedures for coverage of hospital services;

(2) Medical care clients covered by primary care case management are subject to the clients' primary care physicians' approval for hospital services;

(3) For emergency care exemptions for clients described in subsection (2) and (3) of this section, see WAC 388-538-100.

(4) Coverage for medically indigent (MI) clients is limited to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, 388-529-2950, and this chapter:

(a) Out-of-state care, hospital or other medical, is not covered for clients under the MI program; and

(b) Border areas are considered in-state.

(5) Out-of-state medical care is not covered for clients under the medical care services program.

(6) See WAC 388-550-1100(3) for chemical-dependent pregnant clients.

(7) Only Medicaid categorically needy and medically needy clients under twenty-one years of age, or sixty-five years of age or older may receive care in a state mental institution or approved psychiatric facility.

(8)(a) For clients eligible for both Medicare and Medicaid hospitalization, MAA pays deductibles and coinsurance, unless the client has exhausted his or her Medicare part A benefits.

(i) MAA payment is limited in amount so that when added to the Medicare payment, the total amount is no more than what the department pays for the same service when provided to a Medicaid eligible, non-Medicare client.

(ii) Providers must accept the total Medicare/Medicaid amount as payment in full.

(iii) Beneficiaries are not liable for any additional charges billed by providers or by a managed care entity.

(iv) Providers or managed care entities that charge beneficiaries excess amounts are subject to sanctions.

(b) If such benefits are exhausted, the department pays for hospitalization for such clients subject to MAA rules.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-1200, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2300 Repealed. See Disposition Table at beginning of this chapter.

WAC 388-550-2431 Hospice services—Inpatient payments. See chapter 388-551 WAC, Alternatives to hospital services, subchapter I—Hospice services.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2431, filed 2/26/99, effective 3/29/99.]

WAC 388-550-2501 Acute physical medicine and rehabilitation (acute PM&R) program—General. **Acute physical medicine and rehabilitation (acute PM&R)** is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services during the acute phase of rehabilitation. It requires prior authorization by medical assistance administration (MAA).

(1) A multidisciplinary team coordinates individualized client **acute PM&R** services at an MAA-approved rehabilitation facility to achieve the following for the client:

(a) Improved health and welfare; and

(b) Maximum physical, social, psychological and vocational potential.

(2) MAA determines the length of stay based on individual cases and community standards of care for **acute PM&R** services.

(3) When MAA's authorized acute period of rehabilitation ends, the provider transfers the client to a more appropriate level of care. Therapies may continue to help the client achieve maximum potential through other covered programs such as:

(a) Home health services (see subchapter II of chapter 388-551 WAC);

(b) Nursing facilities (see chapter 388-97 WAC); or

(c) Outpatient hospital services (see chapter 388-550 WAC).

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2501, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2511 Acute PM&R definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to this subchapter. Defined words and phrases are bolded in the text. In case of any conflicts, this section prevails for this subchapter.

"Accredit" (or "Accreditation") is a term used by nationally recognized health organizations, such as CARF, to state a facility meets community standards of medical care.

"Acute" means an intense medical episode, not longer than two months.

"Acute physical medicine and rehabilitation (acute PM&R)" means a comprehensive inpatient rehabilitative

program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for a diagnostic category for which the client shows significant potential functional improvement.

"**CARF.**" The official name for 'The Rehabilitation Accreditation Commission' of Tucson, Arizona. **CARF** is a national private agency that develops and maintains current, "field-driven" (community) standards through surveys and **accreditations** of rehabilitation facilities.

"**Level A services**" mean hospital-based **acute** rehabilitation services for medically stable clients with conditions that require complex nursing, medical and therapy needs as listed in WAC 388-550-2551(2). Such conditions include, but are not limited to, traumatic brain injuries, spinal cord injuries, and complicated bilateral amputations.

"**Level B services**" mean hospital- or nursing facility-based **acute** rehabilitation services for medically stable clients with new or exacerbated multiple sclerosis, mild head injuries, spinal cord injuries following the removal of the thoracic lumbar sacral orthosis (TLSO), and other medical conditions that require less complex nursing, medical and therapy needs as listed in WAC 388-550-2551(3).

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2511, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2521 Client eligibility requirements for acute PM&R services. (1) Clients in any of the following medical programs are eligible to receive acute PM&R Level A and Level B services:

- (a) Children's health (V);
- (b) Categorically needy program (CNP);
- (c) Categorically needy program - qualified Medicare beneficiary (CNP-QMB);
- (d) General assistance - determination pending for disability (GAX);
- (e) Limited casualty program - medically needy program (LCP-MNP); and
- (f) Medically needy program - qualified Medicare beneficiary (MNP-QMB).

(2) Clients in any of the following programs may receive only **Level A** hospital-based services:

(a) Medically indigent program (MIP) - emergency hospital-based and emergency transportation services. These clients may only receive services when:

- (i) They are transferred directly from an **acute** hospital stay; and
- (ii) The client's **acute PM&R** needs are directly related to the emergency medical need for the hospital stay;
- (b) General assistance unemployable (GAU - No out-of-state care);
- (c) CNP - emergency medical only;
- (d) LCP-MNP - emergency medical only; and
- (e) Alcoholism and drug addiction treatment and support act (ADATSA) (GAW).

(3) Clients in programs not listed in this section are not covered for **acute PM&R** services. See WAC 388-529-0100 and 388-529-0200 for scope of medical coverage.

(4) If a client is enrolled in an MAA Healthy Options managed care plan at the time of acute care admission, that plan pays for and coordinates **acute PM&R** services as appropriate.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111; § 388-550-2521, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2531 Requirements for becoming an MAA Level A or B acute PM&R provider. (1) To provide **acute PM&R** services to medical assistance clients, a provider obtains MAA approval for the facility. To obtain MAA approval for the facility, the provider must:

- (a) Submit a letter of request;
- (b) Include evidence that confirms the requirements listed in subsection (2) and (3) of this section are met; and
- (c) Send the letter and documentation to:
Acute PM&R Program Manager
Division of Health Services Quality Support
Medical Assistance Administration
PO Box 45506
Olympia WA 98504-5506

(2) In order to be approved by MAA as a **Level A** provider, a hospital must be:

- (a) Medicare certified;
- (b) **Accredited** by the joint commission on **accreditation** of hospital organizations (JCAHO);

(c) Licensed by department of health (DOH) as an acute care hospital (as defined by DOH in WAC 246-310-010, Definitions);

(d) **CARF accredited** for comprehensive integrated inpatient rehabilitation programs; and

(e) Operating per the standards set by DOH, excluding the certified rehabilitation registered nurse (CRRN) requirement, in either:

- (i) WAC 246-976-830, Level I trauma rehabilitation designation; or
- (ii) WAC 246-976-840, Level II trauma rehabilitation designation.

(3) In order to be approved by and contracted with MAA as a **Level B** provider, a facility must be:

- (a) Medicare certified;
- (b) Licensed by DOH as an acute care hospital (as defined by DOH in WAC 246-310-010, Definitions) or nursing facility;

(c) **CARF accredited** for comprehensive integrated inpatient rehabilitation programs;

(d) Contracted under MAA's selective contracting program, if in a selective contracting area, unless exempted from the requirement by MAA; and

(e) Operating per the standards set by DOH in WAC 246-976-840, Level II trauma rehabilitation designation, excluding the CRRN requirement.

(4) To obtain conditional contract approval, the applying facility must meet the criteria in subsections (1), (2) and/or (3) of this section, excluding the **CARF accreditation** requirement listed in section (2)(c) and (3)(c) of this section. The facility must:

- (a) Actively operate under **CARF** standards; and

(b) Have begun the process of obtaining full **CARF accreditation**.

(5) MAA will revoke a conditional contract approval if the facility does not obtain full **CARF accreditation** within twelve months of the conditional approval date by MAA.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2531, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2541 Quality of care for acute PM&R clients through audits and reviews. (1) To ensure quality of care, MAA may conduct an on-site review of any MAA-approved **acute PM&R** facility. See WAC 388-501-0130, Administrative controls, for additional information on audits conducted by department staff.

(2) In addition, MAA-approved **Level B** nursing facilities are subject to regular on-site surveys conducted by the department's aging and adult services administration (AASA).

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2541, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2551 How MAA determines client placement in Level A or B acute PM&R. (1) At the time of authorization, MAA determines the most appropriate client placement on a case-by-case basis:

- (a) In the level of care (level A or B);
- (b) In the least restrictive environment; and
- (c) At the lowest cost to MAA.

(2) Examples of client conditions suitable for **Level A** placement include:

- (a) Cognitive and/or motor deficits;
- (b) Brain damage from infectious brain diseases;
- (c) Quadriplegia or paraplegia;
- (d) Skin flap grafts for decubitus ulcers that need close observation by a surgeon, when the client is ready to mobilize or be upright in a chair;
- (e) Extensive burns requiring complex medical care and debridement;
- (f) Bilateral limb loss requiring close observation when the client has complex medical needs;
- (g) Multiple trauma with complicated orthopedic conditions and neurological deficits; or
- (h) Stroke with resulting hemiplegia or severe cognitive deficits, including speech and swallowing deficits requiring close observation with radiological examination.

(3) Examples of client conditions suitable for **Level B** placement include:

- (a) New strokes when medically stable;
- (b) Newly diagnosed or recently exacerbated multiple sclerosis with new loss of function;
- (c) New mild head injury when medically stable; or
- (d) Spinal cord injuries following the removal of a thoracic lumbar sacral orthosis after the client's first phase of acute rehabilitation.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2551, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2561 MAA's requirements for authorizing acute PM&R services. (1) The patient care coordina-

tor or the attending physician must call the MAA clinical consultation team before admitting an MAA client.

(2) The patient care coordinator or attending physician must provide to MAA objective information showing that:

(a) **Acute PM&R** treatment would effectively enable the client to obtain a greater degree of self-care, independence, or both;

(b) The client's medical condition requires that intensive twenty-four-hour inpatient comprehensive **acute PM&R** services be provided in an MAA-approved **acute PM&R** facility; and

(c) The client suffers from severe disabilities including, but not limited to, motor and/or cognitive deficits.

(3) Clients must be medically stable and show evidence that they are physically and cognitively ready to participate in the rehabilitation program. They must be willing and capable to participate at least three hours per day, seven days per week, in **acute PM&R** activities.

(4) For extension of authorization, the facility's rehabilitation staff must provide adequate medical justification, including significant observable improvement in the client's condition, to MAA prior to the expiration of the initial approved stay. If MAA denies the extension, the client must be transferred to an appropriate lower level of care as defined in WAC 388-550-2501(3).

(5) MAA may authorize administrative day reimbursement for clients who do not meet requirements described in this section, or who stay in the facility longer than the community standard's length of stay. The administrative day rate is the statewide Medicaid average daily nursing facility rate as determined by the department.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2561, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2800 Inpatient payment methods and limits. (1) MAA pays hospitals for inpatient hospital services using the rate setting methods identified in the department's approved state plan that includes:

Method	Used for
Negotiated conversion factor	Hospitals participating in the Medicaid hospital selective contracting program under waiver from the federal government
Cost-based conversion factor	Hospitals not participating in or exempt from the Medicaid hospital selective contracting program (DRG method)
Ratio of costs-to-charges	Hospitals or services exempt from DRG payment methods
Fixed per diem rate	Acute Physical Medicine and Rehabilitation (Acute PM&R) Level B contracted facilities

(2) MAA's annual aggregate Medicaid payments to each hospital for inpatient hospital services provided to Medicaid clients must not exceed the hospital's customary charges to the general public for the services (42 CFR § 447.271). MAA will recoup amounts in excess of annual aggregate Medicaid payments to hospitals.

(3) MAA's annual aggregate payments for inpatient hospital services, including state-operated hospitals, must not exceed estimated amounts that MAA would have paid using Medicare payment principles.

(4) When hospital ownership changes, MAA's payment to the hospital must not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(5) Hospitals participating in the medical assistance program must annually submit to the department:

(a) A copy of the hospital's HCFA 2552 Medicare Cost Report; and

(b) A disproportionate share hospital application.

(6) Reports referred to in subsection (5) of this section must be completed according to:

(a) Medicare's cost reporting requirements;

(b) The provisions of this chapter; and

(c) Instructions issued by MAA.

(7) MAA requires hospitals to follow generally accepted accounting principles unless federally or state-regulated.

(8) Participating hospitals must permit MAA to conduct periodic audits of their financial and statistical records.

(9) Payments for trauma services may be enhanced per WAC 246-976-935.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-2800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2800, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2900 Payment limits—Inpatient hospital services. (1) The department pays covered inpatient hospital services only to:

(a) General hospitals that meet the definition in RCW 70.41.020;

(b) Inpatient psychiatric facilities and alcohol or drug treatment centers:

(i) Approved by the department; and

(ii) Not paid directly through the RSNs.

(c) Out-of-state hospitals, subject to conditions specified in WAC 388-550-6700.

(2) MAA does not pay for hospital care and/or services provided to an MAA client enrolled with a managed care plan, when the plan covers those services. Plans have the authority to determine the treatment regimen of coverage as long as they cover all the Medicaid services that MAA reimburses them to cover. Plans may also provide coverage of services beyond that for which Medicaid reimburses them.

(3) MAA does not pay a hospital for care or services provided to a client enrolled in the hospice program, except as provided under chapter 388-551 WAC, subchapter I, Hospice services.

(4) MAA does not pay hospitals for inpatient ancillary services in addition to the DRG payment. The DRG payment includes ancillary services that include, but are not limited to, the following:

(a) Laboratory services;

(b) Diagnostic X-ray and other imaging services, including, but not limited to, magnetic resonance imaging, mag-

netic resonance angiography, computerized axial tomography, and ultrasound;

(c) Drugs and pharmacy services;

(d) Respiratory therapy and related services;

(e) Physical therapy and related services;

(f) Occupational therapy;

(g) Speech therapy and related services;

(h) Durable medical equipment and medical supplies, including infusion equipment and supplies;

(i) Prosthetic devices used during the client's hospital stay or permanently implanted during the hospital stay, such as artificial heart or replacement hip joints; and

(j) Service charges for handling and processing blood or blood derivatives.

(5) Neither MAA nor the client is responsible for payment for additional days of hospitalization when:

(a) A client exceeds the professional activities study (PAS) length of stay (LOS) limitations; and

(b) The provider has not obtained MAA approval for the LOS extension, as specified in WAC 388-550-1700(4).

(6) The LOS limit for a hospitalization is the seventy-fifth percentile of the PAS length of stay for that diagnosis code or combination of codes, published in the *PAS Length of Stay-Western Region edition*, as periodically updated.

(7) Neither MAA nor the client is responsible for payment of elective or nonemergent inpatient services which are included in MAA's selective contracting program and which a client receives in a nonparticipating hospital in a selective contracting area (SCA) unless the provider received prior approval from MAA as required by WAC 388-550-1700 (2)(a). The client, however, may be held responsible for payment of such services if the client contracts in writing with the hospital at least seventy-two hours in advance of the hospital admission to be responsible for payment. See WAC 388-550-4600, Selective contracting program.

(8) MAA may consider hospital stays of twenty-four hours or less short stays, and does not pay such stays under the DRG methodology. The exception for stays of twenty-four hours or less involving the following situations are paid under the DRG system:

(a) Death of a client;

(b) Obstetrical delivery;

(c) Initial care of a newborn; or

(d) Transfer of a client to another acute care hospital.

(9)(a) Under the ratio of costs-to-charges (RCC) method, MAA does not pay for inpatient hospital services provided more than one day prior to the date of a scheduled or elective surgery. These services must not be charged to the client.

(b) Under the DRG method, MAA considers all services provided the day before a scheduled or elective surgery to be included in the hospital's DRG payment for the case.

(c) MAA does not count toward the threshold for hospital outlier status:

(i) Any charges for extra days of inpatient stay prior to a scheduled or elective surgery; and

(ii) The associated services provided during those extra days.

(10) MAA applies the following rules to RCC cases and high-cost DRG outlier cases for costs that exceed the high-cost outlier threshold:

(a) MAA covers hospital stat charges only for specific laboratory procedures determined and published by MAA as qualified stat procedures. Tests generated in the emergency room do not automatically justify a stat order.

(b) MAA pays hospitals for special care charges only when:

(i) The hospital has a department of health (DOH) or Medicare-certified special care unit;

(ii) The special care service being billed, such as intensive care, coronary care, burn unit, psychiatric intensive care, or other special care, was provided in the special care unit;

(iii) The special care service provided is the kind of service for which the special care unit has been DOH- or Medicare-certified; and

(iv) The client's medical condition required the care be provided in the special care unit.

(11) MAA determines its actual payment for a hospital admission by deducting from the basic hospital reimbursement amount those charges which are the client's responsibility (referred to as spend-down) and any third party liability.

(12) MAA reduces reimbursement rates to hospitals for services provided to MI/GAU clients according to the hospital specific ratable and/or equivalency factors, as provided in WAC 388-550-4800.

(13) MAA pays for the hospitalization of a client who is eligible for Medicare and Medicaid only when the client has exhausted the Medicare part A benefits, including the non-renewable lifetime hospitalization reserve of sixty days.

(14) MAA pays in-state and border area hospital accommodation charges by multiplying the hospital's RCC rate to the lesser of the room rate submitted by the hospital to MAA or the accommodation charges billed on the claim.

(15) MAA pays out-of-state accommodation charges at the in-state average RCC rate times the hospital's billed charge.

(16) With regard to room rate submittals to MAA:

(a) A hospital must submit changes on the room rate change form, DSHS 13-687;

(b) Charges must not exceed the hospital's usual and customary charges to the public as required by 42 CFR § 447.271;

(c) New room rates take effect on the effective date stated on the room rate change form, or fourteen calendar days after MAA receives the form, whichever is later;

(d) MAA does not make retroactive room rate changes; and

(e) MAA pays private rooms at the semi-private room rate.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-2900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2900, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3000 DRG payment system. (1) Except where otherwise specified, MAA uses the diagnosis-related group (DRG) system, which categorizes patients into clinically coherent and homogenous groups with respect to

resource use, as the reimbursement method for inpatient hospital services.

(2) MAA periodically evaluates which all-patient grouper (AP-DRG) version to use.

(3)(a) MAA calculates the DRG payment for a particular hospital by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, for that admission by the hospital's cost-based conversion factor, as determined in WAC 388-550-3450.

(b) If the hospital is participating in the selective contracting program, the department multiplies the DRG relative weight for the admission by the hospital's negotiated conversion factor, as specified in WAC 388-550-4600(4).

(4)(a) MAA pays for a hospital readmission within seven days of discharge for the same client when department review concludes the readmission did not occur as a result of premature hospital discharge.

(b) When a client is readmitted to the same hospital within seven days of discharge, and MAA review concludes the readmission resulted from premature hospital discharge, MAA treats the previous and subsequent admissions as one hospital stay and pay a single DRG for the combined stay.

(5) If two different DRG assignments are involved in a readmission as described in subsection (4) of this section, MAA reviews the hospital's records to determine the appropriate reimbursement.

(6) MAA recognizes Medicaid's DRG payment for a Medicare-Medicaid dually eligible client to be payment in full.

(a) MAA pays the Medicare deductible and co-insurance related to the inpatient hospital services provided to clients eligible for Medicare and Medicaid subject to the Medicaid maximum allowable limit set in WAC 388-550-1200(6).

(b) MAA ensures total Medicare and Medicaid payments to a provider for such client does not exceed Medicaid's maximum allowable charges.

(c) MAA pays for those allowed charges beyond the threshold using the outlier policy described in WAC 388-550-3700 in cases where:

(i) Such client's Medicare part A benefits including lifetime reserve days are exhausted; and

(ii) The Medicaid outlier threshold status is reached.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3100 Calculating DRG relative weights. (1) MAA sets Washington Medicaid-specific DRG relative weights, as follows:

(a) Uses the all-patient grouper (AP-DRG) to classify Washington Medicaid hospital admissions data.

(b) Statistically tests each DRG for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards.

(c) Establishes relative weights from Washington Medicaid hospital admissions data. These relative weights may be stable or unstable.

(d) Tests the stability of Washington Medicaid relative weights from subsection (1)(c) of this section using a reasonable statistical test to determine if the weights are stable. MAA accepts as stable and adopts those Washington Medicaid relative weights that pass the reasonable statistical test.

(e) Pays admissions for DRGs having unstable Washington Medicaid relative weights using the RCC method.

(2) When using ratios with a Washington Medicaid relative weight as base, MAA adjusts all stable Medicaid relative weights so that the average weight of the case mix population equals 1.0.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3100, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3381 How MAA pays acute PM&R facilities for Level A services. (1) A Level A rehabilitation facility is paid by MAA according to:

(a) The individual hospital's current ratio of costs-to-charges as described in WAC 388-550-4500, Payment method—RCC; and

(b) MAA's fee schedule as described in WAC 388-550-6000, Payment—Outpatient hospital services.

(2) Level A inpatient acute PM&R room and board includes, but is not limited to:

(a) Facility use;

(b) Medical social services;

(c) Bed and standard room furnishings; and

(d) Nursing services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-3381, filed 8/18/99, effective 9/18/99.]

WAC 388-550-3401 How MAA pays acute PM&R facilities for Level B services. (1) MAA pays a contracted Level B facility for acute PM&R services at a fixed daily rate established by MAA.

(2) MAA may make cost inflation adjustments to the maximum daily rate by using the same inflation factor and schedule that MAA uses to pay independent hospitals. This diagnosis-related group (DRG) reimbursement method is described in WAC 388-550-3450(5)(a).

(3) MAA pays the rate in effect at the time of a client's admission to a facility.

(4) Equipment and services identified in the Level B contract as excluded from the fixed daily rate are paid to the MAA provider that directly provides the equipment or services.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-3401, filed 8/18/99, effective 9/18/99.]

WAC 388-550-3450 Payment method for calculating CBCF rates. (1) For Medicaid accommodation costs, MAA:

(a) Uses each hospital's base period cost data to calculate the hospital's total operating, capital, and direct medical education costs for each of the nine accommodation categories described in WAC 388-550-3150(5); then

(b) Divides those costs per category by total hospital days per category to arrive at a per day accommodation cost; then

(c) Multiplies the per day accommodation cost for each category by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

(2) For ancillary costs MAA:

(a) Uses the base period cost data to calculate total operating, capital, and direct medical education costs for each of the hospital's twenty-nine ancillary categories; then

(b) Divides these costs by total charges per category to arrive at a ratio of costs-to-charges (RCC) per ancillary category; then

(c) Multiplies these RCCs by Medicaid charges per category, as tracked by the Medicaid Management Information System (MMIS), to arrive at total Medicaid ancillary costs per category for the three components (operating, capital, and medical education).

(3) MAA:

(a) Combines Medicaid accommodation and ancillary costs to derive the hospital's total costs for operating, capital, and direct medical education components for the base year; then

(b) Divides the hospital's combined total cost by the number of Medicaid cases during the base year to arrive at an average Medicaid cost per DRG admission; then

(c) Adjusts, for hospitals with a fiscal year ending different than the common fiscal year end, the Medicaid average cost by a factor determined by MAA to standardize hospital costs to the common fiscal year end. MAA adjust the hospital's Medicaid average cost by the hospital's specific case mix index.

(4) MAA caps the Medicaid average cost per case for peer groups B and C at seventy percent of the peer group average. In calculation of the peer group cap, MAA removes the indirect medical education and outlier costs from the Medicaid average cost per admission.

(a) For hospitals in MAA peer groups B or C, MAA determines aggregate costs for the operating, capital, and direct medical education components at the lesser of hospital-specific aggregate cost or the peer group cost cap; then

(b) To whichever is less, the hospital-specific aggregate cost or the peer group cost cap determined in subsection (4) of this section, MAA adds:

(i) The individual hospital's indirect medical education costs, as determined in WAC 388-550-3250(2); and

(ii) An outlier cost adjustment in accordance with WAC 388-550-3350(2).

(5) For an inflation adjustment MAA may:

(a) Multiply the sum obtained in subsection (4) of this section by an inflation factor as determined by the legislature for the period January 1 of the year after the base year through October 31 of the rebase year; then

(b) Reduce the product obtained in (a) of this subsection by the outlier set-aside percentage determined in accordance with WAC 388-550-3350(3) to arrive at the hospital's adjusted CBCF; then

(c) Multiply the hospital's adjusted CBCF by the applicable DRG relative weight to calculate the DRG payment for each admission.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3450, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3450, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3500 Hospital inflation adjustment determinations. Effective on November 1 of each year, MAA may adjust all cost-based conversion factors (CBCF) by an inflation factor, as determined by the legislature and as addressed in subsequent budget notes. MAA does not automatically give an inflation increase to negotiated conversion factors for contracted hospitals participating in the hospital selective contracting program.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3500, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3700 DRG outliers and administrative day rates. (1) MAA calculates high-cost diagnosis-related group (DRG) outlier payments for qualifying cases as follows:

(a) To qualify as a DRG high-cost outlier the allowed charges for a case:

(i) With an admission date prior to July 1, 1999, must exceed a threshold of three times the applicable DRG payment or twenty-eight thousand dollars, whichever is greater; and

(ii) For an admission date on and after July 1, 1999, must exceed a threshold of three times the applicable DRG payment or thirty-three thousand dollars, whichever is greater.

(b) Payment for high-cost outlier cases other than those in subsections (1)(c) and (d) of this section is the applicable DRG payment amount, plus seventy-five percent of the hospital's ratio of costs-to-charges (RCC) rate applied to the allowed charges exceeding the outlier threshold.

(c) Payment for psychiatric high-cost outliers for DRGs 424-432 is at the applicable DRG rate plus one hundred percent of the hospital RCC applied to the allowed charges exceeding the outlier threshold.

(d) Payment for high-cost outlier cases at in-state childrens hospitals is the applicable DRG payment amount, plus eighty-five percent of the hospital's RCC applied to the allowed charges exceeding the outlier threshold.

(2) MAA calculates low-cost DRG outlier payments for qualifying cases as follows:

(a) To qualify as a DRG low-cost outlier, the allowed charges for a case:

(i) With an admission date prior to July 1, 1999, must be less than or equal to ten percent of the applicable DRG payment or four hundred dollars, whichever is greater; and

(ii) With an admission date on and after July 1, 1999, must be less than or equal to ten percent of the applicable

DRG payment or four hundred fifty dollars, whichever is greater.

(b) MAA's payment for low-cost DRG outlier claims is the allowed charges multiplied by the hospital's RCC.

(3) MAA pays hospitals an all-inclusive administrative day rate for those days of hospital stay in which a client no longer needs an acute inpatient level of care, but is not discharged because an appropriate noninpatient hospital placement is not available.

(a) MAA sets payment for administrative days at the statewide average Medicaid nursing facility per diem rate. The administrative day rate is adjusted annually effective November 1.

(b) Ancillary services are not paid during administrative days.

(c) For a DRG payment case, MAA does not pay administrative days until the case exceeds the high-cost outlier threshold for that case.

(d) For DRG-exempt cases, MAA identifies administrative days during the length of stay review process after the client's discharge from the hospital.

(e) If the hospital admission is solely for a stay until an appropriate sub-acute placement can be made, MAA pays the hospital at the administrative day rate from the date of admission.

(4) MAA makes day outlier payments to hospitals, in accordance with section 1923 (a)(2)(C) of the Social Security Act, for exceptionally long-stay clients. A hospital is eligible for the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share (DSH) hospital and the client served is under the age of six, or the hospital may not be a DSH hospital but the client served is a child under age one;

(b) The payment methodology for the admission is DRG;

(c) The charge for the hospitalization is below the high-cost outlier threshold as defined in subsection (1)(a) of this section; and

(d) The client's length of stay is over the day outlier threshold for the applicable DRG. The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

(5) MAA bases the day outlier payment on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate.

(6) MAA's total payment for day outlier claims is the applicable DRG payment plus the day outlier or administrative days payment.

(7) Day outliers are only paid for cases that do not reach high-cost outlier status. A client's outlier claim is either a day outlier or a high-cost outlier, but not both.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3700, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3900 Payment method—Border area hospitals. (1) Under the diagnosis-related group (DRG) payment method:

(a) MAA calculates the cost-based conversion factor (CBCF) of a border area hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(b) For a border area hospital with no HCFA 2552 for the rebasing year, MAA assigns the MAA peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.

(2) MAA calculates:

(a) The ratio of costs-to-charges (RCC) in accordance with WAC 388-550-4500.

(b) For a border area hospital with no HCFA 2552 Medicare cost report, its RCC on the Washington in-state average RCC ratios.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4100 Payment method—New hospitals. (1) For rate-setting purposes, MAA considers as new:

(a) A hospital which began services after the most recent rebased cost-based conversion factors (CBCFs), or

(b) A hospital that has not been in operation for a complete fiscal year.

(2) MAA determines a new hospital's CBCF as the average of the CBCF of all hospitals within the same MAA peer group.

(3) MAA determines a new hospital's ratio of costs-to-charges (RCC) by calculating and using the average RCC rate for all current Washington in-state hospitals.

(4) MAA considers that a change in hospital ownership does not constitute a new hospital.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-4100, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4500 Payment method—RCC. (1)(a) MAA calculates a hospital's ratio of costs-to-charges (RCC) by dividing allowable operating costs by patient revenues associated with these allowable costs.

(b) MAA bases these figures on the annual Medicare cost report data provided by the hospital.

(c) MAA updates hospitals' RCC rates annually with the submittal of new HCFA 2552 Medicare cost report data. Prior to computing the ratio, MAA excludes increases in operating costs or total rate-setting revenue attributable to a change in ownership.

(2) MAA limits a hospital's RCC to one hundred percent of its allowable charges. MAA recoups payments made to a hospital in excess of its customary charges to the general public.

(3) MAA establishes the basic hospital payment by multiplying the hospital's assigned RCC rate by the allowed charges for medically necessary services. MAA deducts client responsibility (spend-down) or third-party liability (TPL) as identified on the billing invoice or by MAA from the basic payment to determine the actual payment due from MAA for that hospital admission.

(4) MAA uses the RCC payment method to reimburse:
 (a) Peer group A hospitals;
 (b) Other DRG-exempt hospitals identified in WAC 388-550-4300; and
 (c) Any hospital for DRG-exempt services described in WAC 388-550-4400.

(5) MAA deems the RCC for in-state and border area hospitals lacking sufficient HCFA 2552 Medicare cost report data the weighted average of the RCC rates for in-state hospitals.

(6) MAA calculates an outpatient ratio of costs-to-charges by dividing the projected costs by the projected charge multiplied by the average RCC.

(a) In no case may the outpatient adjustment factor exceed 1.0.

(b) The outpatient adjustment factor is updated annually effective November 1.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4700 Payment—Non-SCA participating hospitals. (1) In a selective contracting area (SCA), MAA pays any qualified hospital for inpatient hospital services provided to an eligible medical care client for treatment of an emergency medical condition.

(2) MAA pays any qualified hospital for medically necessary but nonemergent inpatient hospital services provided to an eligible medical care client deemed by the department to reside an excessive travel distance from a contracting hospital.

(a) The client is deemed to have an excessive travel burden if the travel distance from a client's residence to the nearest contracting hospital exceeds the client's county travel distance standard, as follows:

<u>County</u>	<u>Community Travel Distance Standard</u>
Adams	25 miles
Asotin	15 miles
Benton	15 miles
Chelan	15 miles
Clallam	20 miles
Clark	15 miles
Columbia	19 miles
Cowlitz	15 miles
Douglas	20 miles
Ferry	27 miles
Franklin	15 miles
Garfield	30 miles
Grant	24 miles
Grays Harbor	23 miles
Island	15 miles
Jefferson	15 miles
King	15 miles
Kitsap	15 miles
Kittitas	18 miles
Klickitat	15 miles
Lewis	15 miles

<u>County</u>	<u>Community Travel Distance Standard</u>
Lincoln	31 miles
Mason	15 miles
Okanogan	29 miles
Pacific	21 miles
Pend Oreille	25 miles
Pierce	15 miles
San Juan	34 miles
Skagit	15 miles
Skamania	40 miles
Snohomish	15 miles
Spokane	15 miles
Stevens	22 miles
Thurston	15 miles
Wahkiakum	32 miles
Walla Walla	15 miles
Whatcom	15 miles
Whitman	20 miles
Yakima	15 miles

(b) If a client must travel outside his/her SCA to obtain inpatient services not available within the community, such as treatment from a tertiary hospital, the client may obtain such services from a contracting hospital appropriate to the client's condition.

(3) MAA requires prior authorization for all nonemer-gent admissions to nonparticipating hospitals in an SCA. See WAC 388-550-1700 (2)(a).

(4) MAA pays a licensed hospital all applicable Medicare deductible and coinsurance amounts for inpatient services provided to Medicaid clients who are also beneficiaries of Medicare part A subject to the Medicaid maximum allowable as established in WAC 388-550-1200 (8)(a).

(5) The department pays any licensed hospital DRG-exempt services as listed in WAC 388-550-4400.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4700, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4800 Hospital payment method—State-only programs. (1) The medical assistance administration (MAA):

(a) Calculates payments to hospitals for state-only MI/medical care services to clients according to the:

- (i) Diagnosis-related group (DRG); or
 - (ii) Ratio of costs-to-charges (RCC) methodologies; and
- (b) Reduces hospitals' Title XIX rates by their ratable and/or equivalency factors (EQ), as applicable.

(2) MAA calculates ratables by:

(a) Adding together a hospital's Medicare and Medicaid revenues, along with the value of the hospital's charity care and bad debts. MAA deducts the hospital's low-income disproportionate share (LIDSH) revenue from this total to arrive at the hospital's community care dollars; then

(b) Subtracting revenue generated by hospital-based physicians from total hospital revenue. Both revenues are as reported in the hospital's HCFA 2552 cost report; then

(c) Divides the amount derived in step (2)(a) by the amount derived in step (2)(b) to obtain the ratio of community care dollars to total revenue; then

(d) Subtracts the result of step (2)(c) from 1.000 to obtain the hospital's ratable. The hospital's Title XIX cost-based conversion factor (CBCF) or RCC rate is multiplied by (1-ratable) for a MI or medical care services client.

(e) The payments for MI/medical care services clients are mathematically represented as follows:

MI/medical care services RCC = Title XIX RCC x (1-Ratable)

MI/medical care services CBCF = Title XIX Conversion Factor x (1-Ratable) x EQ

(3) MAA updates each hospital's ratable annually on August 1.

(4) MAA:

(a) Uses the EQ to hold the DRG reimbursement rates for the MI/medical care services programs at their current level prior to any rebasing. MAA applies the EQ only to the Title XIX DRG CBCFs. MAA does not apply the EQ when the DRG rate change is due to the application of an inflation factor.

(b) Calculates a hospital's equivalency factor as follows:

EQ = (Current MI/medical care services conversion factor)/(Title XIX DRG rate x (1-ratable))

(5) Effective for hospital admissions on or after December 1, 1991, MAA reduces its payment for MI (but not medical care services) clients further by multiplying the payment by ninety-seven percent. MAA applies this payment reduction adjustment to the MIDSH methodology in accordance with section 3(b) of the "Medicaid Voluntary Contributions and Provider-Specific Tax Amendment of 1991."

(6) When the MI/medical care services client has a trauma that qualifies under the trauma program, MAA pays the full Medicaid Title XIX amount when care has been provided in a nongovernmental hospital designated by the department of health (DOH) as a trauma services center. MAA gives an annual grant for trauma services to governmental hospitals certified by DOH.

[Statutory Authority: RCW 74.09.080, 74.09.730, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271 and 2652. 99-14-026, § 388-550-4800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4800, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4900 Disproportionate share payments. (1) As required by section 1902 (a)(13)(A) of the Social Security Act, the medical assistance administration (MAA) gives consideration to hospitals which serve a disproportionate number of low-income clients with special needs by making a payment adjustment to eligible hospitals. MAA considers this adjustment a disproportionate share payment.

(2) MAA considers a hospital a disproportionate share hospital if both the following apply:

(a) The hospital's Medicaid inpatient utilization rate (MIPUR) is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving

Medicaid payments in the state, or its low-income utilization rate (LIUR) exceeds twenty-five percent; and

(b) The hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals. This requirement does not apply to a hospital:

(i) The inpatients of which are predominantly individuals under eighteen years of age; or

(ii) Which did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(3) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(4) MAA may consider a hospital a disproportionate share hospital if both of the following apply:

(a) The hospital has a MIPUR of not less than one percent; and

(b) The hospital meets the requirement of subsection (2)(b) of this section.

(5) MAA administers the low-income disproportionate share (LIDSH) program and may administer any of the:

(a) Medically indigent disproportionate share (MIDSH);

(b) General assistance-unemployable disproportionate share (GAUDSH);

(c) Small rural hospital assistance program disproportionate share (SRHAPDSH);

(d) Teaching hospital assistance program disproportionate share (THAPDSH);

(e) State teaching hospital financing program disproportionate share (STHFPDSH);

(f) County teaching hospital financing program disproportionate share (CTHFPDSH); and

(g) Public hospital district disproportionate share (PHDDSH).

(6) MAA allows a hospital to receive any one or all of the disproportionate share hospital (DSH) payment adjustments discussed in subsection (5) of this section when the hospital:

(a) Applies to MAA; and

(b) Meets the eligibility requirements for the particular DSH payment program, as discussed in WAC 388-550-5000 through 388-550-5400.

(7) MAA ensures each hospital's total DSH payments do not exceed the individual hospital's DSH limit, defined as:

(a) The cost to the hospital of providing services to Medicaid clients, including clients served under Medicaid managed care programs;

(b) Less the amount paid by the state under the non-DSH payment provision of the state plan;

(c) Plus the cost to the hospital of providing services to uninsured patients; and

(d) Less any cash payments made by uninsured clients.

(8) MAA's total annual DSH payments must not exceed the state's DSH allotment for the federal fiscal year.

If the DSH statewide allotment is exceeded, MAA recoups overpayments from hospitals in the following program order:

(a) PHDDSH;

(b) THAPDSH;

(c) CTHFPDSH;

(d) STHFPDSH;

(e) SRHAPDSH;

(f) MIDSH;

(g) GAUDSH; and

(h) LIDSH.

[Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4, 99-14-040, § 388-550-4900, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5000 Payment method—LIDSH. (1)

A hospital serving the department's clients is eligible for a low-income disproportionate share hospital (LIDSH) payment adjustment if the hospital meets the requirements of WAC 388-550-4900(2).

(2) MAA pays hospitals considered eligible under the criteria in subsection (1) of this section. The total LIDSH payment amounts equal the funding set by the state's appropriations act for LIDSH. The amount that the state appropriates for LIDSH may vary from year to year.

(3) MAA distributes LIDSH payments to individual hospitals as follows by:

(a) For each LIDSH-eligible hospital, determining the standardized Medicaid inpatient utilization rate (MIPUR). The MIPUR is standardized by dividing the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals; then

(b) Multiplies the hospital's standardized MIPUR by the hospital's most recent case mix index, and then by the hospital's most recent fiscal year Title XIX admissions, and lastly by the hospital's profitability factor. MAA then multiplies the product by an initial random base amount; then

(c) Compares the sum of all annual LIDSH payments to the appropriated amount. If the amounts differ, MAA progressively selects a new base amount by trial and error until the sum of the LIDSH payments to hospitals equals the appropriated amount.

[Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4, 99-14-040, § 388-550-5000, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5100 Payment method—MIDSH. (1)

MAA considers a hospital eligible for the medically indigent disproportionate share hospital (MIDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);

(b) Is an in-state or border area hospital;

(c) Provides services to clients under the medically indigent program; and

(d) Has a low-income utilization rate of one percent or more.

(2) MAA determines the MIDSH payment for each eligible hospital in accordance with WAC 388-550-4800.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5100, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050,

70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5150 Payment method—GAUDSH.

(1) MAA considers a hospital eligible for the general assistance-unemployable disproportionate share hospital (GAUDSH) payment if the hospital:

- (a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);
- (b) Is an in-state or border area hospital;
- (c) Provides services to clients under the medical care services program; and
- (d) Has a low-income utilization rate (LIUR) of one percent or more.

(2) MAA determines the GAUDSH payment for each eligible hospital in accordance with WAC 388-550-4800, except that the payment is not reduced by the additional three percent specified in WAC 388-550-4800(4).

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5150, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5200 Payment method—SRHAPDSH. (1) MAA considers a hospital eligible for the small rural hospital assistance program disproportionate share hospital (SRHAPDSH) payment if the hospital:

- (a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);
- (b) Is an in-state hospital;
- (c) Is a small, rural hospital, defined as a hospital with fewer than seventy-five licensed beds and located in a city or town with a nonstudent population of thirteen thousand or less; and
- (d) Provides at least one percent of its services to low-income patients in rural areas of the state.

(2)(a) MAA pays hospitals qualifying for SRHAPDSH payments from a legislatively appropriated pool.

(b) MAA determines each individual hospital's SRHAPDSH payment as follows: The total dollars in the pool will be multiplied by the percentage derived from dividing the Medicaid payments to the individual hospital during the fiscal year that is two years previous to the state fiscal year immediately preceded by the total Medicaid payments to all SRHAPDSH hospitals during the same hospital fiscal year.

(3) MAA's SRHAPDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid clients and uninsured indigent patients. MAA reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5200, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5250 Payment method—THAPDSH.

(1) MAA considers a hospital eligible for the teaching hospital assistance program disproportionate share hospital (THAPDSH) program if the hospital:

- (a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);
- (b) Is a Washington State University hospital; and
- (c) Has a Medicaid inpatient utilization rate (MIPUR) of twenty percent or more.

(2) MAA funds THAPDSH payments with legislatively appropriated monies. MAA divides the legislatively appropriated THAPDSH amount equally between qualifying hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5250, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5300 Payment method—STHFPDSH.

(1) MAA considers a hospital eligible for the state teaching hospital financing program disproportionate share hospital (STHFPDSH) program if the hospital:

- (a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);
- (b) Is a state-owned university or public corporation hospital (border area hospitals are excluded);
- (c) Provides a major medical teaching program, defined as a program in a hospital with more than one hundred residents and/or interns; and
- (d) Has a Medicaid inpatient utilization rate (MIPUR) of at least twenty percent.

(2) MAA:

(a) Pays hospitals deemed eligible under the criteria in subsection (1) of this section a STHFPDSH payment from the legislatively appropriated pool specifically designated for DSH payments to state and county teaching hospitals.

(b) Limits STHFPDSH payments to eligible hospitals to seventy percent of the legislatively appropriated pool for DSH payments to state and county teaching hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5300, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5350 Payment method—CTHFPDSH. (1) MAA considers a hospital eligible for the county teaching hospital financing program disproportionate share hospital (CTHFPDSH) payment if the hospital:

- (a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);
- (b) Is a county hospital in Washington state (border area hospitals are excluded), so designated by the county in which located;
- (c) Provides a major medical teaching program, defined as a program in a hospital with more than one hundred residents and/or interns; and
- (d) Has a low-income utilization rate (LIUR) of at least twenty-five percent.

(2) MAA:

(a) Pays hospitals considered eligible under the criteria in subsection (1) of this section a CTHFPDSH payment from the legislatively appropriated pool specifically designated for DSH payments to state and county teaching hospitals.

(b) Limits CTHFPDSH payments to eligible hospitals to thirty percent of the legislatively appropriated pool for DSH payments to state and county teaching hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5350, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5400 Payment method—PHDDSH.

(1) MAA considers a hospital eligible for the public hospital district disproportionate share hospital (PHDDSH) payment if the hospital:

- (a) Meets the criteria in WAC 388-550-4900 (2)(b) and (4);
- (b) Is a public district hospital in Washington state or a border area hospital owned by a public corporation; and
- (c) Provides at least one percent of its services to low-income patients.

(2) MAA pays hospitals considered eligible under the criteria in subsection (1) of this section a PHDDSH payment amount from the legislatively appropriated PHDDSH pool.

[Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5400, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5600 Administrative appeal for hospital rate reimbursement. The hospital appeals and dispute process follows the procedures as stated in WAC 388-502-0220, Administrative appeal for contractor/provider rate reimbursement.

[Statutory Authority: RCW 74.08.090 and 74.09.730. 99-16-070, § 388-550-5600, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6000 Payment—Outpatient hospital services. (1)(a) Excluding nonallowable revenue codes and the services specified in subsection (2) below MAA determines allowable costs for hospital outpatient services by the application of the hospital-specific outpatient ratio of costs to charges (RCC).

(b) MAA does not pay separately for ancillary hospital services which are included in the hospital's RCC reimbursement rate.

(2) MAA pays the lesser of billed charges or MAA's published maximum allowable fees for the following outpatient services:

- (a) Laboratory/pathology;
- (b) Radiology, diagnostic and therapeutic;
- (c) Nuclear medicine;
- (d) Computerized tomography scans, magnetic resonance imaging, and other imaging services;
- (e) Physical therapy;
- (f) Occupational therapy;
- (g) Speech/language therapy; and
- (h) Other hospital services as identified and published by the department.

(3) MAA is not responsible for payment of hospital care and/or services provided to a client enrolled in a MAA-contracted, prepaid medical plan when the client fails to use:

- (a) For a nonemergent condition, a hospital provider under contract with the plan;
- (b) In a bona fide emergent situation, a hospital provider under contract with the plan; or
- (c) The provider whom MAA has authorized to provide and receive payment for a service not covered by the prepaid plan, but covered under the client's medical assistance program.

(4) Providers or managed care entities that charge Medicare beneficiaries excess amounts are subject to sanctions as listed in 42 U.S.C. 1320A-7b(d)(1). These sanctions include a fine of up to twenty-five thousand dollars or imprisonment of up to five years, or both.

(5) MAA considers a hospital stay of twenty-four hours or less as an outpatient short stay. MAA does not pay an outpatient short stay under the DRG system except when it involves one of the following situations:

- (a) Death of a client;
- (b) Obstetrical delivery;
- (c) Initial care of a newborn; or
- (d) Transfer of a client to another acute care hospital.

(6) MAA does not pay for patient room and ancillary services charges beyond the twenty-four period for outpatient stays.

(7) MAA does not cover short stay unit, emergency room facility, and labor room charges in combination when these billing periods overlap.

(8) MAA requires that the hospital's bill to the department shows the admitting, principal, and secondary diagnoses. Include the attending physician's name and MAA provider number.

(9) Payments for trauma services may be enhanced per WAC 246-976-935.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v), 42 C.F.R. 447.271 and 42 C.F.R. 11303. 99-14-028, § 388-550-6000, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-6000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6000, filed 12/18/97, effective 1/18/98.]

Chapter 388-551 WAC

ALTERNATIVES TO HOSPITAL SERVICES

WAC

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WAC 388-551-1000 Hospice program. (1) Hospice is a twenty-four hour program coordinated by a **hospice interdisciplinary team**. The hospice program allows the **terminally ill** client to choose physical, pastoral/spiritual, and psychosocial comfort rather than cure. Hospitalization is used only for acute symptom management.

(2) Hospice care is initiated by the choice of client, **family**, or physician. The client's physician must certify a client as appropriate for hospice care.

(3) Hospice care may be in a client's temporary or permanent place of **residence**.

(4) Hospice care is ended by the client or family (**revocation**), the hospice agency (**discharge**), or death.

(5) Bereavement care is provided to the **family** of the client who chooses hospice care. It provides emotional and spiritual comfort associated with the death of a hospice client.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1000, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1010 Hospice definitions. The following definitions and those found in WAC 388-500-0005, Medical definitions have the following meanings for this subchapter. Defined words and phrases are bolded in the text.

"Biologicals" means medicinal preparations including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products.

"Brief period" means six days or less.

"CSO" means the client's community services office of the department's economic services administration.

"Discharge" means an agency ends hospice care for a client. See WAC 388-551-1350 for details.

"Election period" means the time, ninety or sixty days, that the client is certified as eligible for and chooses to receive hospice care. See WAC 388-551-1310 for details.

"Family" means any person(s) important to the client, as defined by the client.

"HCS" means the client's home and community services office of the aging and adult services administration.

"Hospice interdisciplinary team" means the following health professionals who plan and deliver hospice care to a client as appropriate under the direction of a certified physician: home health aides monitored by a registered nurse, therapists (physical, occupational, speech-language), registered nurses, physicians, social workers, counselors, volunteers, and others as necessary.

"Palliative" means medical treatment designed to reduce pain or increase comfort, rather than cure.

"Plan of care." See WAC 388-551-1320 for details.

"Residence" means where the client lives for an extended period of time.

"Revoke" and **"revocation"** mean a client or family member's choice to stop receiving hospice care. See WAC 388-551-1220 for details.

"Terminally ill" means the client has a life expectancy of six months or less, assuming the client's disease process runs its natural course.

"Twenty-four-hour day" means a day beginning and ending at midnight.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1010, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1200 Client eligibility for hospice care. (1) A client must be eligible for one of the following Medicaid programs to receive hospice care:

- Categorically needy program (CNP);
- General assistance — disability determination pending (GAX);
- Limited casualty program - medically needy program (LCP-MNP); or
- Children's health (V).

(2) An eligible Medicaid client who voluntarily chooses hospice care must be certified by a physician as **terminally ill** before MAA pays for hospice care.

(3) Clients enrolled in one of MAA's healthy options managed care plans receive all hospice services directly through their plan. The managed care plan must arrange or provide all hospice services for a managed care client.

(4) Hospice clients attain institutional status as described in WAC 388-513-1320 when they elect and are certified for hospice care. See WAC 388-513-1380 for the client's financial participation requirements.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1200, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1210 Services included in the hospice daily rate. (1) In the client's individual **plan of care**, the **hospice interdisciplinary team** identifies the specific Hospice services and supplies to be provided to the client.

- The services must be all of the following:
 - Medically necessary for **palliative** care;
 - Related to the client's **terminal illness**;
 - Prescribed by the client's attending physician, alternate physician, or hospice medical director;
 - Supplied or arranged for by the hospice provider; and
 - Included in the client's **plan of care**.

(3) The following intermittent services and supplies, paid by MAA's hospice daily rate, must be available from and offered by the hospice provider for the client as determined by the client's **hospice interdisciplinary team**:

- Medical equipment and supplies** that are medically necessary for **palliative** care;
- Drugs and biologicals** used primarily for the relief of pain and management of symptoms;
- Home health aide services** furnished by qualified aides of the hospice agency. A registered nurse must com-

plete a home-site supervisory visit every two weeks to assess aide services provided;

(d) **Physical therapy, occupational therapy, and speech-language therapy** to manage symptoms or enable the client to safely perform ADLs (activities of daily living) and basic functional skills;

(e) **Physician services** related to administration of the **plan of care**;

(f) **Nursing care** provided through the hospice agency by either:

(i) A registered nurse; or

(ii) A licensed practical nurse under the supervision of a registered nurse;

(g) **Medical social services** provided through the hospice agency by a social worker under the direction of a physician;

(h) **Counseling services** provided through the hospice agency to the client and his or her **family** members or caregivers;

(i) **Medical transportation services**; and

(j) **Short-term, inpatient care**, provided in a Medicare-certified hospice inpatient unit, hospital, or nursing facility.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1210, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1300 How to become a MAA hospice provider. (1) To be reimbursed by MAA, a hospice agency must be:

(a) Medicare, Title XVIII certified; and

(b) Enrolled with MAA as a provider of hospice care.

(2) All services provided through a hospice agency must be performed by qualified personnel as required through Medicare's certification process in effect as of February 1, 1999. For more information on Medicare certifications, contact:

Department of Health
Hospice Certification Program
Mailstop 47852
Olympia, Washington, 98504-7852.

(3) Freestanding hospice agencies licensed as hospitals by the department of health must sign an additional selective contract with MAA to receive payment from MAA.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1300, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1310 Certifications (election periods) for hospice clients. A client chooses to receive Hospice care through a series of time-limited periods, called "**election periods.**" An example of this process is WAC 388-551-1315. Hospice providers are responsible for obtaining physician certifications for these **election periods.**

(1) A client's hospice coverage must be available for two initial ninety-day **election periods** followed by an unlimited number of succeeding sixty-day **election periods.**

(2) The hospice provider must document the client's medical prognosis of a specific **terminal illness** in the client's hospice record. This written certification must be filed in the

client's hospice record for each election period. The certification must meet all of the following criteria:

(a) For the **initial election period**, signatures of the hospice medical director and the client's attending physician; and

(b) For **subsequent election periods**:

(i) Signature of the hospice medical director; and

(ii) Verbal certifications by the hospice medical director or the client's attending physician must be documented in writing no later than two calendar days after hospice care is initiated or renewed.

(3) The provider must file election statements in the client's hospice medical record. This election statement must include:

(a) Name and address of the hospice;

(b) Proof that client was fully informed about hospice care and waiver of other services;

(c) Effective date of the election; and

(d) Signature of the client or their representative.

(4) When a client's hospice coverage ends within an **election period**, the remainder of that **election period** is forfeited.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1310, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1315 Example of how hospice client certifications (election periods) work. This is an example of how election periods, as described in WAC 388-551-1310, work:

(1) Client chooses hospice care, physician certifies the client;

(2) Client is on hospice care for the first ninety-day period;

(3) Physician recertifies the client for the second ninety-day period;

(4) Client revokes hospice care, on the sixty-third day of the second ninety-day period (one hundred and fifty-three days since original certification);

(5) Hospice care for the client stops on the sixty-third day of the second ninety-day period (one hundred and fifty-three days since original certification);

(6) Client decides to re-elect hospice care, eleven days later, the seventy-fourth day of the second ninety-day period (the one hundred and sixty-fourth day since original certification);

(7) Client forfeits the right to the remaining sixteen days of the second ninety-day period; and

(8) Does the physician re-certify the client for hospice care?:

(a) If yes, the client may immediately begin a new sixty-day election period; or

(b) If no, the client is not currently eligible to receive hospice care.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1315, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1320 Hospice plan of care. (1) The hospice agency must establish the client's hospice **plan of care** in accordance with Medicare requirements before hospice ser-

vices are delivered. Hospice services delivered must be consistent with that **plan of care**.

(2) A registered nurse or physician must conduct an initial assessment of the client and must develop the **plan of care** with at least one other member of the **hospice interdisciplinary team**.

(3) The **hospice interdisciplinary team** must review in a case planning conference the **plan of care**, no later than two working days after it is developed.

(4) The **plan of care** must be reviewed and updated every two weeks by at least three members of the **hospice interdisciplinary team**, including at least:

- (a) A registered nurse;
- (b) A social worker; and
- (c) One other **hospice interdisciplinary team** member.

(5) Also see WAC 246-331-135 for the department of health's plan of care requirements.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1320, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1330 Hospice coordination of care. (1)

Once a client chooses hospice care from a hospice agency, that client gives up the right to:

(a) Covered Medicaid hospice services and supplies received at the same time from another hospice agency; and

(b) Any covered Medicaid services and supplies received from any other provider and which are related to the **terminal illness**.

(2) Services and supplies not covered by the Medicaid hospice benefit are paid separately, if covered under the client's Medicaid eligibility. These services include but are not limited to:

(a) COPEs (community options program entry system) as determined and paid by the department's aging and adult services administration (AASA); and

(b) Medically intensive home care program (MIHCP) as determined by the department's division of developmentally disabled.

(3) Clients eligible for coordinated community aids services alternatives (CCASA) are not eligible for hospice coverage.

(4) The hospice provider must coordinate all the client's medical management for the **terminal illness**.

(5) All of the client's providers, including the hospice provider, must coordinate:

- (a) The client's health care; and
- (b) Services available from other department programs, such as COPEs.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1330, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1340 When a client leaves hospice without notice. When a client chooses to leave hospice care or refuses hospice care without giving the hospice provider a **revocation** statement, as required by WAC 388-551-1360, the hospice provider must do all of the following:

(1) Notify MAA's hospice coordinator within **five working days** of becoming aware of the client's decision (see WAC 388-551-1400 for further requirements);

(2) Stop billing MAA for hospice payment;

(3) Notify the client, or the client's representative, that the client's **discharge** has been reported to MAA; and

(4) Document the effective date and details of the **discharge** in the client's hospice record.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1340, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1350 Discharges from hospice care. A hospice provider may **discharge** a client from hospice care when the client:

(1) Is no longer certified for hospice care;

(2) Is no longer appropriate for hospice care; or

(3) Seeks treatment for the **terminal illness** from outside the **plan of care** as defined by the **hospice interdisciplinary team**.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1350, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1360 Ending hospice care (revocations). (1) A client or a **family** member may choose to stop hospice care at any time by signing a **revocation** statement.

(2) The **revocation** statement documents the client's choice to stop Medicaid Hospice care. The **revocation** statement must include all of the following:

(a) Client's signature;

(b) Date the **revocation** was signed; and

(c) Actual date that the client chose to stop receiving hospice care.

(3) The hospice agency must keep any explanation supporting any difference in the signature and **revocation** dates in the client's hospice records.

(4) The hospice agency must keep the **revocation** statement in the client's hospice record.

(5) After a client **revokes** hospice care, the remaining days on the current **election period** are forfeited. The client may enter the next consecutive **election period** immediately. The client does not have to wait for the forfeited days to pass before entering the next consecutive **election period**.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1360, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1400 Hospice providers must notify the department. (1) Notification within five working days avoids duplicative payments for services related to a client's terminal illness. Hospice providers must notify the MAA hospice coordinator, and either the client's CSO or HCS as appropriate.

(2) Hospice providers must report any changes in the client's hospice status within **five working days** from when a MAA client:

(a) Begins the first day of hospice care;

(b) Changes hospice agencies. Clients may change hospice agencies only once per election period. Both the old and

new hospice providers must supply the department as described in subsection (1) of this section with:

- (i) The effective date of **discharge** from the old agency; and
 - (ii) The effective date of the admit to, the name of, and the provider number of the new agency;
 - (c) **Revokes** the hospice benefit (home or institutional);
 - (d) **Discharges** from hospice care;
 - (e) Becomes an institutional facility resident;
 - (f) Leaves an institutional facility as a resident; or
 - (g) Dies.
- (3) A hospice agency must submit a client's assessment to MAA within five working days of MAA's request for that assessment.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1400, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1410 Hospice providers must notify institutional providers. Hospice providers must notify a client's institutional provider of the changes described in WAC 388-551-1400.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1410, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1500 Availability requirements for hospice care. All services related to the client's **terminal illness** are included in the daily rate through one of the following four levels of hospice care:

- (1) **Routine care** for each day the client is at their **residence**, with no restriction on length or frequency of visits, dependent on the client's needs.
- (2) **Continuous care** is acute episodic care received by the client to maintain the client at home and addresses a **brief** period of medical crisis. Continuous care consists predominantly of nursing care. This benefit is limited to:
 - (a) A minimum of eight hours of care provided during a **twenty-four-hour day**;
 - (b) Nursing care that must be provided by a registered or licensed practical nurse for more than half the period of care; and
 - (c) Homemaker, home health aide, and attendant services that may be provided as supplements to the nursing care.
- (3) **Inpatient respite care** is care received in an approved nursing facility or hospital to relieve the primary caregiver. This benefit is limited to:
 - (a) No more than five consecutive days; and
 - (b) A client not residing in a nursing facility.
- (4) **General inpatient hospice care** is for pain and symptom management that cannot be provided in other settings.
 - (a) The services must conform to the client's written **plan of care**.
 - (b) This benefit is limited to **brief** periods of care in MAA-approved:
 - (i) Hospitals;
 - (ii) Nursing facilities; or
 - (iii) Hospice inpatient facilities.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1500, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1510 Payment method for hospice providers. This section describes payment methods for Hospice care provided under WAC 388-551-1500 to hospice clients.

- (1) Prior to submitting a claim to MAA, the hospice provider must file written certification in the client's hospice record per WAC 388-551-1310.
- (2) MAA may pay for Hospice care provided to clients in one of the following settings:
 - (a) A client's **residence**;
 - (b) Inpatient respite services; or
 - (c) General inpatient as follows:

DAY OF	PAID AT
Admit	General Inpatient
Brief Period	General Inpatient
Death	General Inpatient
Other Discharge	Routine

- (3) To be paid by MAA, the hospice provider must provide and/or coordinate MAA covered:
 - (a) Medicaid hospice services; and
 - (b) Services that relate to the client's **terminal illness** at the time of the hospice admit.
- (4) MAA does not pay hospice providers for the client's last day, except for the day of death.
- (5) Hospice providers must bill MAA for their services using hospice-specific revenue codes.
- (6) MAA pays hospice providers for services (not room and board) at a daily rate calculated by one of the following methods and adjusted for current wages:
 - (a) Payments for services delivered in a client's **residence** (routine and continuous home care) are based on the county location of the client's residence for that particular client; or
 - (b) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.
- (7) MAA pays nursing facility room and board payments to hospice agencies, not licensed as hospitals, at a day rate as follows:
 - (a) Directly to the hospice provider at ninety-five percent of the nursing facility's lowest current Medicaid day rate;
 - (b) The hospice agency pays the nursing facility at a day rate no greater than the nursing facility's lowest current Medicaid daily rate; and
 - (c) The correct amount of the patient's participation must be:
 - (i) Collected by the hospice agency as directed by the department each month; and
 - (ii) Forwarded to the nursing facility.
- (8) MAA pays nursing facility room and board payments to free-standing hospice agencies licensed as hospitals by using MAA's administrative statewide average day rate in effect at the time the contract is signed.
- (9) The department pays for COPES services clients directly to the COPES provider.
 - (a) Patient participation in that case is paid separately to the COPES provider.

(b) Hospice providers bill MAA directly for hospice services, not the COPES program.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1510, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1520 Payment method for nonhospice providers. (1) Hospitals which provide inpatient care to clients in the hospice program for medical conditions not related to their **terminal illness** may be paid according to chapter 388-550 WAC, Hospital services.

(2) MAA pays attending physicians who are not employed by the hospice agency at their usual amount through the resource based relative value scale (RBRVS) fee schedule:

(a) For direct physician care services provided to a hospice client;

(b) When the provided services are not related to the **terminal illness**; and

(c) When the client's providers, including hospice provider, coordinate the health care provided.

[Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1520, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1530 Payment method for Medicaid-Medicare dual eligible clients. (1) MAA does not pay for any hospice care provided to a client covered by part A Medicare (hospital insurance).

(2) MAA may pay for hospice care provided to a client:

(a) Covered by part B Medicaid (medical insurance); and

(b) Not covered by part A Medicare.

(3) Hospice providers must bill Medicare before billing Medicaid, except for hospice nursing facility room and board.

(4) All the limitations and requirements related to hospice care described in this chapter apply to the payments described in this section.

[Statutory Authority: RCW 74.09.520 and 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1530, filed 4/9/99, effective 5/10/99.]

WAC 388-551-2000 Home health services—General. The purpose of the medical assistance administration (MAA) home health program is to reduce the costs of health care services by providing equally effective, more conservative, and/or less costly treatment in a client's home.

Home health services consist of skilled nursing and **specialized therapies** provided in a client's **residence**. Home health aide services may be provided in addition to these services. The client must be **homebound**, as determined by documentation submitted to MAA during the client's focused program review period. Services provided are for acute, intermittent, short term, and intensive courses of treatment. See chapter 388-515 WAC for clients needing chronic, long-term maintenance care.

[Statutory Authority: RCW 74.08.090 and 74.09.530, 99-16-069, § 388-551-2000, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2010 Home health—Definitions. Words and abbreviations in bold have the following defini-

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tions for this chapter. See also chapter 388-500 WAC for other definitions and abbreviations used by the department.

"Home health agency" means an agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

"Home health services" mean skilled health care (nursing, specialized therapy, and home health aide) services provided in the client's residence on a part-time or intermittent basis by a Title XVIII Medicare and Title XIX Medicaid home health provider. See also WAC 388-551-2000.

"Homebound" means a physician has certified that the client is medically or physically confined to the home, and under normal circumstances, lacks the ability to leave home without a considerable and taxing effort. The client may be considered homebound if absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive medical treatment.

"Plan of treatment (POT)" (also known as **"plan of care (POC)"**) means a written plan of treatment that is established and periodically reviewed and signed by both a physician and a home health agency provider, that describes the home health care to be provided at the client's **residence**. See WAC 388-551-2210.

"Residence" means a client's home or place of living not including a hospital, skilled nursing facility, or residential facility with skilled nursing services available.

"Specialized therapy" means skilled therapy services provided to **homebound** clients which includes:

(1) Physical;

(2) Occupational; or

(3) Speech/audiology services.

See WAC 388-551-2110.

[Statutory Authority: RCW 74.08.090 and 74.09.530, 99-16-069, § 388-551-2010, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2020 Home health services—Eligible clients. (1) Clients in the following MAA programs are eligible to receive **home health services** subject to the limitations described in this chapter. Chapter 388-551 WAC does not apply to clients enrolled in MAA's managed care plans.

(a) Categorically needy program (CNP);

(b) Limited casualty program - medically needy program (LCP-MNP);

(c) General assistance expedited (GA-X) (disability determination pending); and

(d) Medical care services (MCS) programs:

(i) General assistance - unemployable (GA-U); and

(ii) Alcoholism and drug addiction treatment and support act (ADATSA) (GA-W).

(2) Clients in the following emergency-only MAA programs are eligible to receive **home health services** subject to the limitations described in this chapter. Coverage is also limited to two skilled nursing visits per eligibility enrollment period. **Specialized therapy** services and home health aide visits are not covered:

(a) Categorically needy program (CNP) - emergency-only.

(b) Limited casualty program - medically needy program (LCP-MNP)-emergency only.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2020, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2100 Covered home health services—

Nursing. (1) Skilled nursing services involve observation, assessment, treatment, teaching, training, management and/or evaluation requiring the skills of:

- (a) A registered nurse; or
- (b) A licensed practical nurse under the supervision of a registered nurse.

(2) MAA may pay for up to two skilled nursing visits per day. See WAC 388-551-2220 (3), (4) and (5).

(3) Coverage for home health nursing services is limited to **homebound** clients, except as listed in subsection (4) of this section.

(4) MAA covers home health nursing services for non-homebound clients on a limited basis only when the client is unable to access similar services in a less costly setting, as documented by the provider and approved by MAA.

(5) A brief skilled nursing visit occurs when only one of the following activities is performed during a visit:

- (a) An injection or blood draw;
- (b) Placement of oral medications in containers (e.g., envelopes, cups, medisets); or
- (c) A refill of insulin syringes.

(6) MAA may cover brief skilled nursing visits for a client with chronic needs, for a short time, until a long term care plan is implemented.

(7) MAA limits services provided to a client enrolled in either of the emergency medical programs listed in WAC 388-551-2020 (2)(a) and (b), to two skilled nursing visits within their eligibility enrollment period.

(8) To receive infusion therapy clients must:

- (a) Be willing and capable of learning and managing their infusion care; or
- (b) Have a caregiver willing and capable of learning and managing the client's infusion care.

(9) MAA covers infant phototherapy:

- (a) For up to five skilled nursing visits per infant;
- (b) When provided by a Medicaid approved infant phototherapy agency; and
- (c) When the infant is diagnosed with hyperbilirubinaemia.

(10) MAA covers limited high risk obstetrical services:

- (a) For a medical condition that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;
- (b) During the span of home health agency services, if enrollment in or referral to the following providers of First Steps has been verified:
 - (i) Maternity support services (MSS); or
 - (ii) Maternity case management (MCM);
- (c) When provided by a registered nurse who has either:
 - (i) National prenatal certification; or
 - (ii) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years; and
- (d) For up to three home health visits per pregnancy.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2100, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2110 Covered home health services—

Specialized therapy. (1) MAA may pay for up to one specialized therapy visit per day, per type of specialized therapy.

(2) To receive specialized therapy services, a client must be homebound.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2110, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2120 Home health services—Aides.

(1) MAA may pay for up to one home health aide visit per day.

(2) MAA pays for home health aide services only when the services are provided under the supervision of and in conjunction with:

- (a) Skilled nursing services; or
- (b) Specialized therapy services.

(3) MAA covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2120, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2130 Home health services—Noncovered.

(1) MAA does not cover the following **home health services** and expenses:

- (a) Medical social work services;
- (b) Psychiatric skilled nursing services;
- (c) Pre- and postnatal skilled nursing services except as listed under WAC 388-551-2100(10);
- (d) Additional administrative costs billed above the visit rate (these costs are included in the visit rate and may not be billed separately);
- (e) Well baby follow-up care;
- (f) Services performed in hospitals, correctional facilities, skilled nursing facilities or a residential facility with skilled nursing services available;
- (g) Home health aide services that are not provided in conjunction with skilled nursing or **specialized therapy** services;
- (h) Health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change);
- (i) Home health **specialized therapies** and home health aide visits for clients in the following programs:
 - (i) CNP - emergency medical only; and
 - (ii) LCP-MNP - emergency medical only;
- (j) Skilled nursing visits for a client when a **home health agency** cannot safely meet the medical needs of that client within **home health services** program limitations (e.g., for a client to receive infusion therapy services, the caregiver must be willing and capable of managing the client's care);
- (k) More than one of the same type of specialized therapy and/or home health aide visit per day;

(l) Home health visits made without a written physician order unless the verbal order is:

- (i) Written prior to or on the date of the visit; and
- (ii) Signed by the physician within forty-five days.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2130, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2200 Home health services—Eligible providers. A home health provider may contract with MAA to be a Medicaid provider if the provider is Title XVIII (Medicare) certified and licensed by the state as a **home health agency**. Providers must have an active Medicaid provider number to bill MAA.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2200, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2210 Home health providers—Requirements. For any delivered **home health service** to be payable, MAA requires home health providers to develop and implement an individualized **plan of treatment (POT)** for the client.

(1) The **POT** must:

- (a) Be documented in writing and be located in the client's home health medical record;
- (b) Be developed and supervised by a licensed registered nurse or licensed therapist;
- (c) Reflect the physician's orders and client's current health status;
- (d) Be reviewed and revised by a physician at least every sixty-two calendar days and signed by a physician within forty-five days of the verbal order;
- (e) Contain specific goals and treatment plans; and
- (f) Be available to department staff or its designated contractor(s) on request.

(2) The provider must include in the **POT** all of the following:

- (a) The primary diagnosis (the diagnosis that is most related to the reason the client qualifies for **home health services**);
- (b) The medical diagnoses and prognosis, including date(s) of onset or exacerbation;
- (c) A discharge plan;
- (d) The type(s) of equipment required;
- (e) A description of each planned service and goals related to the services provided;
- (f) Specific procedures and modalities;
- (g) A description of the client's mental status;
- (h) Rehabilitation potential;
- (i) A list of permitted activities;
- (j) A list of safety measures taken on behalf of the client; and
- (k) A list of medications which indicates:
 - (i) Any new prescription prescribed; and
 - (ii) Which medications are changed for dosage or route of administration.

(3) The provider must include in or attach to the **POT**:

- (a) A description of the client's functional limits and the effects;
- (b) Significant clinical findings;

(c) Dates of recent hospitalization; and

(d) If the client is not **homebound**, a description of why **home health services** are necessary. The description must include:

(i) A written statement noting coordination with, or referral to, the client's department of social and health services-assigned case manager; or

(ii) An assessment of the client and the client's access to community resources, including attempts to use appropriate alternatives to meet the client's home health needs.

(4) The individual client medical record must comply with community standards of practice, and must include documentation of:

(a) Supervisory visits for home health aide services per WAC 388-551-2120(3);

(b) All medications administered and treatments provided;

(c) All physician orders and change orders, with notation that the order was received prior to treatment;

(d) Signed physician new orders and change orders;

(e) Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;

(f) Interdisciplinary team communications;

(g) Inter-agency and intra-agency referrals;

(h) Medical tests and results; and

(i) Pertinent medical history.

(5) The provider must document at least the following in the client's medical record:

(a) Skilled interventions per the **POT**;

(b) Any clinical change in client status;

(c) Follow-up interventions specific to a change in status with significant clinical findings; and

(d) Any communications with the attending physician.

(6) The provider must include the following documentation in the client's visit notes when appropriate:

(a) Any teaching, assessment, management, evaluation, patient compliance, and client response;

(b) Weekly documentation of wound care, size, drainage, color, odor, and identification of potential complications and interventions provided; and

(c) The client's physical system assessment as identified in the **POT**.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2210, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2220 Home health providers—Payments. (1) Payment to home health providers is:

(a) A set visit rate for each discipline provided to a client;

(b) Based on the county location of the providing **home health agency**; and

(c) Updated by general vendor rate changes.

(2) For clients eligible for Medicaid and Medicare, MAA may pay for services described in this chapter only when Medicare does not cover those services. The maximum payment for each service is Medicaid's maximum payment.

(3) Providers must submit documentation to the department during any MAA focused program review period. Doc-

umentation includes, but is not limited to, the requirements listed in WAC 388-551-2210.

(4) After MAA receives the documentation, MAA's medical director or designee reviews the client's medical records for program compliance and quality of care.

(5) MAA may take back payment for any insufficiently documented home health care service when the MAA medical director or designee determines that:

(a) The service was not medically necessary (defined in WAC 388-500-0005) or reasonable;

(b) Clients were able to receive care outside of the home (see definition of **homebound** in this chapter and WAC 388-551-2100(3)); or

(c) The service was not in compliance with program policy.

(6) Covered **home health services** for clients enrolled in a Healthy Options managed care plan are paid for by that plan.

[Statutory Authority: RCW 74.08.090 and 74.09.530, 99-16-069, § 388-551-2220, filed 8/2/99, effective 9/2/99.]

Chapter 388-552 WAC

OXYGEN AND RESPIRATORY THERAPY

WAC

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WAC 388-552-001 Scope. (1) This chapter applies to:

(a) Medical assistance administration (MAA) clients who require medically necessary **oxygen** and/or respiratory therapy equipment, supplies, and services in their homes and nursing facilities; and

(b) Providers who furnish **oxygen** and respiratory therapy equipment, supplies and services to eligible MAA clients.

(2) Instructions for clients covered by Medicare are located in Medicare's Durable Medical Equipment Regional Carrier (DMERC) Manual.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530, 99-13-049, § 388-552-001, filed 6/9/99, effective 7/10/99.]

WAC 388-552-005 Definitions. The following definitions and those in WAC 388-500-0005 apply to this chapter. If a definition in WAC 388-500-0005 differs with the defini-

tion in this section, the definition in this section applies. Defined words and phrases are bolded in the text.

"Authorized prescriber" means a health care practitioner authorized by law or rule in the state of Washington to prescribe oxygen and respiratory therapy equipment, supplies, and services.

"Base year," as used in this chapter, means the year in which the oxygen and respiratory therapy billing instructions' current fee schedule is adopted.

"Maximum allowable" means the maximum dollar amount MAA reimburses a provider for a specific service, supply, or piece of equipment.

"Oxygen" means United States Pure (USP) medical grade liquid or gaseous oxygen.

"Oxygen and respiratory therapy billing instructions" means a booklet containing procedures for billing, which is available by writing to Medical Assistance Administration, Division of Program Support, PO Box 45562, Olympia, WA, 98504-5562.

"Oxygen system" means all equipment necessary to provide oxygen to a person.

"Portable system" means a small system which allows the client to be independent of the stationary system for several hours, thereby providing mobility outside of the residence.

"Provider" means a person or company with a signed core provider agreement with MAA to furnish **oxygen** and respiratory therapy equipment, supplies, and services to eligible MAA clients.

"Respiratory care practitioner" means a person certified by the department of health according to chapter 18.89 RCW and chapter 246-928 RCW.

"Stationary system" means equipment designed to be used in one location, generally for the purpose of continuous use or frequent intermittent use.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530, 99-13-049, § 388-552-005, filed 6/9/99, effective 7/10/99.]

WAC 388-552-100 Client eligibility. (1) All MAA fee-for-service clients are eligible for **oxygen** and respiratory therapy equipment, supplies, and services when medically necessary, with the following limitations:

(a) Clients on the medically indigent program are not eligible under this chapter; and

(b) Clients on the categorically needy/qualified Medicare beneficiaries and medically needy/qualified Medicare beneficiaries programs are covered by Medicare and Medicaid as follows:

(i) If Medicare covers the service, MAA will pay the lesser of:

(A) The full co-insurance and deductible amounts due, based upon Medicaid's allowed amount; or

(B) MAA's **maximum allowable** for that service minus the amount paid by Medicare.

(ii) If Medicare does not cover or denies equipment, supplies, or services that MAA covers according to this chapter, MAA reimburses at MAA's **maximum allowable**; except, MAA does not reimburse for clients on the qualified Medicare beneficiaries (QMB) only program.

(2) Services for clients enrolled in a healthy options managed care plan receive all **oxygen** and respiratory therapy equipment, supplies, and services through their designated plan, subject to the plan's coverages and limitations.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-100, filed 6/9/99, effective 7/10/99.]

WAC 388-552-200 Providers—General responsibilities. (1) The provider must verify that the client's original prescription is signed and dated by the **authorized prescriber** no more than ninety days prior to the initial date of service. The prescription must include, at a minimum:

(a) The client's medical diagnosis, prognosis, and documentation of the medical necessity for **oxygen** and/or respiratory therapy equipment, supplies, and/or services, and any modifications;

(b) If **oxygen** is prescribed:

(i) Flow rate of **oxygen**;

(ii) Estimated duration of need;

(iii) Frequency and duration of **oxygen** use; and

(iv) Lab values or **oxygen** saturation measurements upon the client's discharge from the hospital.

(2) The provider must provide instructions to the client and/or caregiver on the safe and proper use of equipment provided.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-200, filed 6/9/99, effective 7/10/99.]

WAC 388-552-210 Required records. (1) A provider must maintain legible, accurate, and complete charts and records for each client. These records must support and justify claims that the provider submits to MAA for reimbursement. Records must include, at a minimum the:

(a) Date(s) of service;

(b) Client's name and date of birth;

(c) Name and title of person performing the service, when it is someone other than the billing practitioner;

(d) Chief complaint or reason for each visit;

(e) Pertinent medical history;

(f) Pertinent findings on examination;

(g) **Oxygen**, equipment, supplies, and/or services prescribed or provided;

(h) The original and subsequent prescriptions according to the requirements in WAC 388-552-200 and 388-552-220;

(i) Description of treatment (when applicable);

(j) Recommendations for additional treatments, procedures, or consultations;

(k) X-rays, tests, and results;

(l) Plan of treatment/care/outcome;

(m) Logs of oxygen saturations and lab values taken to substantiate the medical necessity of continuous **oxygen**, as required by WAC 388-552-220;

(n) Logs of oximetry readings if required by WAC 388-552-380 for a client seventeen years of age or younger; and

(o) Recommendations and evaluations if required by WAC 388-552-230 for the infant apnea monitor program.

(2) The provider must make required charts and records available to DSHS or its contractor(s) upon request.

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(3) MAA may require additional information in order to process a submitted claim.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-210, filed 6/9/99, effective 7/10/99.]

WAC 388-552-220 Requirements for oxygen providers. Oxygen providers must:

(1) Obtain a renewed prescription every six months if the client's condition warrants continued service;

(2) Verify, at least every six months, that **oxygen** saturations or lab values substantiate the need for continued **oxygen** use for each client. The provider may perform the **oxygen**-saturation measurements. MAA does not accept lifetime certificates of medical need (CMNs).

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-220, filed 6/9/99, effective 7/10/99.]

WAC 388-552-230 Requirements for infant apnea monitors. (1) MAA does not reimburse for apnea monitors unless the provider has a respiratory care practitioner or registered nurse with expertise in pediatric respiratory care who is responsible for their apnea monitor program.

(2) MAA does not require a confirming second opinion for the initial rental period for diagnoses of apnea of prematurity, primary apnea, obstructed airway, or congenital conditions associated with apnea. For other diagnoses, a neonatologist's confirming assessment and recommendation must be maintained as a second opinion in the client's file. The initial rental period must not exceed six months.

(3) Regardless of diagnosis, the provider must maintain in the client's file, a neonatologist's clinical evaluation justifying each subsequent rental period.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-230, filed 6/9/99, effective 7/10/99.]

WAC 388-552-240 Requirements for respiratory care practitioners. (1) A respiratory care practitioner must comply with chapter 18.89 RCW and chapter 246-928 WAC to qualify for reimbursement.

(2) A respiratory care practitioner must complete at least the following in each client visit:

(a) Check equipment and ensure equipment settings continue to meet the client's needs; and

(b) Communicate with the client's physician if there are any concerns or recommendations.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-240, filed 6/9/99, effective 7/10/99.]

WAC 388-552-300 Coverage. (1) MAA covers medically necessary oxygen and respiratory therapy equipment, supplies, and services subject to the limitations in this chapter. MAA approves additional oxygen and respiratory therapy equipment, supplies, and services on a case-by-case basis if medically necessary.

(2) MAA does not reimburse for a service or product if any of the following apply:

(a) The service or product is not covered by MAA;

(b) The service or product is not medically necessary;

(c) The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; or

(d) The client and provider do not meet the requirements in this chapter.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-300, filed 6/9/99, effective 7/10/99.]

WAC 388-552-310 Coverage—Oxygen and oxygen equipment. (1) MAA reimburses for oxygen provided to:

(a) Clients eighteen years of age or older with:

(i) $PO_2 < =$ fifty-five mm on room air; or

(ii) $SaO_2 < =$ eighty-eight percent on room air; or

(iii) $PaO_2 < =$ fifty-five mm on room air.

(b) Clients seventeen years of age or younger to maintain SaO_2 at:

(i) Ninety-two percent; or

(ii) Ninety-four percent in a child with cor pulmonale or pulmonary hypertension.

(2) MAA may cover spare tanks of oxygen and other equipment if the provider and attending physician document that travel distance or potential weather conditions could reasonably be expected to interfere with routine delivery of such equipment and supplies.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-310, filed 6/9/99, effective 7/10/99.]

WAC 388-552-320 Coverage—Continuous positive airway pressure (CPAP) and supplies. (1) MAA covers the rental and/or purchase of medically necessary CPAP equipment and related accessories when all of the following apply:

(a) The results of a prior sleep study indicate the client has sleep apnea;

(b) The client's attending physician determines that the client's sleep apnea is chronic;

(c) CPAP is the least costly, most effective treatment modality;

(d) The item is to be used exclusively by the client for whom it is requested;

(e) The item is FDA-approved; and

(f) The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

(2) MAA covers the rental of CPAP equipment for a maximum of two months. Thereafter, if the client's primary physician determines the equipment is tolerated and beneficial to the client, MAA reimburses for its purchase.

(3) Refer to **oxygen and respiratory therapy billing instructions** to determine which CPAP accessories are covered.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-320, filed 6/9/99, effective 7/10/99.]

WAC 388-552-330 Coverage—Ventilator therapy, equipment, and supplies. (1) MAA covers medically necessary ventilator equipment rental and related disposable supplies when all of the following apply:

(a) The ventilator is to be used exclusively by the client for whom it is requested;

(b) The ventilator is FDA-approved; and

(c) The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

(2) MAA's monthly rental payment includes medically necessary accessories, including, but not limited to: Humidifiers, nebulizers, alarms, temperature probes, adapters, connectors, fittings, and tubing.

(3) MAA covers a secondary (back-up) ventilator at fifty percent of the monthly rental if medically necessary.

(4) MAA covers the purchase of durable accessories for client-owned ventilator systems according to the fee schedule in the current **oxygen and respiratory therapy billing instructions**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-330, filed 6/9/99, effective 7/10/99.]

WAC 388-552-340 Coverage—Infant apnea monitor program. (1) A provider must comply with WAC 388-552-230 to qualify for reimbursement for the infant apnea monitor program.

(2) MAA covers infant apnea monitors on a rental basis.

(3) MAA includes all home visits, follow-up calls, and training in the rental allowance.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-340, filed 6/9/99, effective 7/10/99.]

WAC 388-552-350 Coverage—Respiratory and ventilator therapy. (1) MAA covers prescribed medically necessary respiratory and ventilator therapy services in the home.

(2) Therapy services must be provided by a certified respiratory care practitioner;

(3) MAA does not reimburse separately for respiratory and ventilator therapy services provided to clients residing in nursing facilities. This service is included in the nursing facility's per diem.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-350, filed 6/9/99, effective 7/10/99.]

WAC 388-552-360 Coverage—Suction pumps and supplies. (1) MAA covers suction pumps and supplies when medically necessary for deep oral or tracheostomy suctioning.

(2) MAA may cover one stationary and one portable suction pump for the same client if warranted by the client's condition. The provider and attending physician must document that either:

(a) Travel distance or potential weather conditions could reasonably be expected to interfere with the delivery of medically necessary replacement equipment; or

(b) The client requires suctioning while away from the client's place of residence.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-360, filed 6/9/99, effective 7/10/99.]

WAC 388-552-370 Coverage—Inhalation drugs and solutions. Inhalation drugs and solutions are included in the prescription drug program. Refer to chapter 388-530 WAC.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-370, filed 6/9/99, effective 7/10/99.]

WAC 388-552-380 Coverage—Oximeters. (1) MAA covers oximeters for clients seventeen years of age or younger when the client has one of the following conditions:

- (a) Chronic lung disease, is on supplemental oxygen, and is at risk for desaturation with sleep, stress, or feeding;
- (b) A compromised or artificial airway, and is at risk for major obstructive events or aspiration events; or
- (c) Chronic lung disease, requires ventilator or BIPAP support, and may be at risk for atelectasis or pneumonia as well as hypoventilation.

(2) The provider must review oximetry needs and fluctuations in oxygen levels monthly, and log results in the client's records.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-380, filed 6/9/99, effective 7/10/99.]

WAC 388-552-390 Coverage—Nursing facilities. (1) MAA reimburses according to this chapter for the chronic use of medically necessary oxygen, and oxygen and respiratory equipment and supplies to eligible clients who reside in nursing facilities.

(2) Nursing facilities are reimbursed in their per diem rate for:

- (a) Oxygen and oxygen equipment and supplies used in emergency situations; and
- (b) Respiratory and ventilator therapy services.

(3) Nursing facilities with a "piped" oxygen system may submit a written request to MAA for permission to bill MAA for oxygen. See **oxygen and respiratory therapy billing instructions**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-390, filed 6/9/99, effective 7/10/99.]

WAC 388-552-400 Reimbursement for covered services. (1) A provider must bill MAA according to the procedures and codes in the current **oxygen and respiratory therapy billing instructions**.

(2) MAA does not reimburse separately for telephone calls, mileage, or travel time. These services are included in the reimbursement for other equipment and/or services.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-400, filed 6/9/99, effective 7/10/99.]

WAC 388-552-410 Reimbursement methods. MAA bases the decision to rent or purchase medical equipment for a client, or pay for repairs to client-owned equipment, on the least costly and/or equally effective alternative.

(1) Rental.

(a) Types of rental equipment:

- (i) Equipment that normally requires frequent maintenance (such as ventilators and concentrators) is reimbursed on a rental basis for as long as medically necessary; and
- (ii) Equipment with lower maintenance requirements (such as suction pumps and humidifiers) is reimbursed on a rental basis for a specified rental period, after which the equipment is considered purchased and owned by the client.

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Refer to the **oxygen and respiratory therapy billing instructions** for detailed information.

(b) The monthly rental rate includes, but is not limited to:

- (i) A full service warranty covering the rental period;
- (ii) Any adjustments, modifications, repairs or replacements required to keep the equipment in good working condition on a continuous basis throughout the total rental period;
- (iii) All medically necessary accessories and disposable supplies, unless separately billable according to current **oxygen and respiratory therapy billing instructions**;
- (iv) Instructions to the client and/or caregiver for safe and proper use of the equipment; and
- (v) Cost of pick-up and delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

(2) Purchase.

(a) Purchased equipment becomes the property of the client;

(b) MAA reimburses for:

(i) Equipment that is new at the time of purchase, unless otherwise specified in current **oxygen and respiratory therapy billing instructions**; and

(ii) One maintenance and service visit every six months for purchased equipment.

(c) MAA does not reimburse for:

- (i) Defective equipment;
- (ii) The cost of materials covered under the manufacturer's warranty; or
- (iii) Repair or replacement of equipment if evidence indicates malicious damage, culpable neglect, or wrongful disposition.

(d) The reimbursement rate for purchased equipment includes, but is not limited to:

- (i) A manufacturer's warranty for a minimum warranty period of one year for medical equipment, not including disposable/ non-reusable supplies;
- (ii) Instructions to the client and/or caregiver for safe and proper use of the equipment; and
- (iii) The cost of delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

(e) The provider must make warranty information, including date of purchase and warranty period, available to MAA upon request.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-410, filed 6/9/99, effective 7/10/99.]

WAC 388-552-420 Reimbursement methodology. MAA, at its discretion, uses the following methods to determine the **maximum allowable** amount for each purchased and rented item and service:

(1) Monthly rental reimbursement methodology.

- (a) Medicare's fee as of October 31 of the year prior to the base year; or
- (b) A **maximum allowable** equal to:
 - (i) One-tenth of the purchase **maximum allowable** for that product; or

(ii) If MAA does not reimburse for the purchase of that product, one-tenth of the amount calculated using the methodology in subsection (1) of this section.

(2) Purchase reimbursement methodology.

(a) Medicare's fee as of October 31 of the year prior to the **base year**; or

(b) A **maximum allowable** equal to the seventieth percentile price of an array of input prices.

(i) The number of input prices included in each array may be limited by MAA based on consideration of product quality, cost, available alternatives, and client needs.

(ii) An input price used in the **maximum allowable** calculation is the lesser of:

(A) Eighty percent of the manufacturer's list or suggested retail price as of October 31 of the **base year**; or

(B) One hundred thirty-five percent of the wholesale acquisition cost as of October 31 of the **base year**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-420, filed 6/9/99, effective 7/10/99.]

Chapter 388-810 WAC

**ADMINISTRATION OF COUNTY CHEMICAL
DEPENDENCY PREVENTION, TREATMENT, AND
SUPPORT PROGRAM**
(Formerly chapter 440-25 WAC)

WAC

388-810-005	What is the purpose of this chapter?
388-810-010	What definitions apply to this chapter?
388-810-020	What are the qualifications to be a county chemical dependency program coordinator?
388-810-030	What are the qualifications to be a county-designated chemical dependency specialist?
388-810-040	Who determines the service priorities for the county chemical dependency prevention, treatment, and support program?
388-810-050	How are available funds allocated for the county chemical dependency program?
388-810-060	How much money can a county claim for the administration of its chemical dependency prevention, treatment, and support program?
388-810-070	How will funds be made available to the county?
388-810-080	May a county subcontract for chemical dependency prevention, treatment, and support services?
388-810-090	How does a county request an exemption?

WAC 388-810-005 What is the purpose of this chapter? The purpose of this chapter is to describe the planning, contracting, and provision of chemical dependency prevention, treatment, and support services through counties (see chapter 70.96A RCW).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-005, filed 9/20/99, effective 10/21/99.]

WAC 388-810-010 What definitions apply to this chapter?

"**County**" means each county or two or more counties acting jointly.

"**County chemical dependency program coordinator**" means a person appointed by the county legislative authority as the chief executive officer responsible for carrying out the duties under chapter 70.96A RCW.

"**County chemical dependency prevention, treatment, and support program**" means services and activities funded by the department through a negotiated contract between a county and the department.

"**Department**" means the department of social and health services (DSHS).

"**Designated chemical dependency specialist**" means a person designated by the county chemical dependency program coordinator to perform the involuntary commitment duties under chapter 70.96A RCW.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-010, filed 9/20/99, effective 10/21/99.]

WAC 388-810-020 What are the qualifications to be a county chemical dependency program coordinator? A county chemical dependency program coordinator must have training and experience in:

(1) Chemical dependency prevention, intervention, and treatment strategies used in combating chemical dependency; and

(2) Administration of social and/or human services programs, sufficient to perform the following duties:

(a) Providing general supervision over the county chemical dependency prevention, treatment, and support program;

(b) Preparing plans and applications for funds to support the county chemical dependency prevention, treatment, and support program;

(c) Monitoring the delivery of services to assure conformance with plans and contracts;

(d) Providing staff support to the county alcoholism and other drug addiction board;

(e) Selecting the county designated chemical dependency specialist(s) to perform the intervention, involuntary detention and commitment duties as described under RCW 70.96A.120 and 70.96A.140; and

(f) Advising DSHS, county courts, law enforcement agencies, hospitals, chemical dependency programs, and other local health care and service agencies in the county as to who has been designated as the chemical dependency specialist(s).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-020, filed 9/20/99, effective 10/21/99.]

WAC 388-810-030 What are the qualifications to be a county-designated chemical dependency specialist? A county-designated chemical dependency specialist must:

(1) Be certified as a chemical dependency professional (CDP) by the department of health under chapter 18-205 RCW, or meet or exceed the requirements to be eligible to be certified as a CDP as described in chapter 246-811 WAC;

(2) Demonstrate knowledge of the laws regarding the involuntary commitment of chemically dependent adolescents and adults; and

(3) Demonstrate knowledge and skills in differential assessment of mentally ill and chemically dependant clients.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-030, filed 9/20/99, effective 10/21/99.]

WAC 388-810-040 Who determines the service priorities for the county chemical dependency prevention, treatment, and support program? (1) DSHS determines the service priorities for services funded by the department.

(2) DSHS must inform the county of the service priorities during the contract negotiation process.

(3) Counties must follow DSHS's service priorities when delivering chemical dependency program services supported by department funds.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-040, filed 9/20/99, effective 10/21/99.]

WAC 388-810-050 How are available funds allocated for the county chemical dependency program? (1) For the purposes of this section, "county" means the legal subdivision of the state, regardless of any agreement between two counties.

(2) The department shall allocate the funds available to the counties through funding formulas jointly developed with representatives of the counties, to carry out the intent of the federal and state legislated appropriations including any budget provisos.

(3) For information on current funding formulas, contact: Chief Financial Officer, Division of Alcohol and Substance Abuse, P.O. Box 45330, Olympia, Washington 98504-5330, Telephone: (360) 438-8088.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-050, filed 9/20/99, effective 10/21/99.]

WAC 388-810-060 How much money can a county claim for the administration of its chemical dependency prevention, treatment, and support program? A county may not use more than ten percent of the chemical dependency prevention, treatment, and support program funds managed by the county for administering the program.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-060, filed 9/20/99, effective 10/21/99.]

WAC 388-810-070 How will funds be made available to the county? (1) DSHS and each county negotiates and executes a county contract before the department reimburses the county for chemical dependency prevention, treatment, and support program services.

(2) DSHS may authorize the county to continue providing services according to a previous county contract and reimburse at the average level of the previous contract, in order to continue services until the department executes a new contract.

(3) DSHS may make advance payments to a county, if the payments facilitate sound program management.

(4) DSHS may require fiscal and program reports.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-070, filed 9/20/99, effective 10/21/99.]

WAC 388-810-080 May a county subcontract for chemical dependency prevention, treatment, and support services? A county may subcontract for services specified in the contract.

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[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-080, filed 9/20/99, effective 10/21/99.]

WAC 388-810-090 How does a county request an exemption? (1) A county may request an exemption to these rules by sending a written request to the department.

(2) DSHS may grant an exemption if the department's assessment of the exemption request:

(a) Ensures the exemption does not undermine the legislative intent of chapter 70.96A RCW; and

(b) Shows that granting the exemption does not adversely affect the quality of the services, supervision, health, and safety of department customers.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-090, filed 9/20/99, effective 10/21/99.]

Chapter 388-815 WAC

DRUG-FREE WORKPLACE PROGRAMS

(Formerly chapter 440-26 WAC)

WAC

388-815-005	Purpose.
388-815-010	Definitions.
388-815-020	Eligible employers.
388-815-030	Certification of employer to L&I.
388-815-100	Employer certification procedures.
388-815-110	Certification maintenance.
388-815-120	Program oversight.
388-815-130	Denial of certification.
388-815-140	Decertification.
388-815-160	Hearings, appeals.
388-815-200	Program requirements—Policy statement.
388-815-205	Program requirements—Notifications.
388-815-210	Program requirements—Substance abuse testing.
388-815-215	Program requirements—How employers get certified through a clean card program.
388-815-220	Program requirements—Employee assistance program.
388-815-230	Supervisor training.
388-815-240	Employee education.
388-815-250	Confidentiality.

WAC 388-815-005 Purpose. Employer certification rules related to providing a drug-free work place program are hereby adopted under the authority and purposes of chapter 127, Laws of 1996.

[99-20-023, recodified as § 388-815-005, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-005, filed 7/25/96, effective 8/25/96.]

WAC 388-815-010 Definitions. Unless the context clearly indicates otherwise, the definitions in this section apply throughout this chapter.

(1) "Alcohol" means ethyl alcohol, hydrated oxide of ethyl, or spirits of wine, from whatever source or by whatever process produced.

(2) "Alcohol test" means a chemical, biological, or physical instrumental analysis administered for the purpose of determining the presence or absence of alcohol within an individual's body systems.

(3) "Clean card program" means a drug-free workplace program which allows employers with rotating groups of employees an alternative method of participating in the drug-free workplace discount program. In addition to the other requirements of this chapter, clean card programs

require random testing instead of repetitive pre-employment testing.

(4) "Department" means the department of social and health services, division of alcohol and substance abuse.

(5) "Drug" means amphetamines, cannabinoids, cocaine, phencyclidine (PCP), methadone, methaqualone, opiates, barbiturates, benzodiazepines, propoxyphene, or a metabolite of any such substances.

(6) "Drug test" means a chemical, biological, or physical instrumental analysis administered on a specimen sample for the purpose of determining the presence or absence of a drug or its metabolites within the sample.

(7) "Drug-free workplace program" means a set of workplace-based policies and procedures designed to reduce workplace involvement with alcohol and other drugs, and increase safety, productivity, and worker health. For the purpose of these regulations, "drug-free workplace program" is synonymous with "substance abuse testing program" as used in chapter 127, Laws of 1996.

(8) "Employee" means a person who is employed for salary, wages, or other remuneration by an employer.

(9) "Employee assistance program" means a program designed to assist in the identification and resolution of job performance problems associated with employees impaired by personal concerns. A minimum level of core services must include: Consultation and professional, confidential, appropriate, and timely problem assessment services; short-term problem resolution; referrals for appropriate diagnosis, treatment, and assistance; follow-up and monitoring; employee education; and supervisory training. Any employee assistance program under this chapter must contain a two-year employee follow-up and monitoring component.

(10) "Employer" means an employer subject to Title 51 RCW but does not include the state or any department, agency, or instrumentality of the state; any county; any city; any school district or educational service district; any municipal corporation, or any self-insured employer.

(11) "Injury" means a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result and occurring from without, and such physical conditions as result therefrom.

(12) "Job applicant" means a person who has applied for employment with an employer and has been offered employment conditioned upon successfully passing a drug test and may have begun work pending the results of the drug test.

(13) "L & I" means the department of labor and industries.

(14) "Last-chance agreement" means a notice to an employee who is referred to the employee assistance program due to a verified positive alcohol or drug test or for violating an alcohol or drug-related employer rule that states the terms and conditions of continued employment with which the employee must comply.

(15) "Random testing" means a method of selecting employees for alcohol or drug testing through a scientifically valid method, such as computer-based generation of employee identification numbers, in which each employee has an equal chance of being chosen each time selections are made. Random testing is sometimes called "lottery" testing.

(16) "Random testing pool" means the total of all employees of the employers in a clean card program.

(17) "Rehabilitation program" means a chemical dependency treatment program approved by the department that is capable of providing expert identification, assessment, and treatment of employee drug or alcohol abuse in a confidential and timely service. Any rehabilitation program under this chapter must contain the capacity to provide a two-year continuing care component.

(18) "Substance abuse test" or "test" means a chemical, biological, or physical instrumental analysis administered on a specimen sample for the purpose of determining the presence or absence of a drug or its metabolites in a urine sample or of alcohol within a breath sample.

(19) "Verified positive test result" means a confirmed positive test result obtained by a laboratory meeting the standards specified in this chapter that has been reviewed and verified by a medical review officer in accordance with medical review officer guidelines promulgated by the United States Department of Health and Human Services.

(20) "Workers' compensation premium" means the medical aid fund premium and the accident fund premium under Title 51 RCW.

[99-20-023, recodified as § 388-815-010, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 49.82.130. 98-20-045, § 440-26-010, filed 9/30/98, effective 10/31/98. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-010, filed 7/25/96, effective 8/25/96.]

WAC 388-815-020 Eligible employers. (1) A private Washington state employer, as defined in WAC 440-26-010(9), who, prior to July 1, 1996, does not have in place a drug-free workplace program as described in subsection (2) of this section may be eligible for the worker compensation premium discount as described under chapter 127, Laws of 1996, provided the employer:

(a) Participates in the state workers compensation insurance fund, as described under chapter 51.16 RCW;

(b) Remains in good standing with L&I as of the certification date with respect to premium payment obligations;

(c) Has medical insurance which includes chemical dependency treatment benefits available to full-time employees otherwise eligible for benefits, whether through an employer, union, or jointly-sponsored plan; and

(d) Makes application for certification and agrees to provide a drug-free workplace program in accordance with these rules.

(2) An employer shall not be eligible for the discount program if, prior to July 1, 1996, the employer already has a drug-free workplace program in place that includes all the following elements:

(a) A policy statement including:

(i) Prohibitions concerning the possession, use, or being under any influence of drugs or alcohol during working hours; and

(ii) Assurance that an employee will not be terminated solely for a first-time verified positive drug or alcohol test, but will be given the opportunity for job retention through a last chance agreement.

(b) Drug testing in pre-employment and post-accident situations, and alcohol testing in post-accident situations; and

(c) An employee assistance program from the list approved by the division of alcohol and substance abuse which provides the employee assistance program services required by WAC 440-26-220.

[99-20-023, recodified as § 388-815-020, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-020, filed 7/25/96, effective 8/25/96.]

WAC 388-815-030 Certification of employer to L&I.

The department shall notify the employer and the department of labor and industries of the employer's certification as a drug-free workplace when the department has:

- (1) Received and approved the employer's application for certification or renewal of certification; and
- (2) Received the required certification fee.

[99-20-023, recodified as § 388-815-030, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-030, filed 7/25/96, effective 8/25/96.]

WAC 388-815-100 Employer certification procedures. (1) An eligible employer shall:

(a) Obtain from the department an application packet of information on how to become certified as a drug-free workplace; and

(b) Ensure that the application materials demonstrate compliance with all the elements required in chapter 127, Laws of 1996.

(2) The applicant employer shall submit:

(a) A completed application;

(b) If applicable, a statement that:

(i) The employer's drug-free workplace policy has been negotiated with employee unions; or

(ii) The union has waived its right to bargain, as required by the National Labor Relations Board.

(c) An initial certification fee in accordance with the fee schedule included in the application packet.

[99-20-023, recodified as § 388-815-100, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-100, filed 7/25/96, effective 8/25/96.]

WAC 388-815-110 Certification maintenance. The department shall renew certification as a drug-free workplace program annually. An employer's continued certification and renewal shall be contingent upon:

(1) Submission of information requested by the department in an annual certification renewal process, including information from the employer's EAP and drug testing service;

(2) Correction of or department approval of a plan to correct deficiencies found during periodic on-site surveys and complaint investigations related to the drug-free workplace program. During on-site surveys and complaint investigations, employer representatives shall allow or assist department representatives to:

(a) Examine any part of the program as needed;

(b) Review and evaluate records, including employee personnel files, policies, procedures, fiscal records, data, and other documents as the department requires to determine compliance; and

(c) Conduct individual interviews with employees and management.

(3) Payment of annual certification renewal fees within thirty days of the date of billing.

[99-20-023, recodified as § 388-815-110, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-110, filed 7/25/96, effective 8/25/96.]

WAC 388-815-120 Program oversight. (1) The department shall provide ongoing program oversight and investigate apparent areas of employer noncompliance with the requirements of this chapter.

(2) The department may initiate such investigation as necessary to determine whether drug-free workplace certification should be maintained after:

(a) Initial review of the application;

(b) Review of complaints from employees; or

(c) Random site visits to participating employers.

(3) When an employer's program is found out of compliance with regulations herein, the department shall offer:

(a) Assistance to the employer in correcting any deficiency; and

(b) A plan of correction.

(4) If the employer fails to correct the deficiency within a time period specified by the plan of correction, the department may initiate procedures to decertify the employer from the premium discount program.

[99-20-023, recodified as § 388-815-120, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-120, filed 7/25/96, effective 8/25/96.]

WAC 388-815-130 Denial of certification. The department may deny an employer's application for certification or renewal when any of the following conditions occurs and is not satisfactorily resolved:

(1) The employer obtains or attempts to obtain or renew certification by fraudulent means or misrepresentation;

(2) The employer fails to provide all of the information or signed consents required in the application process in accordance with the department's request;

(3) The employer fails to pay the required fee;

(4) The employer's program is not in compliance with chapter 127, Laws of 1996.

[99-20-023, recodified as § 388-815-130, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-130, filed 7/25/96, effective 8/25/96.]

WAC 388-815-140 Decertification. The department shall decertify an employer from the premium discount program if the employer:

(1) Ceases to implement a drug-free workplace program for which the employer has been certified;

(2) Fails to correct deficiencies discovered and disclosed in writing to the employer by the department;

(3) Voluntarily cancels certification; or

(4) Fails to pay the required certification fee.

[99-20-023, recodified as § 388-815-140, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-140, filed 7/25/96, effective 8/25/96.]

WAC 388-815-160 Hearings, appeals. In the event of an employer's decertification, the department shall:

- (1) Notify the employer and the department of labor & Industries of the decertification; and
- (2) Inform the employer of hearing and appeal rights under the Administrative Procedure Act, chapter 34.05 RCW.

[99-20-023, recodified as § 388-815-160, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-160, filed 7/25/96, effective 8/25/96.]

WAC 388-815-200 Program requirements—Policy statement. To be certified for the worker compensation premium discount, an employer shall provide a drug-free workplace program that operates under written policy and procedures that:

- (1) Notify employees that the use of or being under any influence of alcohol during working hours is prohibited;
- (2) Notify employees that the use, purchase, possession, or transfer of drugs or having illegal drugs in their system is prohibited and that prescription or nonprescription medications are not prohibited when taken in accordance with a lawful prescription or consistent with standard dosage recommendations;
- (3) Identify the types of testing an employee or job applicant may be required to submit to and the criteria used to determine when such a test will be required;
- (4) Identify the consequences of refusing to submit to a drug test required by the employer's policy;
- (5) Identify the actions the employer may take against an employee or job applicant on the basis of a verified positive test result;
- (6) Assure employees of the possibility of job retention through a last chance agreement;
- (7) Describe the conditions of and process for implementing a last chance agreement;
- (8) Contain a statement that an employee or job applicant who receives a verified positive test result may contest or explain the result to the employer through the employer's medical review officer within five working days after receiving written notification of the positive test result;
- (9) Describe how the employer will provide information to an employee or job applicant advising them of the existence of the drug-free workplace program;
- (10) Describe employee confidentiality;
- (11) Describe how the employer will advise the employees of the employee assistance program required by this chapter;
- (12) Describe how the employer will provide the supervisor training and employee education required by this chapter;
- (13) Contain a statement informing employees of the provisions of the federal Drug-free Workplace Act, if applicable to the employer; and
- (14) Notify employees that the employer may discipline an employee for failure to report an injury in the workplace, not for filing a claim.

[99-20-023, recodified as § 388-815-200, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-200, filed 7/25/96, effective 8/25/96.]

WAC 388-815-205 Program requirements—Notifications. (1) An employer who, prior to July 1, 1996, has not required drug or alcohol testing of employees shall give all employees at least sixty days notice before instituting drug and alcohol testing as part of the drug-free workplace program described in this chapter. The department shall not require employers with drug and alcohol testing policies in effect prior to July 1, 1996 to provide a sixty-day notice period.

(2) An employer shall include notice of substance abuse testing to all job applicants.

(3) An employer shall:

(a) Post notice of the employer's drug-free workplace policy, including its substance abuse testing provisions, in an appropriate and conspicuous location on the employer's premises; and

(b) Make copies of the employer's policy available without request for inspection by employees or job applicants of the employer during regular business hours.

(4) An employer shall make reasonable efforts to help non-English-speaking employees and job applicants understand provisions of the policy.

[99-20-023, recodified as § 388-815-205, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-205, filed 7/25/96, effective 8/25/96.]

WAC 388-815-210 Program requirements—Substance abuse testing. (1) To be certified for the worker compensation premium discount, an employer shall provide a drug-free workplace program that includes substance abuse testing. In conducting substance abuse testing the program shall:

(a) Require all job applicants not enrolled in a clean card program as described in WAC 440-26-215 to submit to a drug test after extending a conditional offer of employment. The employer may use a refusal to submit to a drug test or a verified positive test as a basis for not hiring the job applicant.

(b) Investigate each workplace injury that results in a worker needing off-site medical attention and require an employee to submit to drug and alcohol tests if the employer reasonably believes the employee has caused or contributed to an injury which resulted in the need for off-site medical attention. An employer need not require that an employee submit to drug and alcohol tests if a supervisor, trained in accordance with WAC 440-26-230, reasonably believes that the injury was due to the inexperience of the employee or due to a defective or unsafe product or working condition, or other circumstances beyond the control of the employee. Under this chapter, a first-time verified positive test result may not be used as a sole basis to terminate an employee's employment. However, nothing in this section prohibits an employee from being terminated for reasons other than the positive test result.

(c) Require employees referred to the employee assistance program as a result of a verified positive drug or alcohol test or an alcohol or drug-related incident in violation of employer rules to submit to drug and alcohol testing in conjunction with any recommended rehabilitation program. If the employee assistance program determines that the

employee does not require treatment services, the employee shall still be required to participate in follow-up testing. However, if an employee voluntarily enters an employee assistance program, without a verified positive drug or alcohol test or a violation of any drug or alcohol related employer rule, follow-up testing is not required. If follow-up testing is conducted, the employer shall ensure the frequency of the testing is at least four times a year for a two-year period after completion of the rehabilitation program and advance notice of the testing date may not be given. A verified positive follow-up test result shall normally require termination of employment.

(2) This section does not prohibit an employer from conducting other drug or alcohol testing, such as upon reasonable suspicion or a random basis, although neither reasonable suspicion nor random testing is required under this chapter.

(3) Laboratory analysis of drug specimens, both initial and confirmatory, must be performed by laboratories approved either by the substance abuse and mental health administration, or the College of American Pathologists under the Forensic Urine Drug Testing program (FUDT).

(4) Specimen collection and substance abuse testing under this section must be performed in accordance with regulations and procedures approved by the United States Department of Health and Human Services and/or the United States Department of Transportation Regulations as described in 49 C.F.R. Sec. 382.305 (1994). These regulations and procedures include:

(a) Cutoff levels for alcohol and drug testing; and

(b) Controlled substances for which testing must be done: Marijuana, cocaine, amphetamines, opiates, and phenylclidine.

Employers may test for any drug listed in WAC 440-26-010(4). Employers certified through a clean card program must also comply with department of transportation regulations regarding the selection process for random testing and conduct a minimum fifty percent annual random testing rate for controlled substances as described in 49 C.F.R. Sec. 382.305 (1994).

(5) Within five working days after receipt of a verified positive test result from the laboratory, an employer shall inform an employee or job applicant in writing of the positive test result, the consequences of the result, and the options available to the employee or job applicant, and shall furnish to the employee or job applicant, upon request, a copy of the test result.

(6) An employer shall pay the cost of all drug or alcohol tests that the employer requires of employees and job applicants under this chapter.

(7) An employee or job applicant shall pay the cost of additional tests not required by the employer.

[99-20-023, recodified as § 388-815-210, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 49.82.130. 98-20-045, § 440-26-210, filed 9/30/98, effective 10/31/98. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-210, filed 7/25/96, effective 8/25/96.]

WAC 388-815-215 Program requirements—How employers get certified through a clean card program. Employers wishing to be certified for the drug-free workplace discount program through a clean card program must

observe the application procedures in WAC 440-26-100. They must submit application materials to the department which include:

(1) A signed application form which contains an assurance of the employer's involvement in a clean card program;

(2) A statement that the employer's policy has been negotiated with employee unions where applicable; and

(3) A policy statement which, in addition to the other requirements of WAC 440-26-200, also includes:

(a) A requirement that:

(i) New employees either verify status in the clean card program, or submit to a pre-employment test; and

(ii) All company employees be subject to random testing.

(b) A description of the major provisions of the employer's clean card program.

[99-20-023, recodified as § 388-815-215, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 49.82.130. 98-20-045, § 440-26-215, filed 9/30/98, effective 10/31/98.]

WAC 388-815-220 Program requirements—Employee assistance program. (1) To be certified for the worker compensation premium discount, an employer shall provide a drug-free workplace program that includes an employee assistance program approved by the department in accordance with section 7, chapter 127, Laws of 1996.

(2) The employer's employee assistance program shall provide the employer with a system for dealing with employees whose job performances are declining due to unresolved personal problems, including alcohol or other drug-related problems, marital problems, or legal or financial problems.

(3) The employer's employee assistance program shall have a primary focus on the rehabilitation of employees suffering from alcohol or drug addiction, and shall:

(a) Provide a professional chemical dependency evaluation to every employee given the opportunity for job retention through a last chance agreement after being found in violation of the employer's drug-free workplace policy, and to every employee at their request;

(b) Refer the employee for appropriate treatment according to an individualized treatment plan as indicated by the evaluation and required under section 8 of chapter 127, Laws of 1996. Only treatment programs approved by the department shall provide treatment under this chapter;

(c) Monitor the employee's progress for a minimum of two years both while in treatment and during the period of the last chance agreement, modifying the continuing care provisions as clinically indicated; and

(d) Notify the employer when an employee is not substantially compliant with the requirements of the last chance agreement, including ongoing treatment and continuing care recommendations.

(4) The employer's employee assistance program, in accordance with subsection (3) of this section, shall normally provide services required by this chapter in a face-to-face manner by staff who are:

(a) Certified as chemical dependency counselors by the National Association of Alcohol and Drug Abuse Counselors (NAADAC), the International Certification Reciprocity Consortium/Alcohol and Drug Abuse (ICRC), the Chemical

Dependency Counselor Certification Board of Washington state, or the Northwest Indian Alcohol/Drug Specialist Certification Board; or

(b) Qualified as chemical dependency counselors as defined in chapter 440-22 WAC, Certification requirements for chemical dependency treatment service providers; or

(c) Qualified to perform Substance Abuse Professional (SAP) duties as defined in U.S. Department of Transportation Regulations.

(5) To encourage employee self-referral to the employee assistance program outside of drug-free workplace policy violations, the employer shall:

(a) Notify employees of the benefits and services of the employee assistance program;

(b) Publish notice of the employee assistance program in conspicuous places and explore effective means of publicizing the services; and

(c) Provide employees with notice of the policies and procedures regarding access to and use of the employee assistance program.

[99-20-023, recodified as § 388-815-220, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-220, filed 7/25/96, effective 8/25/96.]

WAC 388-815-230 Supervisor training. An employer shall provide all supervisory personnel with a minimum of two hours of supervisor training that includes but is not limited to, the following information:

(1) The relationship of job performance deficiencies to unresolved personal problems;

(2) How to recognize signs of employee substance abuse;

(3) How to document and corroborate signs of employee substance abuse;

(4) How to refer employees to the employee assistance program;

(5) Circumstances and procedures for post-injury testing;

(6) Supervisor responsibilities in a last chance agreement; and

(7) Employee confidentiality.

[99-20-023, recodified as § 388-815-230, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-230, filed 7/25/96, effective 8/25/96.]

WAC 388-815-240 Employee education. (1) An employer shall provide all employees with an annual education program on substance abuse, in general, and its effects on the workplace, specifically.

(2) The education program shall be a minimum of one hour during regular working hours and include, but not be limited to, the following information:

(a) The explanation of the disease model of addiction for alcohol and drugs;

(b) The effects and dangers of the commonly abused substances in the workplace;

(c) The employer's policies and procedures regarding substance abuse in the workplace;

(d) How to access the employer's employee assistance program for any appropriate assistance; and

(e) How employees who wish to obtain substance abuse treatment can do so.

(3) An employer with employees who have difficulty communicating in English shall make reasonable efforts to help the employees understand the substance of the education program.

[99-20-023, recodified as § 388-815-240, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-240, filed 7/25/96, effective 8/25/96.]

WAC 388-815-250 Confidentiality. In implementing a drug-free workplace program under this chapter, an employer shall observe all relevant federal and state laws and regulations concerning the confidentiality of information, in compliance with section 12, chapter 127, Laws of 1996.

[99-20-023, recodified as § 388-815-250, filed 9/28/99, effective 9/28/99. Statutory Authority: 1996 c 127 § 13. 96-16-015, § 440-26-250, filed 7/25/96, effective 8/25/96.]

Chapter 388-818 WAC

DEAF AND HARD OF HEARING SERVICES

(Formerly chapter 388-43 WAC)

WAC

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WAC 388-818-001 Scope. (1) The office of deaf and hard of hearing services (ODHHS) within the department of social and health services (DSHS):

(a) Provides DSHS information relating to deaf, hard of hearing, and/or deaf-blind;

(b) Provides DSHS technical assistance regarding deafness;

(c) Provides DSHS training and workshops on deafness; and

(d) Assists DSHS in securing sign language interpreters services for DSHS deaf clients.

(2) ODHHS maintains and oversees the telecommunication access services (TDD relay and distribution program), and serves as administrator responsible for the DSHS advisory committee on deafness.

[99-20-022, recodified as § 388-818-001, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-001, filed 12/30/93, effective 1/30/94.]

WAC 388-818-002 Regional centers. The office of deaf and hard of hearing services (ODHHS) shall contract with regional centers for the deaf and hard of hearing.

[99-20-022, recodified as § 388-818-002, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-002, filed 12/30/93, effective 1/30/94.]

WAC 388-818-003 Services. (1) Within the available funds, contractors shall provide quality human services for a person who is deaf or hard of hearing.

(2) Within available funds, and as specified by contract, the department shall ensure the Washington regional service centers provide:

- (a) Information services relating to deafness services;
- (b) Coordination among private and public agencies, the office of deaf and hard of hearing services (ODHHS), regions, and the deaf community;
- (c) Training and consultative services to public and private agencies;
- (d) Advocacy for a deaf or hard of hearing client;
- (e) Assistance to a deaf or hard of hearing client in applying for and securing programs and services from DSHS;
- (f) Assistance and perform other duties relating to deafness as required by the contract; and
- (g) Share information among local deaf and hard of hearing organizations.

[99-20-022, recodified as § 388-818-003, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-003, filed 12/30/93, effective 1/30/94.]

WAC 388-818-005 Definitions. The following definitions shall apply in this chapter, unless the context otherwise requires:

(1) "Amplifier" means an electrical device for use with a telephone which amplifies the sounds being received during a telephone call or a telephone with built-in amplification.

(2) "Applicant" means a person who applies for a teletypewriter (hereinafter TTY), amplifier, telebraille, large visual display, or signal device.

(3) "Audiologist" means a person who has a masters or doctoral degree in audiology and a certificate of clinical competence in audiology from the American Speech, Hearing, and Language Association.

(4) "Deaf" means a condition of severe or complete absence of auditory sensitivity where the primary effective receptive communication mode is visual or tactile, or both.

(5) "Deaf-blind" means a hearing loss and a visual impairment that require use of a TTY to communicate effectively on the telephone, and may require a specific telecommunications device for a person with limited sight, as certified under WAC 388-43-010.

(6) "Department" means the department of social and health services.

(7) "Distribution center" means a facility under contract to DSHS services including but not limited to:

- (a) Providing literature about TAS programs;
- (b) Providing space for qualified trainers to instruct recipients in the use of telecommunications equipment;
- (c) Point of contact for persons to communicate with ODHHS or TAS.

(8) "Federal poverty level guidelines" means the poverty level established by P.L. 97-35 § 52 (codified at 42 USC § 9747), § 673(2) (codified at 42 USC § 99202(2)) as amended;

and the Poverty Income Guideline updated annually in the Federal Register.

(9) "Hard of hearing" means a condition of some absence of auditory sensitivity with residual hearing which may be sufficient to process linguistic information through audition with or without amplification under favorable listening conditions, or a condition of other auditory handicapping conditions.

(10) "Hearing disabled" means a hearing loss that requires use of either a TTY, telebraille, large visual display or an amplifier to communicate effectively on the telephone, and may require the use of a signal device to indicate when the telephone is ringing, as certified under WAC 388-43-010.

(11) "ODHHS" means the office of deaf and hard of hearing services, department of social and health services.

(12) "Official application date" means the date the department received the completed telecommunications equipment application form.

(13) "Qualified trainer" means a person knowledgeable about the appropriate use of TTYs, amplifiers, telebrailles, and/or signal devices, capable of instructing recipients with differing hearing and vision disabilities.

(14) "Recipient" means a person who or organization which has received a state-issued TTY, amplifier, telebraille, large visual display, or signal device.

(15) "School age" means a child five years to seventeen years of age.

(16) "Signal device" means a electronic device that alerts a hearing impaired or deaf-blind recipient of an incoming telephone call.

(17) "Speech disabled" means a speech disability that requires the use of a TTY to communicate effectively on the telephone.

(18) "TAS" means the telecommunications access service, governed by the office of deaf and hard of hearing services, department of social and health services.

(19) "Telebraille" means an electrical device for use with a telephone and TTY that utilizes a braille display to receive messages.

(20) "Telecommunications equipment/device" means amplifier, TTY, telebraille, large visual display, and signaling devices.

(21) "Telecommunications relay center" means a facility authorized by DSHS to provide telecommunications relay services.

(22) "Telecommunications relay service (TRS)" means a telephone service through facilities equipped with specialized equipment and staffed by communications assistants who relay conversations between people who use TTYs and people who use the general telephone network.

(23) "Teletypewriter (TTY)" means an electrical device for use with a telephone that utilizes a keyboard, acoustic coupler, and display screen to transmit and receive messages. Also known as "TDD" (telecommunications device for the deaf) or "TT" (text telephone).

[99-20-022, recodified as § 388-818-005, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-005, filed 12/30/93, effective 1/30/94.]

WAC 388-818-010 Eligibility requirements. (1) An eligible applicant shall:

- (a) Be hearing or speech disabled or deaf-blind; and
- (b) Be a resident of Washington state; and
- (c) Be at least school age as defined under WAC 388-43-005(15); or
- (d) Be the parent/guardian applying on behalf of a child four years of age or younger who has been certified in writing, as specified under subsection (2)(a) through (f) of this section; and

(e) Meet total annual family income and family size requirements as set forth under section 020 of this chapter.

(2) An eligible applicant shall be certified in writing as hearing disabled, speech disabled, or deaf-blind by one of the following:

- (a) A person licensed to practice medicine in the state of Washington;
- (b) An audiologist in Washington as specified under WAC 388-43-005;
- (c) A vocational rehabilitation counselor in a local division of vocational rehabilitation office;
- (d) A deaf specialist or coordinator at one of the community service centers for the deaf and hard of hearing in the state;
- (e) A deaf-blind specialist or coordinator at Helen Keller regional office, Washington deaf-blind service center, or an eye specialist; or
- (f) A certified speech pathologist practicing in the state of Washington.

(3) TAS may require additional documentation to determine if the applicant meets the eligibility requirements under sections 010 and 020 of this chapter.

(4) At the time an applicant applies for equipment, the applicant shall provide the department information on family income and family size.

(5) At the time an applicant applies for equipment, the department shall notify the applicant of the legal consequences if the applicant provides false information.

(6) The department shall ensure an eligible organization meets the following criteria:

- (a) The organization must provide a copy of the certificate of incorporation as a nonprofit organization and its bylaws, to indicate that the intent of the organization is to represent the hearing or speech disabled or deaf-blind persons statewide;
- (b) The organization must have represented hearing or speech disabled or deaf-blind persons statewide in the last three years; and
- (c) The organization must have a telephone number which is either listed or available through statewide publicity for the hearing disabled.

[99-20-022, recodified as § 388-818-010, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-010, filed 1/11/95, effective 2/1/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-010, filed 12/30/93, effective 1/30/94.]

WAC 388-818-020 Approval of application for initial device or request for replacement device. (1) An applicant shall fill out:

- (a) An application form; and
 - (b) A declaration of income statement.
- (2) If the department determines an applicant is eligible, TAS shall approve the application except as provided under WAC 388-43-030 (1)(a) or (b).
- (3) An eligible applicant's reported total family income and family size described under this subsection shall determine the applicant's level of financial responsibility in obtaining the equipment:
- (a) The department shall determine client participation by a sliding scale based on zero percent to two hundred percent of the most recent federal poverty level; and
 - (b) The department shall ensure the sliding scale is adjusted yearly following the new federal poverty level publication.
- (4) A recipient of equipment shall own the equipment, with the exception of a telebraille and tactile signalling device, if the department distributed the equipment before May 15, 1993. When a telecommunications device distributed before May 15, 1993 breaks after warranty has expired, the recipient shall renew the equipment application as an original application as described under this chapter.
- (5) The department shall provide an eligible recipient initial or replacement equipment based on the availability of equipment and/or funds.
- (6)(a) "DEC" means a deductible employee contribution;
 - (b) "Dependent" means a relative who depends on the family income for at least half of the relative's support;
 - (c) "Family size" means a person or a person and the person's spouse, if not legally separated, and the person's dependents;
 - (d) "S corporation" means a domestic corporation with one class of stock having thirty-five or less shareholders who are United States citizens;
 - (e) "SEP" means a simplified employee pension.
- (7) Income includes, but is not limited to:
- (a) Earned income, such as wages and tips;
 - (b) Unearned income, such as interest, dividends, and pensions;
 - (c) Family's share of income from S corporations, partnerships, estates, and trusts;
 - (d) Gains from the sale or exchange (including barter) of real estate, securities, coins, gold, silver, gems, or other property;
 - (e) Gain from the sale or exchange of the family's main home;
 - (f) Accumulation distributions from trusts;
 - (g) Original issue discount, distribution from SEPs and DEC's;
 - (h) Amounts received in place of wages from accident and health plans if the employer paid for the policy;
 - (i) Bartering income;
 - (j) Tier 2 and supplemental annuities under the Railroad Retirement Act;
 - (k) Life insurance proceeds from a policy the family cashed in if the proceeds are more than the premiums paid;
 - (l) Endowments;
 - (m) Lump-sum distribution;
 - (n) Prizes and awards;
 - (o) Gambling winnings;

- (p) Social Security;
- (q) Capital gains;
- (r) Child support received.

[99-20-022, recodified as § 388-818-020, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-020, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-020, filed 12/30/93, effective 1/30/94.]

WAC 388-818-030 Denial of initial application or request for replacement device. (1) Denial of initial application. TAS shall deny an original application for a TTY, amplifier, telebraille, large visual display, or signal device if an applicant:

(a) Does not meet the eligibility requirements of WAC 388-43-010; or

(b) Has already been issued a similar device from TAS.

(2) Denial of replacement request. TAS shall deny a request for replacement of a TTY, amplifier, telebraille, large visual display, or signal device if the recipient:

(a) Reported a family income of one hundred sixty-five percent and above on the federal poverty level; or

(b) Subjected a previously issued device, either through negligence or intent, to abuse, misuse, unauthorized repair, or other negligent or intentional conduct which resulted in damage to the equipment; or

(c) Failed to file with the police a report of stolen equipment within fifteen working days of discovering the theft; or

(d) Failed to file with the police or the fire department a report of fire having damaged the equipment within fifteen working days of the incident of the fire; or

(e) Lost the equipment; or

(f) Failed to obtain approval from the department before moving or traveling out of state with state-loaned equipment.

[99-20-022, recodified as § 388-818-030, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-030, filed 12/30/93, effective 1/30/94.]

WAC 388-818-040 Application renewal process. (1) An applicant may renew application for telecommunications equipment when two years have elapsed since the initial distribution or when the equipment breaks, whichever comes later.

(2) When either two years have elapsed since initial distribution or the equipment breaks, the applicant shall:

(a) Complete a new application including recent information on total annual family income and family size.

(b) Undergo the same procedures as first-time applicants.

[99-20-022, recodified as § 388-818-040, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-040, filed 12/30/93, effective 1/30/94.]

WAC 388-818-050 Notice of approval or denial. (1) Approved applications. When an original application has been approved, TAS shall inform the applicant in writing of:

(a) The official date the department received the applicant's completed application form;

(b) The time line by which a qualified trainer will contact the applicant.

(2) A qualified trainer shall notify the eligible applicant:
(a) That the applicant was approved to receive a TTY, amplifier, telebraille, large visual display, or signal device; and

(b) To arrange for training and distribution.

(3) Denied applications. If the department denies an original application, TAS shall inform the applicant in writing of:

(a) The official date the applicant's completed application form was received by the department;

(b) The reasons for the denial; and

(c) Any applicable procedures for appeal, as well as the circumstances under which the applicant may re-apply.

[99-20-022, recodified as § 388-818-050, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-050, filed 12/30/93, effective 1/30/94.]

WAC 388-818-060 Review by department. (1) An applicant or recipient, whose application for an original or replacement device governed under this chapter has been denied, may request the department to review this decision. The applicant or recipient shall:

(a) Submit this request in writing to TAS specifying the basis for the request; and

(b) Ensure TAS receives this request within thirty days of the receipt of the denial notice.

(2) Within thirty days after TAS has received the request for review by ODHHS, the department shall inform the applicant or recipient in writing of the disposition of the request.

(3) If the applicant or recipient disagrees with the decision by the department, the applicant or recipient may appeal as described under chapters 10-08 and 388-08 WAC.

[99-20-022, recodified as § 388-818-060, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-060, filed 12/30/93, effective 1/30/94.]

WAC 388-818-070 Distribution. (1) The department shall issue personal service contracts to qualified persons or agencies to act as qualified trainers. The department shall ensure reasonable accessibility to such training for a person with a hearing or speech disability or for a person who is deaf-blind.

(2) A qualified trainer shall have various responsibilities, which include, but are not limited to:

(a) Conducting individual and group training for the applicants in the use of the equipment;

(b) Conducting individual and group training for the applicants in the use of the telecommunications relay service;

(c) Requiring all recipients, legal guardians, or legal custodians to sign:

(i) A conditions of acceptance form for state-owned equipment; or

(ii) A statement of rights and responsibilities for client-owned equipment.

(d) Distributing TTYs, amplifiers, telebrailles, large visual displays, and signal devices to applicants; and

(e) Submitting monthly reports and billing as required by TAS.

(3) In the use of any devices distributed under this chapter, neither the TAS nor the contracted qualified trainers shall provide:

- (a) Replacement batteries for any telecommunications equipment;
- (b) Replacement paper for TTYs;
- (c) Replacement light bulbs for signal devices;
- (d) Payment of the recipient's telephone bill; or
- (e) Any other extraneous cost incurred by the recipient.

[99-20-022, recodified as § 388-818-070, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-070, filed 12/30/93, effective 1/30/94.]

WAC 388-818-080 Training. (1) The qualified trainers shall provide training on proper equipment use and care to all recipients, legal guardians, or legal custodians.

(2) The qualified trainers shall be responsible for determining the training needs of the recipients and the time and length of training that would be most appropriate.

(3) The department shall not issue a device until an applicant has demonstrated ability to properly utilize all equipment issued to the applicant. The department may waive this requirement through a written release in which the applicant attests that the applicant has the ability to properly utilize all equipment issued to the applicant.

(4) If the applicant is seventeen years of age or younger, the applicant's legal guardian or legal custodian shall attend the training on appropriate equipment use and care.

[99-20-022, recodified as § 388-818-080, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-080, filed 12/30/93, effective 1/30/94.]

WAC 388-818-090 Ownership and liability. (1) The department shall provide TTYs, amplifiers, telebrailles, large visual displays, and signal devices to a person eligible under subsection (1)(a), (b), and (c) of this section at no charge in addition to the basic exchange rate if:

(a) The person is eligible for participation in the Washington telephone assistance program under RCW 80.36.470;

(b) The person's annual family income is equal to or less than one hundred sixty-five percent of the federal poverty level; or

(c) The person is a child five years to seventeen years of age whose parent or guardian has a family income less than or equal to two hundred percent of the federal poverty level.

(2) After determining the person may be eligible to receive the telecommunications equipment at no charge, the department shall:

(a) Loan the equipment as needed by the applicant; and

(b) Ensure the applicant understands that the equipment remains the sole property of the state of Washington.

(3) A recipient, the recipient's legal guardian, or the recipient's legal custodian shall return a state-loaned TTY and/or other device to the TAS or appropriate distribution center when the recipient:

(a) Moves from a permanent Washington residence to a location outside of Washington;

(b) Does not have need of the state-loaned telecommunications device; or

(c) Has been notified by TAS to return the device.

(4) A recipient, the recipient's legal guardian, or the recipient's legal custodian shall be liable for any damage to or loss of any device issued under this chapter.

(5) TAS may deny a replacement request if a previously issued device:

(a) Was neglected, abused, misused, or abused through unintentional conduct causing damage;

(b) Was not reported as stolen or burned to either police or fire department within fifteen working days; or

(c) Was lost.

(6) TAS shall establish policies for the sale or salvage of any device returned and not appropriate for reassignment.

(7) A person shall not remove a state-owned TTY, amplifier, telebraille, large visual display, or other signal device from the state of Washington for a period longer than ninety days without the written permission of TAS.

(8) TAS may grant permission to remove a state-owned TTY, amplifier, telebraille, large visual display, or signal device from the state for more than ninety days after determining it is in the best interest of the recipient and the department.

(9) A person eligible under subsection (1)(b) of this section with a family income greater than one hundred sixty-five percent and less than or equal to two hundred percent of the federal poverty level shall be assessed a charge for the cost of TTYs, amplifiers, telebrailles, large visual displays, and signal devices based on a sliding scale of charges established under WAC 388-43-020 (2)(a) and (b).

(10) The department shall determine all TTYs, amplifiers, telebrailles, large displays, and signal devices under chapter 304, Laws of 1987, for which the recipient paid all or part of the equipment's cost to be the sole property of the recipient. The department shall determine the level of financial responsibility toward the purchase of the equipment by the federal poverty level guidelines as described under WAC 388-43-020 (2)(a) and (b).

(11) The department shall provide an eligible recipient a two-year warranty on equipment valued at four hundred dollars or more.

(12) Limiting the number of TTYs per household. The department shall consider that the telecommunications equipment needs of all household members have been met when one TTY has been issued to that household, unless exceptional circumstances are defined and approved by the department.

(13) The department shall receive payment before an eligible recipient receives a TTY, amplifier, telebraille, large visual display, or a signal device.

(14) A recipient shall sign and agree to warranty requirements on a TTY, telebraille, or large visual display at the time the recipient purchases this equipment.

(15) A recipient shall not receive a financial refund for the return of a TTY, amplifier, telebraille, large visual display, or signal device unless:

(a) The equipment is returned to the TAS office within thirty days after it was received by the client; and

(b) The equipment is clean, in good condition and in its original packaging.

(16) The department shall charge a person, eligible under subsection (1)(b) of this section whose income exceeds two

hundred percent of the federal poverty level, the entire cost to the department of purchasing the equipment provided to that person.

(17) The department may waive part or all of the charges assessed under sections 010 and 020 if the department finds that:

(a) The eligible person requires telebraille equipment or other equipment of similar cost; or

(b) The charges normally assessed for the equipment under this subsection would create an exceptional or undue hardship on the eligible person.

(18) The department may determine certification of family income by the eligible person, the person's guardian, or head of household as sufficient to determine eligibility.

[99-20-022, recodified as § 388-818-090, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-090, filed 12/30/93, effective 1/30/94.]

WAC 388-818-110 Telecommunications relay service. The department shall award contracts for the operation and maintenance of the statewide telecommunications relay service.

[99-20-022, recodified as § 388-818-110, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-110, filed 12/30/93, effective 1/30/94.]

WAC 388-818-130 Uses for returned equipment. (1) TAS shall issue, as available, the clean and working equipment, which has little or no warranty time left and has been returned to TAS by clients, free of charge to:

(a) Organizations serving hearing/speech disabled, deaf, and/or deaf-blind persons statewide; and

(b) Lending libraries of hospitals and/or hospice facilities.

(2) Organizations receiving used TAS equipment free of charge shall be thereafter responsible for equipment maintenance.

[99-20-022, recodified as § 388-818-130, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-130, filed 1/11/95, effective 2/11/95.]

Chapter 388-820 WAC

COMMUNITY RESIDENTIAL SERVICES AND SUPPORT

(Formerly chapter 275-26 WAC)

WAC

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WAC 388-820-005 Purpose. (1) The purpose of these standards is to specify measures which shall carry out the legislative intent of Title 71A RCW authorizing the department to provide or contract for the provision of services to clients with developmental disabilities residing in community residential settings.

(2) Residential services shall provide eligible clients the opportunity to:

(a) Enjoy all rights and privileges under the Constitution and laws of the United States and the state of Washington;

(b) Participate in community life with nonhandicapped and less-handicapped persons to the greatest extent possible; and

(c) Achieve a greater measure of independence and fulfillment.

[99-19-104, recodified as § 388-820-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-005, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-005, filed 2/9/83.]

WAC 388-820-010 Definitions. (1) "Agency" means the department-certified entity providing residential instruction and support services to clients.

(2) "Certification" means the determination of satisfactory compliance with the rules and regulations outlined as referenced under this chapter.

(3) "Client" means a person the division determines under RCW 71A.16.040 and WAC 275-27-026 eligible for division-funded services.

(4) "Client/provider account" means an account in the name of one client where the client or client's provider has the authority to make deposits or withdrawals. The banking laws under RCW 30.22.040 refer to this as an "agency account."

(5) "Client services" means instruction and support activities promoting the following client-centered benefits:

(a) Health and safety:

(i) Needing and using health services;

(ii) Dealing with illness and injury and first aid procedures;

(iii) Learning about basic nutrition;

(iv) Maintaining good health;

(v) Obtaining mental health services when needed;

(vi) Learning about human sexuality;

(vii) Being aware of fire evacuation plans;

(viii) Knowing emergency procedures, including how to use 911 or a local emergency number;

(ix) Being aware of burglary protection strategies; and

(x) Learning self-protection.

(b) Personal power and choice:

(i) Securing housing and furnishings reflecting personal preferences, life style, and financial means;

(ii) Expressing opinions and making decisions;

(iii) Learning and exercising rights and responsibilities;

- (iv) Improving communication skills;
- (v) Participating in various activities, including new experiences;
- (vi) Exercising a voter's rights;
- (vii) Learning about available protection and advocacy services; and
- (viii) Making career choices.
- (c) Positive recognition by self and others:
 - (i) Creating positive self-esteem and feelings of self-worth;
 - (ii) Choosing valued social roles; and
 - (iii) Having choices influencing valued perception of self and others.
- (d) Integration in the physical and social life of the community:
 - (i) Residing in areas convenient to shopping, banking, eating, worshiping, learning, making friends, and otherwise participating in community life;
 - (ii) Assisting people to use available transportation;
 - (iii) Meeting new people and participating with other members of the community in shared activities; and
 - (iv) Accessing educational and vocational opportunities.
- (e) Positive relationships:
 - (i) Establishing, maintaining, expanding, and improving relationships by providing personal interaction opportunities with people;
 - (ii) Involving the client's family, guardian, or representative in planning and decision making which affect the client;
 - (iii) Resolving disagreements among clients or among clients and family, friends, neighbors, and co-workers;
 - (iv) Coping with the loss of a significant relationship, such as the death of a friend or family member, end of a relationship, loss of a job, or change of staff.
- (f) Competence and self-reliance:
 - (i) Learning and using skills useful to the client, such as meal planning, grocery shopping, meal preparation, cleaning laundry, using household appliances, money management and budgeting, and use of leisure time in settings where the skills are needed;
 - (ii) Identifying situations in which the client needs or desires assistance from others;
 - (iii) Accomplishing tasks requiring the assistance of staff or others; and
 - (iv) Acquiring and using adaptive devices and equipment.
- (6) "Department" means the department of social and health services of the state of Washington.
- (7) "Depositor," when utilized in determining the rights of persons to funds in an account, means a person who owns the funds.
- (8) "Division" means the division of developmental disabilities of the department of social and health services.
- (9) "Exemption" means the department's approval of a written request for an exception to a rule in this chapter.
- (10) "Facility based" means a residence which is owned, leased, or rented by an entity other than the client.
- (11) "Frequency" means how often a designated event has occurred.

(12) "Group home" means a residence licensed by the applicable state authority and operated by an agency certified by the division of developmental disabilities.

(13) "Group training home" means a residence meeting the definition of RCW 71A.22.020(2) and which is operated by an agency certified by the division of developmental disabilities as defined under RCW 71A.22.040.

(14) "Imprest fund" means a petty cash fund which has a pre-established limit. The total of the cash in the fund and receipts from withdrawals from the fund equal the pre-established limit.

(15) "Individual account" means one account in the name of one client primarily managed by a provider.

(16) "Individual client cash" means one client's cash controlled by the provider.

(17) "Instruction" means goal-oriented teaching addressing skill acquisition and skill enhancement.

(18) "Nonfacility based" means the client owns, leases, sub-leases, or rents a residence although others, except the department, may guarantee the client's credit.

(19) "Nursing assistant" means a nursing assistant-registered under chapter 18.88A RCW, or a nursing assistant-certified under chapter 18.88A RCW.

(20) "Provider" means the agency or individual with which the department contracts for providing client instruction and support services.

(21) "Reprisal" means any negative action taken as retaliation against an employee. A rebuttable presumption is raised that reprisal has occurred if a negative action occurs within a year of a refusal to delegate or accept delegation. Occurring as a result of a lawful employee action, "reprisal" includes, but is not limited to:

- (a) Harassment;
- (b) Firing;
- (c) Demotion; or
- (d) Disciplinary action.

(22) "Residence" means the place or home where a client resides.

(23) "Residential service" means work or duties performed by the provider to meet clients' daily living needs and enhance clients' lives.

(24) "Secretary" means the secretary of social and health services or the secretary's designee.

(25) "Severity" means the seriousness of the occurrence as determined by the:

(a) Actual or potential negative outcomes for residents; or

(b) Extent to which the resident's physical, mental, or psychosocial well-being is compromised or threatened.

(26) "Support" means:

(a) Assistance to a client in performance of necessary functions or tasks; or

(b) The performance of a task on behalf of a client, that is, someone else does the client's task.

(27) "Trust account" means an account containing two or more clients' funds where the provider has the authority to make deposits or withdrawals.

[99-19-104, recodified as § 388-820-010, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-010, filed 5/1/96, effective 6/1/96. Statutory Authority:

RCW 71A.12.080, 91-17-005 (Order 3230), § 275-26-010, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-010, filed 2/9/83.]

WAC 388-820-015 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 275-26-010(9) provided an:

(a) Assessment of the exemption request ensures granting the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not affect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

[99-19-104, recodified as § 388-820-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080, 91-17-005 (Order 3230), § 275-26-019, filed 8/9/91, effective 9/9/91.]

WAC 388-820-020 Certification. (1) Initial certification.

(a) The agency's application for initial certification shall include a mission statement, budget forecast, staff coverage schedule, staff in-service training plan, and agency policies and procedures. The department shall provide the county a copy of the agency's application. The department shall review the recommendations from the county.

(b) The agency shall file with the department a statement of assurance stating the agency shall not:

(i) Refuse a client's admission to the agency;

(ii) Deny participation in the activities of the agency; or

(iii) Deny employment at the agency on the grounds of:

(A) Race;

(B) Religion;

(C) Marital status;

(D) Age;

(E) Sexual orientation;

(F) Color;

(G) Creed;

(H) National origin; or

(I) Handicapping condition, including communicable diseases and HIV/AIDS.

(c) The agency shall comply with:

(i) Relevant federal, state, and local laws and ordinances; and

(ii) Department-established standards of care, instruction, and support.

(d) Initial certification may be granted upon assurance the agency shall comply with the rules and regulations outlined under chapter 275-26 WAC within one hundred eighty days of the effective date.

(e) Upon receipt of initial certification, the agency shall be approved for receiving referrals and serving clients.

(f) In the event initial certification expires before the date of formal evaluation and review, the department may extend initial certification for a specified period of time, not to exceed one hundred eighty days.

(2) Regular certification.

(a) Upon the department's determination of satisfactory compliance with the rules and regulations described and ref-

erenced herein, through formal evaluation and review under WAC 275-26-030, the department may certify an agency as approved for continued referral of and service provision to clients.

(b) The agency's certification may be granted for either a one-year or two-year period, but the department may require a more frequent certification review.

(c) The county may submit recommendations to the department before certification.

(d) Regular certification may be extended for a period not to exceed one hundred eighty days.

(3) Provisional certification.

(a) An agency found out of compliance with the provisions of this chapter may be subject to provisional certification not to exceed one hundred eighty days.

(b) When the agency does not comply with the requirements of chapter 275-26 WAC within the one hundred eighty days, the department shall initiate certification revocation. If the agency contests the department's ruling, the agency may request an administrative review conference as described under WAC 275-26-022.

(c) The department's notice of denial, modification, suspension, or revocation of certification is governed by chapter 43.20A RCW and section 95, chapter 175, Laws of 1989.

(d) When an agency comes into compliance with the requirements of chapter 275-26 WAC within one hundred eighty days, the department may grant a regular one-year or two-year certification.

(4) Decertification:

(a) When the department determines the agency does not comply with this chapter the department may revoke the agency's certification as governed under chapter 43.20A RCW and section 95, chapter 175, laws of 1989;

(b) If the agency contests the department's decision, the agency may request an administrative review conference as described under WAC 275-26-022.

[99-19-104, recodified as § 388-820-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080, 91-17-005 (Order 3230), § 275-26-020, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 86-08-003 (Order 2349), § 275-26-020, filed 3/20/86; 83-05-017 (Order 1945), § 275-26-020, filed 2/9/83.]

WAC 388-820-025 Review and evaluation. (1) The department shall review and/or evaluate the agency's services as set forth by law or this chapter. Evaluation shall occur biennially, but the department may require more frequent evaluations.

(2) The department may, at any time, review each client's records and activities to ensure the agency continues serving the client's needs, interests, and welfare.

(3) The department shall file a report of the evaluation results. When the agency is out of compliance with the standards and regulations contained in chapter 275-26 WAC and department contracts, the report shall specify the corrective action to be implemented within a specific time. When corrective action is not implemented within the specified time, the department may withdraw the agency's certification as described under WAC 275-26-020.

(4) The department shall have the right to conduct additional evaluations or audits of the agency as the department deems necessary.

[99-19-104, recodified as § 388-820-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-021, filed 8/9/91, effective 9/9/91.]

WAC 388-820-030 Administrative review conference—Adjudicative proceeding process. (1) Within twenty-eight days after a community residential support agency is notified of a certification determination it wishes to challenge, the agency shall request, in writing, that the division director or the division director's designee review such determination. The agency shall:

(a) Sign the request;

(b) Identify the challenged determination and the date thereof; and

(c) State as specifically as practicable the issues and regulations involved and the grounds for the agency's contention that the determination is erroneous. The agency shall include with the request copies of any documentation the agency intends to rely on to support its position.

(2) After receiving a timely request meeting the criteria of this section, the director shall contact the agency to schedule a conference for the earliest mutually convenient time. The director shall schedule the conference for no later than thirty days after a properly completed request is received, unless both parties agree, in writing, to a specific later date. The conference may be conducted by telephone unless either the department or the agency requests, in writing, the conference be held in person.

(3) The agency and appropriate representatives of the department shall attend the conference. The agency shall bring to the conference, or provide to the department in advance of the conference, any documentation the agency intends to rely on to support the agency's contentions. The parties shall clarify and attempt to resolve the issues at the conference. If additional documentation is needed to resolve the issues, a second session of the conference shall be scheduled for not later than thirty days after the initial session unless both parties agree in writing to a specific later date.

(4) Unless informal agreement has been reached at the conference, a written decision by the director of the division of developmental disabilities shall be furnished to the agency within sixty days after the conclusion of the conference.

(5)(a) An agency contesting the director's determination shall within twenty-eight days of receipt of the determination:

(i) File a written application for an adjudicative proceeding by a method showing proof of receipt with the office of appeals; and

(ii) Include in or with the application:

(A) A specific statement of the issue or issues and law involved;

(B) The grounds for contesting the director's determination; and

(C) A copy of the director's determination being contested.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 43.20A.205,

this chapter, and chapter 388-08 WAC. If any provision in this chapter conflicts with chapter 388-08 WAC, the provision in this chapter governs.

[99-19-104, recodified as § 388-820-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-022, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-26-022, filed 2/5/90, effective 3/1/90. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-022, filed 2/9/83.]

WAC 388-820-035 Eligibility for residential services and support. Any client authorized by the division of developmental disabilities shall be eligible for residential services as defined by this chapter.

[99-19-104, recodified as § 388-820-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-025, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-025, filed 2/9/83.]

WAC 388-820-040 Client remuneration. Clients performing work for the agency shall be given remuneration in accordance with wage and hour laws and requirements stipulated by federal and state law, unless the United States Department of Labor or state department of labor and industries has granted written exemption.

[99-19-104, recodified as § 388-820-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-050, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-050, filed 2/9/83.]

WAC 388-820-045 Administration. (1) The owner or board of directors of the agency shall have department-approved written statements including, but not limited to, the following:

(a) Agency philosophy, objectives, and goals;

(b) Program description and admission criteria;

(c) Policies and procedures describing the following:

(i) Division administrative policy number one prohibiting abuse:

(A) The agency administrator shall complete and file with the division the document entitled division of developmental disabilities administrative policy number one prohibiting a client's mistreatment, neglect, or abuse. The agency shall retain a copy of the document; and

(B) All agency staff working with clients shall sign a similar department-approved document. The agency shall keep the document on record.

(ii) Organizational chart and description showing all supervisory relationships;

(iii) Definition of staff roles and responsibilities, including the person designated to act in the absence of the administrator;

(iv) Criminal background inquiries required under chapter 388-330 WAC;

(v) Client confidentiality and release of information;

(vi) Client rights and grievance procedure;

(vii) Protection of client's financial interests, including management of client accounts, if applicable;

(viii) Drug administration, supervision, handling, storage, and disposal;

(ix) Self-administration of drugs, prescribed or not;

(x) Response to and contingency planning for:

- (A) Medical emergencies;
- (B) Natural or other disasters;
- (C) Missing persons;
- (D) Clients involved with law enforcement; and
- (E) Unmanageable client behavior.

(xi) Notification of client's guardian and/or relatives in case of emergency.

(2) Following emergencies, as defined under WAC 275-27-020, the agency shall:

- (a) Immediately notify the department orally of a serious incident or emergency as described in department policy;
- (b) Submit a written incident report to the department as required by law or policy; and
- (c) Notify the client's guardian or legal representative.

[99-19-104, recodified as § 388-820-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-055, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-055, filed 2/9/83.]

WAC 388-820-050 Personnel. (1) The owner or board of directors of the agency shall maintain current written personnel policies and procedures which shall be made available to all employees.

(2) Personnel policies and practices shall not discriminate against any employee or applicant for employment because of race, color, sex, religion, national origin, creed, marital status, sexual orientation, age, Vietnam era or disabled veteran status, or the presence of any sensory, mental, or physical handicap, including communicable diseases, and HIV/AIDS, provided the sensory, mental, or physical handicap does not prevent the job's specific performance.

(3) Agency-employed staff shall meet the following minimum requirements:

- (a) Have a background inquiry clearance by the authorized state agency;
- (b) Exhibit mature behavior and the ability to make independent judgments;
- (c) Be twenty-one years of age or older when employed as an administrator;
- (d) Be eighteen years of age or older when employed as a direct care staff; and
- (e) Have attained a high school diploma or GED equivalent. Current employees are exempt from subsection (3)(e) effective the date of this amendatory act.

(4) Agency employees shall treat a client with dignity and consideration, respecting the client's civil and human rights at all times.

(5) The performance of the administrator and each employee shall be evaluated, in writing, annually or more often by the agency. An owner/administrator is exempt from this requirement.

(6) The administrator or administrator's designee shall be responsible for:

- (a) Recruiting, employing, and arranging for residential services staff training;
- (b) Terminating from employment any employee performing in an unsatisfactory manner; and
- (c) Preparing and maintaining policies and procedures pertaining to clients personnel and financial records; and

(d) Securely storing client, personnel and financial records.

(7) Clients shall not be routinely involved in the instruction and support of other clients.

[99-19-104, recodified as § 388-820-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-060, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-060, filed 2/9/83.]

WAC 388-820-055 Staffing. (1) An agency shall provide sufficient staff to administer the program and perform instruction and support services.

(2) An agency shall provide the client with immediate access to staff or the means to contact staff twenty-four hours a day, seven days each week.

(3) An agency required to have twenty-four-hour, on-duty staff coverage shall have a department-approved staff coverage schedule:

- (a) At the time of certification; and
- (b) When substantial changes occur. The agency shall retain a copy of department approval of their staffing schedule.

(4) Staff availability.

(a) An agency operating a residential program shall have a designated administrator.

(b) Each facility-based residence shall maintain staffing requirements applicable to the specific licensing regulations and contract requirements under which the agency operates.

(c) When only one direct care staff member is on duty, the agency shall make or have provisions for a second person on call in case of an emergency.

[99-19-104, recodified as § 388-820-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 93-04-029 (Order 3504), § 275-26-065, filed 1/27/93, effective 2/27/93; 91-17-005 (Order 3230), § 275-26-065, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-065, filed 2/9/83.]

WAC 388-820-060 Staff training. (1) The agency shall orient the new employee to the agency's philosophy, goals, policies, procedures, and program services within the first:

- (a) Two weeks of employment for staff scheduled to work twenty hours or more per week; or
- (b) Four weeks of employment for staff scheduled to work less than twenty hours per week.

(2) The agency shall ensure new employees receive a minimum of twelve hours of training during the first six weeks of employment. Such training shall include a combination of orientation, instruction, and on-the-job training.

(3) The agency shall provide a minimum of twenty training hours to each direct service employee during the subsequent five employment months. Such staff training shall include, but not be limited to:

- (a) Basic first aid/CPR;
- (b) Knowledge and transmission of Hepatitis B; and
- (c) Knowledge and transmission of human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS).

(4) The agency shall review and explain the current instruction and support plan for each client for whom the employee provides direct services before the employee works alone with the client.

(5) The agency shall document orientation, review, and training activities.

[99-19-104, recodified as § 388-820-060, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-070, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-070, filed 2/9/83.]

WAC 388-820-065 Individual service plan. The agency shall participate with department staff, the client, the client's guardian or legal representative, and other interested persons in the development of the individual service plan (ISP), under RCW 71A.18.010 and WAC 275-27-060, as required for each client.

[99-19-104, recodified as § 388-820-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-071, filed 8/9/91, effective 9/9/91.]

WAC 388-820-070 Instruction and support. (1) The agency shall develop a written individual instruction and support plan (IISP) for each client:

(a) Based on the goals established in the department's individual service plan (ISP);

(b) Reflecting the client's preferences and concurrence;

(c) Identifying activities promoting one or more of the following client services:

(i) Health and safety;

(ii) Personal power and choice;

(iii) Positive recognition by self and others;

(iv) Integration in the physical and social life of the community;

(v) Positive relationships; and

(vi) Competence and self-reliance.

(d) Identifying the specific goal and describing the methods of instruction and support promoting client-centered benefits and independence in the community.

(2) The agency shall:

(a) Implement the individual instruction and support plan (IISP) in a manner:

(i) Appropriate to the age of the client;

(ii) Taking place or occurring in typical community settings; and

(iii) Resulting in opportunities for:

(A) Positive change;

(B) Personal growth; and

(C) Development toward maximum independence.

(b) Document progress toward achieving the benefits described in the individual instruction and support plan (IISP);

(c) Review the plan semi-annually or more often;

(d) Consult with other providers serving the client and other interested persons as needed to coordinate and promote the individual instruction and support plan (IISP); and

(e) Revise the individual instruction and support plan (IISP) as benefits are achieved.

[99-19-104, recodified as § 388-820-070, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-072, filed 8/9/91, effective 9/9/91.]

WAC 388-820-075 Health services. (1) The agency shall have a means and procedure for ensuring a client has

access to personal care and hygiene services, health services, mental health services, and dental services. For a client for whom the agency provides an average of thirty hours or more of service per month, the agency shall provide instruction and support to the client by:

(a) Maintaining health records;

(b) Assisting the client to arrange appointments with health professionals;

(c) Assisting and ensuring transportation for the client to health services;

(d) Monitoring the client's implementation of medical treatment prescribed by health professionals; and

(e) Communicating directly with health professionals, when indicated.

(2) For each client for whom the agency provides an average of thirty hours or more a month, the agency shall ensure the client receives an annual physical and dental examination unless an exemption is granted, in writing, from the appropriate medical professional.

(3) The agency shall document client refusal to participate in health care services. Documentation shall include:

(a) A written description of events concerning client refusal to participate in health services; and

(b) A written plan to teach the client the benefits of health care participation.

[99-19-104, recodified as § 388-820-075, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-073, filed 8/9/91, effective 9/9/91.]

WAC 388-820-080 Nurse delegation. (1) Before being authorized to perform a delegated nursing care task, staff shall:

(a) Be a nursing assistant-registered or nursing assistant-certified;

(b) Complete nurse delegation core training as approved by the department. The training includes but is not limited to:

(i) Nurse delegation laws and protocols;

(ii) Basic medical knowledge; and

(iii) Medication administration.

(c) The certified community residential services agency shall document this training activity and a certificate shall be issued to the nursing assistant upon completion of the required training.

(2) Nursing assistants delegated a nursing care task in compliance with the nursing care quality assurance commission requirements shall perform the task:

(a) In compliance with all requirements and protocols established by the commission in chapter 246-840 WAC;

(b) Only for the specific client who was the subject of the delegation; and

(c) Only with the consent of the client or a person authorized to provide consent for health care on behalf of the client under this section and RCW 7.70.065. "Persons authorized to provide consent for health care" shall be a member of one of the following classes of persons in the following order of priority:

(i) Legal guardian, if any;

(ii) An individual who holds a durable power of attorney for health care decisions;

(iii) The client's spouse;

(iv) The client's children who are at least eighteen years of age;

(v) The client's parents; and

(vi) The client's adult siblings.

(3) The nursing assistant shall not transfer delegated authority to perform the nursing care tasks to another nursing assistant.

(4) The nursing assistant:

(a) May consent or refuse to consent to perform a delegated nursing care task;

(b) Shall be responsible for the nursing assistant's own actions with regard to the decision to consent or refuse to consent to the performance of the delegated task; and

(c) The nursing assistant shall not be subject to any employer reprisal for refusing to accept delegation of a nursing care task.

(5) The agency shall post and keep posted in a conspicuous place or places where notices to employees are customarily posted, the toll free telephone number established by aging and adult services administration for receiving complaints regarding delegation of specific nursing tasks to nursing assistants.

[99-19-104, recodified as § 388-820-080, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-074, filed 5/1/96, effective 6/1/96.]

WAC 388-820-085 Client records. (1) The client's records shall include, but not be limited to, the following:

(a) The client's name, address, and Social Security number;

(b) The client's guardian or legal representative's name, address, and telephone number;

(c) Copies of legal guardianship papers, if any;

(d) Client health records:

(i) Names, addresses, and telephone numbers of relatives or responsible persons and the name, address, and telephone number of the client's:

(A) Physician;

(B) Dentist;

(C) Mental health provider; or

(D) Others providing client health care services.

(ii) Health care providers' instructions regarding health care needed, including appointment dates and date of next appointment if appropriate;

(iii) Written documentation that the health care providers' instructions have been followed; and

(iv) A record of prosthesis and other artificial parts;

(e) A copy of the department's individual service plan (ISP); and

(f) The client's agency-developed individual instruction and support plan (IISP).

(2) The agency shall maintain and keep current documentation of:

(a) Instruction and support activities for each client as a basis for review, study, and evaluation of the overall progress in programs provided by the agency to the participating clients;

(b) Semi-annual review of the IISP;

(c) Consultation with other service providers and other interested persons;

(d) IISP revisions and changes; and

(e) Other activities relevant to the client.

(3) The agency serving a client an average of thirty hours or more a month shall assist the client in maintaining a current, written property record. The record shall include:

(a) A list of personal possessions, including clothing the client purchases, with a value of one hundred dollars or more per item;

(b) A list of items the client owns when moving into the program;

(c) Description and identifying numbers, if any;

(d) The date of acquisition of items purchased after moving into the program;

(e) The date and reason for addition or removal from the record; and

(f) The signature of the staff making the entry.

(4) Individual providers shall maintain records as required by the department.

(5) The agency shall consider all client record information:

(a) Privileged and confidential;

(b) Available to the department, to the client, and to residential services staff, as needed, to provide client services;

(c) Available to the county developmental disabilities board when the department requests it as allowed under RCW 71A.14.070.

(6) The agency shall prepare and record all record entries:

(a) In ink;

(b) At the time of or immediately following the occurrence of the event recorded, in legible writing, dated, and signed by the person making the entry.

(7) Any transfer or inspection of records, except under subsection (5) of this section, shall be authorized by a release of information form, specific to the transfer or inspection signed by the client or guardian.

[99-19-104, recodified as § 388-820-085, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-075, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-075, filed 2/9/83.]

WAC 388-820-090 Nurse delegation—Penalties. (1)

The department shall impose a civil fine of not less than two hundred fifty dollars and not more than one thousand dollars on any provider that knowingly performs or knowingly permits an employee to perform a nursing task except as delegated by a nurse under:

(a) Chapter 18.88A RCW; and

(b) Chapter 246-840 WAC (nursing care quality commission regulations).

(2) When assessing civil fines, the investigator shall consider:

(a) Severity of occurrence;

(b) Frequency of occurrence; and

(c) Other relevant factors relating to the occurrence.

(3) The department shall make technical assistance available to providers for purposes of education and assistance in order to help providers comply with nurse delegation rules and protocols.

(a) The department's technical assistance program shall include:

(i) Requested or voluntarily accepted technical assistance visits during which or soon after which the department informs the provider of violation of law or agency rules;

(ii) How to access the technical assistance;

(iii) Printed information;

(iv) Information and assistance by phone;

(v) Training meetings;

(vi) Other appropriate methods to provide technical assistance; and

(vii) A list of organizations that provide technical assistance.

(b) The provider shall be given a reasonable period of time to correct violations identified during a technical assistance visit before any civil penalty provided by law is imposed for those violations except as provided in subsection (3)(c) of this section;

(c) A civil penalty may be issued during a technical assistance visit if:

(i) The provider has previously been:

(A) Subject to an enforcement action for the same or similar type of violation of the same statute or rule; or

(B) Given previous notice of the same or similar type of violation of the same statute or rule; or

(ii) The violation has a probability of placing a person in danger of death or bodily harm.

(d) Nothing in these rules obligates the department to conduct a technical assistance visit.

(4) Before imposition of a civil fine and for clarification purposes, the department may take substantially the following steps:

(a) Notify the agency of the concern;

(b) Give the agency an opportunity to explain circumstances or present additional information which may clarify concern;

(c) Request the agency to provide additional information if necessary;

(d) Nothing in this rule shall be construed to require the department to impose a fine if a determination is made that no unlawful delegation occurred.

[99-19-104, recodified as § 388-820-090, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-076, filed 5/1/96, effective 6/1/96.]

WAC 388-820-095 Notice of fine and appeal rights.

(1) The department shall give the provider written notice of the civil fine. The department shall ensure the notice:

(a) States the amount and reasons for the fine and the applicable law under which the fine is imposed; and

(b) Informs the provider of the right to request an adjudicative hearing.

(2) A civil fine becomes due twenty-eight days after the service of the written notice of the fine unless the provider requests a hearing in compliance with chapter 34.05 RCW and RCW 43.20A.215. If a hearing is requested, the department shall stay the fine pending a final decision on the matter.

(3) A provider contesting the department's decision to impose a civil fine shall, within twenty-eight days of receipt of the decision:

(a) File a written application for an adjudicative proceeding by a method showing proof of receipt with the Office of Appeals, P.O. Box 2465, Olympia, WA 98504; and

(b) Include in or with the application:

(i) The grounds for contesting the department decision; and

(ii) A copy of the contested department decision.

(4) Administrative proceedings shall be governed by chapter 34.05 RCW, RCW 43.20A.215, and chapter 388-08 WAC. If any provision in this section conflicts with chapter 388-08 WAC, the provision in this section governs.

(5) When a provider disagrees with the department's finding of a violation under this chapter, the provider shall have the right to have the violation reviewed under the department's dispute resolution process.

(6) Upon request by the provider, the department shall expedite the dispute resolution process to review the imposition of a civil fine.

(7) No agency may discriminate or retaliate in any manner against a person because the person made a complaint or cooperated in the complaint investigation.

[99-19-104, recodified as § 388-820-095, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-077, filed 5/1/96, effective 6/1/96.]

WAC 388-820-100 Transportation. (1) The agency shall ensure or provide transportation for medical emergencies and medical appointments and therapies.

(2) The agency shall assist the client with or arrange transportation, in conjunction with the client and the division, for:

(a) Implementation of the individual service plan (ISP);

(b) Implementation of the individual instruction and support plan (IISP);

(c) Work, school or other publicly-funded services;

(d) Leisure or recreation activities; and

(e) Client-requested activities.

(3) An agency vehicle used to transport clients shall be:

(a) In safe operating condition; and

(b) Properly insured for its usage.

[99-19-104, recodified as § 388-820-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-087, filed 8/9/91, effective 9/9/91.]

WAC 388-820-105 Physical requirements. (1) The agency shall ensure facility-based residential services provide clients the following conditions or necessary equipment:

(a) A clean, safe, and healthful environment;

(b) A location in a residential neighborhood within reasonable distance of necessary physical resources, such as stores, banks, laundromats, churches, job opportunities, and other public services;

(c) An adequate first-aid kit or supplies and a first-aid manual; and

(d) Compliance with all licensing regulations, when applicable.

(e) Current facility-based agencies are exempt from subsection 1(b) effective the date of this amendatory act.

(2) The agency shall ensure nonfacility-based residential services provide clients with the following conditions or necessary equipment:

- (a) A clean, safe, and healthful environment;
- (b) Access to client-usable telephone equipment;
- (c) A working smoke detector, light-alarmed if clients are hearing impaired, located in proximity to sleeping rooms;
- (d) A flashlight or other nonelectrical light source in working condition;
- (e) Basic first-aid supplies;
- (f) An evacuation plan, developed and practiced with the client, placed or stored within the living unit;
- (g) A safe storage area for flammable and combustible materials;
- (h) Unblocked exits; and
- (i) Accessibility by customary forms of ingress and egress for space utilized for residential purposes, excluding ladders, folding stairs, or trap doors.

(3) The agency providing nonfacility-based residential services shall document activities with a client relevant to subsection (2) of this section.

[99-19-104, recodified as § 388-820-105, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-095, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-095, filed 2/9/83.]

WAC 388-820-110 Exceptions when allowed. The department may permit the provider to exceed payment for service and payment for additional expenses. Exceptions will be based on a review by the division of the participating tenant's need for extraordinary level of tenant support services. The exception must be approved by the secretary and included in the contract.

[99-19-104, recodified as § 388-820-110, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-097, filed 2/9/83.]

WAC 388-820-115 Payment for service. (1) The department shall pay for residential services provided to eligible clients under department contract or policy.

(2) For a client receiving facility-based residential services and support:

- (a) The client shall pay for cost of care or service from earnings or financial resources under department policy;
- (b) Department payments under this chapter shall be supplemental to other financial resources of the client; and
- (c) When a client's guardian controls the client's income, estate, or trust fund, the guardian shall reimburse the agency as described under this section.

(3) A client receiving nonfacility-based residential services shall pay for their own housing, utilities, food, clothing, and other personal and incidental expenses from earnings and other financial resources.

(4) The department shall require a client to participate in defraying the cost of services when mandated by federal or state statute or regulation.

(5) The provider shall inform the department when the client requires services beyond levels described under chapter 275-26 WAC. The department may approve and provide

payment for additional expenses or services. The provider shall retain a copy of department approval.

(6) To ensure a client is not charged for services provided by state-funded programs, any payment made for health services with client funds shall be supported by the department's written denial.

[99-19-104, recodified as § 388-820-115, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-100, filed 8/9/91, effective 9/9/91.]

WAC 388-820-120 Program set-up cost. (1) The department may enter into a contractual agreement to reimburse the provider for costs incurred to establish the program. The provider's costs shall:

- (a) Be based on a budget negotiated with the department; and
 - (b) Include client costs of establishing a residence.
- (2) The provider shall submit the department-required billing documents.

[99-19-104, recodified as § 388-820-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-107, filed 8/9/91, effective 9/9/91.]

WAC 388-820-125 Change of ownership. (1) An agency shall inform the department in writing sixty days prior to a change of ownership.

(2) On the effective date of a change of ownership, the department shall terminate the department's certification with the previous provider.

(3) The department shall withhold final payment to the previous provider until the previous provider submits and the department accepts all reports and required documents.

[99-19-104, recodified as § 388-820-125, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-110, filed 8/9/91, effective 9/9/91.]

WAC 388-820-130 Accounting procedures for client accounts. (1) Clients' cash or bank accounts controlled by a provider shall be subject to the provisions of this chapter. Clients' accounts shall include, but not be limited to:

- (a) Trust accounts;
 - (b) Client/provider accounts;
 - (c) Individual accounts;
 - (d) Individual client cash; and
 - (e) Imprest fund(s).
- (2) An account the client independently manages shall not be subject to the provisions of this section.
- (3) The provider shall protect a client's financial interests by:
- (a) Making available to the requesting client the money held for the client unless a client's guardian or legal representative makes other arrangements;
 - (b) Securing a client's or client's guardian's or legal representative's written consent for the management of the client's account;
 - (c) Keeping the client's account current by maintaining a running balance;
 - (d) Reconciling the client's account to the bank statement monthly;

(e) Making deposits to the client's account within one week of receiving the client's money;

(f) Preventing the client's account from becoming overdrawn or showing a debit;

(g) Limiting imprest and individual client cash funds to a reasonable amount necessary for the needs of the client, not to exceed fifty dollars per client;

(h) Maintaining documentation to support financial transactions for the specific type of account:

(i) Trust account records shall include:

(A) A control journal;

(B) Monthly bank statements and reconciliations;

(C) Checkbook registers and bankbooks;

(D) Deposit receipts;

(E) Canceled checks;

(F) Receipts for purchases; and

(G) Itemized subsidiary ledgers showing deposits, withdrawals, and interest payments to individual clients.

(ii) Client/provider accounts or individual accounts shall include the following records:

(A) Monthly bank statements and reconciliations;

(B) Checkbook registers and bankbooks showing deposits, withdrawals, and interest payments to the client;

(C) Deposit receipts;

(D) Canceled checks; and

(E) Receipts for purchases.

(iii) Individual client cash fund records shall include:

(A) A detailed ledger;

(B) Monthly reconciliation to the cash amount;

(C) Detailed accounting of money received on behalf of the client, including cash received from writing checks over the purchase amount and disposition of money spent; and

(D) Receipts for purchases costing over twenty dollars.

(iv) Imprest fund records shall include:

(A) A subsidiary ledger;

(B) A monthly reconciliation to the cash amount;

(C) A detailed accounting of money received on behalf of the client and disposition of money spent;

(D) Receipts for purchases over the amount of twenty dollars;

(E) Itemized ledgers showing a client's deposits and withdrawals, and interest payments paid to clients.

(i) Notifying the department when the client's account reaches three hundred dollars less than the maximum amount allowable by federal or state law; and

(j) Making each client's account available for the secretary's audit and inspection.

(k) Making client funds available to the client or a new provider on the day of transfer or movement when there is change of ownership or a client moves.

(4) When a client's provider receives a check made out to the client, the provider assisting the client shall:

(a) Secure the client's signature and designation "for deposit only" and deposit the check to the client's account; or

(b) Secure the client's "x" mark in the presence of another witness; and

(i) Co-sign the check with the designation "for deposit only"; and

(ii) Deposit the check to the client's account.

(5) When a provider manages client/provider accounts and individual accounts, the agency and client checks shall:

(a) Be signed at the time of purchase only;

(b) Be signed by the client;

(c) Be initialed or signed by the staff assisting the client; and

(d) Not be written for amounts greater than a purchase unless the provider maintains required documentation described under subsection (3)(h)(ii) of this section.

(6) A provider shall pay overdraft charges, fees resulting from the provider's error or mismanagement when they control:

(a) Trust accounts;

(b) Client/provider accounts; and

(c) Imprest funds.

(7) A provider shall pay service charges for trust accounts and imprest funds when they control them.

(8) The agency shall retain all clients' financial records for a minimum of six years after audit, settlement or contract termination, including but not limited to:

(a) Client's related bankbooks;

(b) Bank statements;

(c) Checkbooks;

(d) Check registers; and

(e) All voided and canceled checks.

(9) The client's provider may loan money to the client from the provider's funds and collect the debt from the client by installments.

(10) The client's provider shall not:

(a) Charge the client interest for money loaned; or

(b) Borrow funds from the client.

(11) Upon a provider's transfer of ownership or movement of the client the previous provider shall within thirty days:

(a) Give the client, the client's guardian, or the client's legal representative a written accounting of all client's funds held by the provider;

(b) When applicable give the new provider a written accounting, in accordance with generally accepted accounting principles, of all transferred client funds;

(c) Obtain the client's, client's guardian's, or client's legal representative's written receipt for all the transferred funds; and

(d) When applicable, obtain the new provider's written receipt for the transferred funds.

(12) When a client becomes incapacitated or a client's whereabouts are unknown, the client's provider shall within thirty days transfer the client's funds to the client's legal guardian or to the department.

(13) When a client dies, the client's provider shall within thirty days transfer the client's funds to the client's legal guardian or to the department if the client does not have a legal heir.

(14) The provider shall not release client funds to a person other than the client or the client's guardian or legal representative without the written consent of the client or the secretary.

[99-19-104, recodified as § 388-820-130, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-115, filed 8/9/91, effective 9/9/91.]

Chapter 388-825 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES
SERVICES RULES

(Formerly chapter 275-27 WAC)

WAC

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WAC 388-825-020 Definitions. "Abandonment" means action or inaction by a person or entity with a duty to care for a vulnerable adult that leaves the vulnerable person

without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Adolescent" means a DDD eligible child age thirteen through seventeen years.

"Attendant care" means provision of physical and/or behavioral support to protect the safety and well being of a client.

"Best interest" includes, but is not limited to, client-centered benefits to:

- (1) Prevent regression or loss of skills already acquired;
- (2) Achieve or maintain economic self-support;
- (3) Achieve or maintain self-sufficiency;
- (4) Prevent or remedy neglect, abuse, or exploitation of individuals unable to protect their own interest;
- (5) Preserve or reunite families; and
- (6) Provide the least-restrictive setting that will meet the person's medical and personal needs.

"Client or person" means a person the division determines under RCW 71A.16.040 and WAC 388-825-030 eligible for division-funded services.

"Community support services" means one or more of the services listed in RCW 71A.12.040 including, but not limited to the following services: Architectural, case management, early childhood intervention, employment, counseling, family support, respite care, information and referral, health services and equipment, therapy services, and residential support.

"Department" means the department of social and health services of the state of Washington.

"Director" means the director of the division of developmental disabilities.

"Division or DDD" means the division of developmental disabilities of the department of social and health services.

"Emergency" means a sudden, unexpected occurrence demanding immediate action.

"Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

"Family" means individuals, of any age, living together in the same household and related by blood, marriage, adoption or as a result of sharing legal custody of a minor child.

"Family resources coordinator" means the person who is:

- (1) Recognized by the IDEA Part C lead agency; and
- (2) Responsible for:
 - (a) Providing family resources coordination;
 - (b) Coordinating services across agencies; and
 - (c) Serving as a single contact to help families receiving assistance and services for their eligible children who are under three years of age.

"ICF/MR" means a facility certified as an intermediate care facility for the mentally retarded by Title XIX to provide services to the mentally retarded or persons with related conditions.

"ICF/MR Eligible" for admission to an ICF/MR means a person is determined by DDD as needing active treatment as defined in CFR 483.440. Active treatment requires:

- (1) Twenty-four hour supervision; and
- (2) Continuous training and physical assistance in order to function on a daily basis due to deficits in the following

areas: Toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication.

"**Individual**" means a person applying for services from the division.

"**Individual alternative living**" means provision of community-based individualized client training, assistance and/or ongoing support to enable a client to live as independently as possible with minimal services.

"**Individual supportive living service**" (also known as companion home) means provision of twenty-four hour residential support in a nonlicensed home for one adult person with developmental disabilities.

"**Intelligence quotient score**" means a full scale score on the Wechsler, or the intelligence quotient score on the Stanford-Binet or the Leiter International Performance Scale.

"**Medicaid personal care**" is the provision of medically necessary personal care tasks as defined in chapter 388-15 WAC.

"**Nonresidential programs**" means programs including, but not limited to, county-funded habilitation services.

"**Nursing facility eligible**" means a person is assessed by DDD as meeting the requirements for admission to a licensed nursing home as defined in WAC 388-97-235. The person must require twenty-four hour care provided by or under the supervision of a licensed nurse.

"**Other resources**" means resources that may be available to the client, including but not limited to:

- (1) Private insurance;
- (2) Medicaid;
- (3) Indian health care;
- (4) Public school services through the office of the superintendent of public instruction; and
- (5) Services through the department of health.

"**Part C**" means early intervention for children from birth through thirty-five months of age as defined in the Individuals with Disabilities Education Act (IDEA), Part C and 34 CFR, Part 303 and Washington's federally approved grant.

"**Residential habilitation center**" or "**RHC**" means a state-operated facility certified to provide ICF/MR and/or nursing facility level of care for persons with developmental disabilities.

"**RHC capacity**" means the maximum number of eligible persons that can reside in a residential habilitation center without exceeding its 1997 legislated budgeted capacity.

"**Residential programs**" means provision of support for persons in community living situations. Residential programs include DDD certified community residential services and support, both facility-based such as, licensed group homes, and non-facility based, i.e., supportive living, intensive tenant support, and state-operated living alternatives (SOLA). Other residential programs include individual alternative living, intensive individual supportive living services, adult family homes, adult residential care services, nursing homes, and children's foster homes.

"**Respite care**" means temporary residential services provided to a person and/or the person's family on an emergency or planned basis.

"**Secretary**" means the secretary of the department of social and health services or the secretary's designee.

"**Vacancy**" means an opening at a RHC, which when filled, would not require the RHC to exceed its 1997 biannually budgeted capacity, minus:

- (1) Twenty-six beds designated for respite care use; and
- (2) Any downsizing related to negotiations with the Department of Justice regarding community placements.

"**Vulnerable adult**" means a person who has a developmental disability as defined under RCW 71A.10.020.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, amended and recodified as § 388-825-020, filed 11/9/99, effective 12/10/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-020, filed 2/1/99, effective 3/4/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-020, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.14.030 and 71A.16.020. 92-09-115 (Order 3373), § 275-27-020, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-020, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-020, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-020, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-020, filed 3/16/78; Order 1143, § 275-27-020, filed 8/11/76.]

WAC 388-825-025 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 275-27-020(9) provided an:

- (a) Assessment of the exemption shall not undermine the legislative intent of Title 71A RCW; and
 - (b) Evaluation of the exemption request shows granting the exemption shall not adversely effect the quality of the services, supervision, health, and safety of department-served persons.
- (2) Agencies and individual providers shall retain a copy of each department-approved exemption.
- (3) Exemption requests are not subject to appeal.

[99-19-104, recodified as § 388-825-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-023, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-023, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-023, filed 8/9/91, effective 9/9/91.]

WAC 388-825-030 Eligibility for services. (1) A developmental disability is a condition which meets all of the following:

- (a) A condition defined as mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition as described under WAC 275-27-026;
 - (b) Originates before the individual reaches eighteen years of age;
 - (c) Is expected to continue indefinitely; and
 - (d) Results in a substantial handicap.
- (2) Mental retardation is a condition resulting in significantly subaverage general intellectual functioning as evidenced by:
- (a) A diagnosis of mental retardation documented by a licensed psychologist or certified school psychologist; and
 - (b) A substantial handicap when the individual has an intelligence quotient score of more than two standard deviations below the mean using the Stanford-Binet, Wechsler, or Leiter International Performance Scale; and

(c) An intelligence quotient score which is not:
 (i) Expected to improve with treatment, instruction, or skill acquisition above the established level; or
 (ii) Attributable to mental illness or other psychiatric condition; and

(d) Meeting the requirements of developmental disability under subsection (1)(b) and (c) of this section.

(3) Cerebral palsy is a condition evidenced by:

(a) A diagnosis of cerebral palsy by a licensed physician; and

(b) A substantial handicap when, after forty-eight months of age:

(i) An individual needs direct physical assistance in two or more of the following activities:

- (A) Eating;
- (B) Dressing;
- (C) Bathing;
- (D) Toileting; or
- (E) Mobility; or

(ii) An individual meets the requirements under subsection (6)(b) of this section; and

(c) Meeting the requirements under subsection (1)(b) and (c) of this section.

(4) Epilepsy is a condition evidenced by:

(a) A diagnosis of epilepsy by a board-eligible neurologist, including documentation the condition is chronic; and

(b) The presence of partially controlled or uncontrolled seizures; and

(c) A substantial handicap when the individual:

(i)(A) Requires the presence of another individual to monitor the individual's medication, and is certified by a physician to be at risk of serious brain damage/trauma without direct physical assistance from another individual; or

(B) In the case of individuals eighteen years of age or older only, requires the presence of another individual to monitor the individual's medication, and is unable to monitor the individual's own medication resulting in risk of medication toxicity or serious dosage side effects threatening the individual's life; or

(ii) Meets the requirements under subsection (6)(b) of this section; and

(d) Meeting the requirements under subsection (1)(b) and (c) of this section.

(5) Autism is a condition evidenced by:

(a) A specific diagnosis, by a board-eligible psychiatrist or licensed clinical psychologist, of autistic disorder, a particular diagnostic subgroup of the general diagnostic category pervasive developmental disorders; and

(b) A substantial handicap shown by:

(i) The presence of significant deficits of social and communication skills and marked restriction of activities of daily living, as determined by one or more of the following persons with at least one year's experience working with autistic individuals:

- (A) Licensed psychologists;
- (B) Psychiatrists;
- (C) Social workers;
- (D) Certified communication disorder specialists;
- (E) Registered occupational therapists;
- (F) Case managers;

(G) Certificated educators; and

(H) Others; or

(ii) Meeting the requirements under subsection (6)(b) of this section; and

(c) Meeting the requirements under subsection (1)(b) and (c) of this section.

(6) Another neurological or other condition closely related to mental retardation, or requiring treatment similar to that required for individuals with mental retardation is a condition evidenced by:

(a)(i) Impairment of the central nervous system as diagnosed by a licensed physician; and

(ii) A substantial handicap when, after forty-eight months of age, an individual needs direct physical assistance with two or more of the following activities:

- (A) Eating;
- (B) Dressing;
- (C) Bathing;
- (D) Toileting; or
- (E) Mobility; and

(iii) An intelligence quotient score of at least one and one-half standard deviations below the mean, using the Wechsler Intelligence Scale, the Stanford-Binet, or the Leiter International Performance Scale; and

(iv) Meeting the requirements under subsection (1)(b) and (c) of this section; or

(b) A condition evidenced by:

(i) An intelligence quotient score at least one and one-half standard deviations below the mean, using the Wechsler Intelligence Scale, the Stanford-Binet, or the Leiter International Performance Scale; or

(ii) If the individual's intelligence score is higher than one and one-half standard deviations below the mean, then current or previous eligibility for participation in special education, under WAC 392-171-376 through 392-171-451, shall be demonstrated. Such participation shall not currently or at eighteen years of age be solely due to one or more of the following:

- (A) Psychiatric impairment;
- (B) Serious emotional/behavioral disturbance; or
- (C) Orthopedic impairment; and

(iii) A substantial handicap when a standard score of more than two standard deviations below the mean in each of four domains of the adaptive behavior section of the Inventory for Client and Agency Planning (ICAP) is obtained, the domains identified as:

- (A) Motor skills;
- (B) Social and communication skills;
- (C) Personal living skills;
- (D) Community living skills; and

(iv) The ICAP is administered at least every twenty-four months; and

(v) Is not attributable to mental illness, personality and behavioral disorders, or other psychiatric conditions; and

(vi) Meets the requirements under subsection (1)(b) and (c) of this section; or

(c) A child under six years of age at risk of developmental disability, as measured by developmental assessment tools and administered by qualified professionals, showing a substantial handicap as evidenced by one of the following:

(i) A delay of at least twenty-five percent of the chronological age in one or more developmental areas between birth and twenty-four months of age; or

(ii) A delay of at least twenty-five percent of the chronological age in two or more developmental areas between twenty-five and forty-eight months of age; or

(iii) A delay of at least twenty-five percent of the chronological age in three or more developmental areas between forty-nine and seventy-two months of age; and

(iv) Such eligibility shall be subject to review at any time, but at least at thirty-six months of age and at least seventy-two months of age;

(v) Developmental areas as described in subsection (6)(c) of this section are:

(A) Fine or gross motor skills;

(B) Self-help skills;

(C) Expressive and receptive communication skills, including American sign language skills;

(D) Social skills; and

(E) Cognitive, academic, or problem-solving skills.

(vi) Qualified professionals, as described in subsection (6)(c) of this section, include, but are not limited to, the following professionals with at least one year's experience and training in the field of child development and preferably in the area of developmental disabilities:

(A) Licensed physicians;

(B) Licensed psychologists;

(C) Certified communication disorder specialists;

(D) Registered occupational therapists;

(E) Licensed physical therapists;

(F) Case managers;

(G) Registered public health nurses; and

(H) Educators.

(vii) Any standardized developmental assessment tool may be used if the tool:

(I) Is reasonably reliable and valid by professional standards; and

(II) Demonstrates the information required to make a determination of the developmental delay; or

(d) A child under six years of age having a diagnosis of Down Syndrome.

[99-19-104, recodified as § 388-825-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.10.020, 92-04-004 (Order 3319), § 275-27-026, filed 1/23/92, effective 2/23/92. Statutory Authority: RCW 71.20.070, 89-06-049 (Order 2767), § 275-27-026, filed 2/28/89.]

WAC 388-825-035 Determination of eligibility. (1)

The department shall determine an individual eligible for services upon application if the individual meets developmental disability criteria as defined under WAC 275-27-026.

(2) The department may require appropriate documents substantiating the presence of a developmental disability.

(3) When the department uses or requires the Wechsler Intelligence Test for the purposes of this chapter, the department may consider any standardized Wechsler Intelligence Test as a valid measure of intelligence, assuming a full scale score can be obtained.

(4) If, in the opinion of the testing psychologist, an individual is not able to complete all of the subtests necessary to achieve a full scale score on the Wechsler, the department

shall make a professional judgment about the person's intellectual functioning, based upon the information available.

(5) When an applicant has a significant hearing impairment, the department may use or require the Leiter International Performance Scale to determine the individual's intelligence quotient for the purposes of WAC 275-27-026.

(6) When an applicant has a significant vision impairment, the department may use or require the Wechsler verbal intelligence quotient score as the intelligence quotient score for the purposes of WAC 275-27-026.

(7) When an Inventory for Client and Agency Planning (ICAP) is required by the department to demonstrate a substantial handicap, the department shall provide or arrange for the administration of the ICAP.

(8) The department shall determine an applicant's eligibility for services within ten working days of receipt of the completed application and supporting documents.

(9) Any documentation the department requires shall be subject to departmental review. The department may also review client eligibility at any time.

(10) The secretary or designee may authorize eligibility under subsection (1) of this section under the following conditions:

(a) To register a child under eighteen years of age who is eligible for medically intensive home care services, under the department's Title XIX Model 50 waiver program; or

(b) To eliminate the department's requirement for documentation of disability prior to eighteen years of age when:

(i) The applicant is otherwise eligible under WAC 275-27-026; and

(ii) The department and applicant are unable to obtain any documentation of disability originating prior to eighteen years of age; and

(iii) The department has determined the applicant's condition occurred prior to eighteen years of age.

[99-19-104, recodified as § 388-825-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070, 89-06-049 (Order 2767), § 275-27-030, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-030, filed 7/18/84; Order 1143, § 275-27-030, filed 8/11/76.]

WAC 388-825-040 Application for services. (1) Individuals applying for division services shall file an application with one of the division field services offices in the form and manner required by the director.

(2) An individual, advocate, parent, or guardian of such an individual may file an application for services.

(3) DDD shall inform all applicants about the complete spectrum of service options provided by the division, including the existence and availability of residential habilitation centers and community support services.

[99-19-104, recodified as § 388-825-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030, 98-20-044, § 275-27-040, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71.20.070, 84-15-058 (Order 2124), § 275-27-040, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165, 78-04-033 (Order 1280), § 275-27-040, filed 3/16/78; Order 1143, § 275-27-040, filed 8/11/76.]

WAC 388-825-045 Determination for necessary services. (1) Within sixty days from the date of the division's decision that a person is eligible for division funded services,

the appropriate division field services office shall evaluate the person's needs to determine which services, if any, are necessary to serve the client's best interest. DDD shall explain to the person/family their available service options. In addition, DDD shall do what is reasonable to:

(a) Provide choice of service options within available funding that assists people to remain in their homes and communities;

(b) Plan and develop community support services that take into consideration the unique needs of the individual and family.

(2) After the evaluation is completed, and if appropriate, the division will develop an individual service plan pursuant to WAC 275-27-060.

(3) Determination of necessary services is not a guarantee of service authorization or delivery. Service authorization and delivery of services are pursuant to WAC 275-27-230.

(4) The department will develop an outreach program to ensure that eligible persons are aware of all of the services provided by DDD, including community support services and residential habilitation centers.

[99-19-104, recodified as § 388-825-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-050, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-050, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-050, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-050, filed 3/16/78; Order 1143, § 275-27-050, filed 8/11/76.]

WAC 388-825-050 Individual service plan. (1) The division may develop a written individual service plan (ISP) or other planning documents for each person determined eligible for division and department services within ninety days of the eligibility date. Interim services may be provided if necessary.

(2) An ISP shall be based on an assessment of a person's needs and will specify the services adjudged to be in the best interests of the person and meet the person's habilitation needs. The ISP shall be in the form and manner specified by the director.

(3) A person, the parent if a person is seventeen years of age or younger, or the person's guardian, or an advocate, or the service provider may request review or modification of the service plan at any time based on changed circumstances.

(4) The department's implementation of specific provisions of the plan shall require the development, review, and may require significant modifications of the ISP and shall include, to the maximum extent possible:

(a) Appropriate division staff;

(b) The person;

(c) The person's parent or guardian;

(d) Advocate; and

(e) Representatives of the agency or facility which is, or will be, primarily responsible for the implementation of specific provisions of the plan.

(5) An ISP shall be a planning document, and shall not be an authorization for services. An ISP shall not guarantee the authorization or delivery of services. The authorization of such services is described under WAC 275-27-230.

[99-19-104, recodified as § 388-825-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-

060, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-060, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-060, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-060, filed 3/16/78; Order 1143, § 275-27-060, filed 8/11/76.]

WAC 388-825-055 Authorization of services. (1) The division's field services section shall be responsible for authorizing services agreed to by the person/family including, but not limited to:

(a) Placement to and from residential habilitation centers;

(b) Community residential services;

(c) Family support services; and

(d) Nonresidential programs.

(2) The division's authorization of services shall be based on the availability of services and funding.

(3) The division will include the following persons when determining authorized services:

(a) The person;

(b) The person's parent or guardian and may include:

(i) The person's advocate; or

(ii) Other responsible parties.

(4) Per RCW 71A.116.010 the division shall offer adults the choice of admittance to a residential habilitation center if all of the following conditions exist:

(a) An RHC vacancy is available;

(b) Funding, specifically designated for this purpose in the state operating budget, is available for alternative community support services;

(c) The person or their family is requesting residential services;

(d) The person meets ICF/MR or nursing facility eligibility for the available RHC vacancy;

(e) The person is the most in need of residential services as determined by DDD after reviewing all persons determined eligible for ICF/MR or nursing facility level of care. DDD will make this selection based on the following criteria:

(i) The person is age eighteen or older;

(ii) The person's/family's health and safety is in jeopardy due to the lack of necessary residential support and supervision:

(A) Priority is given to eligible persons/families currently without necessary residential supports;

(B) Other eligible persons will be considered based on their risk of losing residential supports due to unstable or deteriorating circumstances.

(f) The person's alternative DDD funded community support services would cost seventy percent or more of the average RHC rate, assuming a minimum household size of three persons.

(5) If RHC capacity is not being used for permanent residents, the division will make these vacancies available for respite care or any other services the department determines are needed and allowable within the rules governing the use of federal funds.

(a) Admission of a child or adolescent to an RHC for respite care requires the written approval of the division director or designee.

(b) Respite care exceeding thirty days in a calendar year is subject to subsection (6) of this section.

(6) The division shall not make an emergency or temporary admission of a person to a residential habilitation center for thirty-one days or more without the written approval of the division director or the director's designee if the admission is not a choice provided under subsection (4) of this section.

(a) Children twelve years of age and younger shall not be admitted to an RHC.

(b) Admission of an adolescent to an RHC can only occur if:

(i) DDD determines that foster placement services cannot meet the emergency needs of the child/family; and

(ii) A voluntary placement plan is in place with DDD with the goal of community placement or family reunification; and

(iii) Progress towards placement planning is reported to the division director at least every ninety days.

(7) The division shall authorize county-funded services only when the:

(a) Service is included in a department contract; and

(b) Person is at least twenty-one years of age and graduated from school during their twenty-first year; or

(c) Person is twenty-two years of age or older; or

(d) Person is two years of age or younger and eligible for early intervention services.

(8) The department shall require a person to participate in defraying the cost of services provided when mandated by state or federal regulation or statute.

[99-19-104, recodified as § 388-825-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-230, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-230, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-230, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-230, filed 7/18/84. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-27-230, filed 3/1/82. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-230, filed 3/16/78; Order 1143, § 275-27-230, filed 8/11/76.]

WAC 388-825-065 Financial services. The division's field services may include services to protect the financial interests of developmentally disabled individuals.

[99-19-104, recodified as § 388-825-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-240, filed 7/18/84; Order 1143, § 275-27-240, filed 8/11/76.]

WAC 388-825-080 Guardianship services. If it appears an eligible individual requires a guardian, the division's field services may assure initiation of and/or assist in guardianship proceedings.

[99-19-104, recodified as § 388-825-080, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-250, filed 7/18/84; Order 1143, § 275-27-250, filed 8/11/76.]

WAC 388-825-100 Notification. (1) The department shall notify the client or applicant, the parent when the client or applicant is a minor, and the guardian when the client or applicant is an adult, of the following decisions:

(a) Denial or termination of eligibility set forth in WAC 275-27-030;

(b) Development or modification of the individual service plan set forth in WAC 275-27-060;

(c) Authorization, denial, reduction, or termination of services set forth in WAC 275-27-230; and

(d) Admission or readmission to, or discharge from, a residential habilitation center.

(2) The notice shall set forth appeal rights pursuant to WAC 275-27-500 and a statement that the client's case manager can be contacted for an explanation of the reasons for the action.

(3)(a) The department shall provide notice of a denial or partial authorization of a family support services request and a statement of reason for denial or partial authorization, or reduction to the person or persons described in subsection (1) of this section. The department shall send such notice no later than five working days before the end of the month previous to the month for which service was requested;

(b) The department shall make available an administrative review of a decision to deny or partially authorize services upon receipt of a written request by a person or persons described in subsection (1) of this section to the administrator of the region in which the client is living. The regional office must receive a request for administrative review by the last working day of the month;

(c) The client shall state in the written request why the client or client's family believes their service priority designation is not correct;

(d) Upon receipt of request for administrative review, the regional administrator or designee shall review the request and the client file; and

(e) The department shall send the results of the administrative review to the client and/or family within the first five working days of the service month for which the client is being denied or receiving a partial authorization for services.

(4) The department shall provide at least thirty days' advance notice of action to terminate a client's eligibility, terminate or reduce a client's service, or discharge a client from a residential habilitation center to the community. Transfer or removal of a client from a service set forth in WAC 275-27-500 (5)(f) is governed by that section, and reduction of family support funding during the service authorization period is covered by subsection (3)(a) of this section.

(5) All parties affected by such department decision shall be consulted, whenever possible, during the decision process by the responsible field services regional office in person and/or by telephone.

(6) The division shall ensure notification to the school district in which a school-aged child is to be placed when a placement decision is reached.

[99-19-104, recodified as § 388-825-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-400, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-400, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-400, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-400, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-400, filed 3/16/78; Order 1143, § 275-27-400, filed 8/11/76.]

WAC 388-825-120 Adjudicative proceeding. (1) A client, former client, or applicant acting on the applicant's own behalf or through an authorized representative has the

right to an adjudicative proceeding to contest the following department actions:

(a) Denial or termination of eligibility set forth in WAC 275-27-030;

(b) Development or modification of the individual service plan set forth in WAC 275-27-060;

(c) Authorization, denial, reduction, or termination of services set forth in WAC 275-27-230;

(d) Admission or readmission to, or discharge from, a residential habilitation center;

(e) A claim the client, former client, or applicant owes an overpayment debt;

(f) A decision of the secretary under RCW 71A.10.060 or 71A.10.070;

(g) A decision to change a client's placement from one category of residential services to a different category of residential services.

(2) Adjudicative proceedings are governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 71A.10.050, the rules in this chapter, and by chapter 388-08 WAC. If any provision in this chapter conflicts with chapter 388-08 WAC, the provision in this chapter shall govern.

(3) The applicant's application for an adjudicative proceeding shall be in writing and filed with the DSHS office of appeals within twenty-eight days of receipt of the decision the appellant wishes to contest.

(4) The department shall not implement the following actions while an adjudicative proceeding is pending:

(a) Termination of eligibility;

(b) Reduction or termination of service, except when the action to reduce or terminate the service is based on the availability of funding and/or service; or

(c) Removal or transfer of a client from a service, except when a condition in subsection (5)(f) of this section is present.

(5) The department shall implement the following actions while an adjudicative proceeding is pending:

(a) Denial of eligibility;

(b) Development or modification of an individual service plan;

(c) Denial of service;

(d) Reduction or termination of service when the action to reduce or terminate the service is based on the availability of funding or service;

(e) After notification of an administrative law judge's (or review judge) ruling that the appellant has caused an unreasonable delay in the proceedings; or

(f) Removal or transfer of a client from a service when:

(i) An immediate threat to the client's life or health is present;

(ii) The client's service provider is no longer able to provide services due to:

(A) Termination of the provider's contract;

(B) Decertification of the provider;

(C) Nonrenewal of provider's contract;

(D) Revocation of provider's license; or

(E) Emergency license suspension.

(iii) The client, the parent when the client is a minor, or the guardian when the client is an adult, approves the decision.

(6) When the appellant files an application to contest a decision to return a resident of a state residential school to the community, the procedures specified in RCW 71A.10.050(2) shall govern the proceeding. These procedures include:

(a) A placement decision shall not be implemented during any period during which an appeal can be taken or while an appeal is pending and undecided unless the:

(i) Client's or the client's representative gives written consent; or

(ii) Administrative law judge (or review judge) after notice to the parties rules the appellant has caused an unreasonable delay in the proceedings.

(b) The burden of proof is on the department; and

(c) The burden of proof is whether the specific placement proposed by the department is in the best interests of the resident.

(7) The initial order shall be made within sixty days of the department's receipt of the application for an adjudicative proceeding. When a party files a petition for administrative review, the review order shall be made within sixty days of the department's receipt of the petition. The decision-rendering time is extended by as many days as the proceeding is continued on motion by, or with the assent of, the appellant.

[99-19-104, recodified as § 388-825-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020, 91-17-005 (Order 3230), § 275-27-500, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-27-500, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 71.20.070, 86-18-049 (Order 2418), § 275-27-500, filed 8/29/86. Statutory Authority: RCW 72.33.161, 84-15-038 (Order 2122), § 275-27-500, filed 7/13/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165, 78-04-033 (Order 1280), § 275-27-500, filed 3/16/78; Order 1143, § 275-27-500, filed 8/11/76.]

WAC 388-825-170 Community alternatives program (CAP). Purpose—Legal basis.

(1) The purpose of this program is to authorize certain home and community-based services for persons with developmental disabilities to provide an alternative to care in an institution for the mentally retarded (IMR).

(2) Community alternatives program (CAP) is a Medicaid program authorized by P.L. 97-35 Section 2176 as approved by the secretary of the U.S. Department of Health and Human Services.

[99-19-104, recodified as § 388-825-170, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.020, 84-07-018 (Order 2086), § 275-27-800, filed 3/14/84.]

WAC 388-825-180 Eligible persons. (1) To be eligible to apply for community alternatives program (CAP) services, the individual must:

(a) Meet the criteria for the division of developmental disabilities (DDD) eligibility.

(b) Meet the criteria for disability as established in the Social Security Act.

(c) Have an income of less than three hundred percent of the federal Supplemental Security Income (SSI) benefit amount.

(d) Need an IMR level of care as determined by a DDD nursing care consultant.

- (i) Require twenty-four hour care and require services that are not provided by a family member, and
- (ii) Have a documented need for habilitation services and training.

(2) Participation in CAP is by choice of the otherwise IMR-eligible person.

[99-19-104, recodified as § 388-825-180, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-810, filed 3/14/84.]

WAC 388-825-190 Community alternatives program (CAP)—Services. (1) The department may authorize the following services under 42 CFR Part 435 as specified in the ISP:

(a) Case management services, including intake, eligibility determination, assessment of need, service coordination, service authorization, placement and case monitoring;

(b) Habilitation services, including instruction, support, and supervision in developing a person's physical skills, personal care, social and community integration skills;

(c) Family support for an eligible person needing support and supervision which the person's family cannot provide; and

(d) Other community-based services.

(2) The department cost of a person's services under CAP shall not exceed one hundred percent of the cost of care in an ICF/MR.

(3) The division shall review CAP eligibility under 42 CFR Part 435 on forms specified by the division director.

[99-19-104, recodified as § 388-825-190, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-820, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-820, filed 3/14/84.]

WAC 388-825-200 What is the purpose of the family support opportunity program? The purpose of the family support opportunity program is to:

(1) Strengthen family functioning through use of the program elements;

(2) Provide a wide range of supports that will assist and stabilize families;

(3) Encourage individuals and local communities to provide support for the persons with developmental disabilities that live with families;

(4) Complement other public and private resources in providing supports;

(5) Recognize the ability of communities to participate in a variety of ways;

(6) Allow families to make use of all program elements according to the individual and family needs; and

(7) Provide assistance to as many families as possible.

[99-19-104, recodified as § 388-825-200, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-180, filed 2/1/99, effective 3/4/99.]

WAC 388-825-205 Who is eligible to participate in the family support opportunity program? (1) All individuals living with their families determined to be developmentally disabled according to WAC 275-27-026 are eligible to participate in the program if their family requires assistance

in meeting their needs. However, the program will fund or provide support services only as funding is available.

(2) Persons currently receiving services under WAC 275-27-220 and 275-27-223, Family support services, may volunteer to participate in the program.

(3) Families will receive program services based on the date of application.

[99-19-104, recodified as § 388-825-205, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-185, filed 2/1/99, effective 3/4/99.]

WAC 388-825-210 What basic services can my family receive from the family support opportunity program? A number of basic services are available. Some services have their own eligibility requirements. Specific services are:

(1) **Case management services:** Your family will benefit from case management services. The family and the case manager will develop a family support plan which includes needs assessment, referral, service coordination, service authorization, case monitoring and coordination for community guide services.

(2) **Community guide services:** Once your case manager assesses your family situation, you will be offered access to the services of a community guide. The community guide will assist your family in using the natural and informal community supports relevant to the age of your family member with developmental disabilities and the specific needs of your family. Community guide services will support your family and help develop connections to your community.

(3) **Short-term intervention services:** Your family may be eligible for up to eleven hundred dollars in short-term intervention funding if necessary services are not otherwise available. This funding is not intended to cover basic subsistence such as food or shelter costs. Short-term intervention funding is available only for those specialized costs directly related to and resulting from your child's disability.

(4) **Personal care services:** Medicaid personal care can provide your family with long-term in-home personal assistance. (See WAC 388-15-880 and 388-15-890.) In home personal assistance may be available through Medicaid personal care or through a state-funded alternative.

(5) **Community alternatives program (CAP) waiver:** If eligible, your family may participate in the CAP waiver program. The CAP waiver gives eligible clients the opportunity to participate in the federal Medicaid program and DDD the opportunity to obtain federal funds for community based services. (See WAC 275-27-800, 275-27-810 and 275-27-820.)

(6) **Early intervention services:** These services are for your children (from birth through thirty-five months old) and include early childhood programs, birth through two public school programs, children with special health care needs programs, and Part C services (IDEA).

(7) **Emergency services:** Your family can request emergency funds to be used to respond to a single incident, situation or short term crisis such as care giver hospitalization, absence, or incapacity. Your request must be made through your case manager and include an explanation of how you

plan to resolve the emergency situation. Your request will be reviewed by the regional administrator or designee. If approved, you will receive emergency services for a limited time period, not to exceed two months.

(8) **Serious need services:** Your family may request serious need funds to take care of needs not met by other basic services, including short-term intervention services, personal care services or use of a community guide. Serious need funds are short or long-term funds used to provide additional support to allow the individual with disabilities to continue living at home.

[99-19-104, recodified as § 388-825-210, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-190, filed 2/1/99, effective 3/4/99.]

WAC 388-825-220 What is the purpose of community guide services? (1) Community guide services are available to support your family and help you become well connected to resources or supports in your community. After an assessment, your case manager will give you information about a community guide, whose services can be used, if desired by the family.

(2) This guide will assist your family in using the natural and informal community supports relevant to the age of your child with developmental disabilities and your family's specific needs.

[99-19-104, recodified as § 388-825-220, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-191, filed 2/1/99, effective 3/4/99.]

WAC 388-825-222 Who can become a community guide? To be a guide, a person must demonstrate his/her connections to the informal structures of their community. The department may contract with an individual, agency or organization. Guides must be knowledgeable about resources in their community and comfortable assisting families and persons with developmental disabilities. DDD will provide appropriate training for community guides within available resources.

[99-19-104, recodified as § 388-825-222, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-192, filed 2/1/99, effective 3/4/99.]

WAC 388-825-224 Does my family have a choice in selecting its community guide? Your family will be offered a choice of community guides that best meets the needs of your family. At your family's discretion, your family resources coordinator may serve as your community guide if your developmentally disabled child is thirty-five months of age or younger.

[99-19-104, recodified as § 388-825-224, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-193, filed 2/1/99, effective 3/4/99.]

WAC 388-825-226 Can the family support opportunity program help my family obtain financial assistance for community guide services? The program will authorize up to two hundred dollars per year for community guide services for your family.

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[99-19-104, recodified as § 388-825-226, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-194, filed 2/1/99, effective 3/4/99.]

WAC 388-825-228 How can short-term intervention services help my family? If your family is eligible, you may receive up to eleven hundred dollars per year in short-term intervention funds to pay for necessary services not otherwise available. Short-term intervention funding cannot be used for basic subsistence such as food or shelter but is available for those specialized costs directly related to and resulting from your child's disability. Short-term intervention funds can be authorized for a one-time only need or for an episodic service need that occurs over a one-year period.

[99-19-104, recodified as § 388-825-228, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-195, filed 2/1/99, effective 3/4/99.]

WAC 388-825-230 Specifically how can short-term intervention funds be used? Short-term intervention funds can be used to purchase a wide range of services and supports, such as:

(1) Respite care, including community activities providing respite, attendant care or nursing care;

(2) Training such as parenting classes and supports such as disability related support groups;

(3) The purchase, rental, loan or refurbishment of specialized equipment, adaptive equipment or supplies not covered by other resources, including Medicaid. Specific examples are mobility devices such as walkers and wheelchairs, communication devices and medical supplies. Diapers may be approved only for those three years of age and older.

(4) Environmental modifications including home damage repairs caused by the client and home modifications made necessary because of a family member's disability;

(5) Occupational therapy, physical therapy, communication therapy, behavior management, visual and auditory services, or counseling needed by developmentally disabled individuals but not covered by another resource such as public schools and child development services funding;

(6) Medical/dental services not covered by any other resource. These services may include the payment of insurance premiums and deductibles but are limited to the portion of the premium or deduction that applies to the client.

(7) Nursing services, not covered by another resource, that cannot be provided by an unlicensed care giver but can only be rendered by a registered or licensed practical nurse. Examples of such services are ventilation, catheterization, and insulin shots;

(8) Special formulas or specially prepared foods necessary because of the client's disability;

(9) Parent/family counseling for grief and loss issues, genetic counseling or behavior management;

(10) Specialized clothing adapted for a physical disability, excessive wear clothing, or specialized footwear;

(11) Specialized utility costs including extraordinary utility costs resulting from the client's disability or medical condition;

(12) If another resource is not available, transportation costs, including gas, ferry or transit cost, so a client can

receive essential services and maintain appointments; per diem costs may be reimbursed for medical appointments; and

(13) Other services approved by a DDD regional administrator or designee, according to established department guidelines.

[99-19-104, recodified as § 388-825-230, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-196, filed 2/1/99, effective 3/4/99.]

WAC 388-825-232 How can serious need funds help my family? Your family may need extraordinary support for children or adults with developmental disabilities living in your home in addition to the basic family support services. The purpose of serious need funds is to help you get that support when you need it. If funding is available, it may be short or long-term in nature and can be used for services such as additional personal care, respite care, behavior management and licensed nursing care.

[99-19-104, recodified as § 388-825-232, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-197, filed 2/1/99, effective 3/4/99.]

WAC 388-825-234 How can my family qualify for serious need funds? Your family may qualify for serious need funds if the following conditions are met:

(1) The basic program services outlined in WAC 275-27-190 (community guide, personal care services, short-term intervention services, etc.) are currently being used by your family or they have been exhausted;

(2) You and your case manager have examined other resources like the medically intensive home care program; private insurance, local mental health programs and programs available through the public schools and have found them either unavailable, inappropriate or insufficient for your needs; and

(3) The support is crucial for the child or adult with developmental disabilities to continue living in your home.

[99-19-104, recodified as § 388-825-234, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-198, filed 2/1/99, effective 3/4/99.]

WAC 388-825-236 How does my family request serious need funds? You must contact your case manager who will submit a written request to the appropriate DDD regional administrator. The request must:

(1) Indicate the type of services your family needs;

(2) Explain why those services can only be obtained through the use of serious need funds;

(3) Outline the changes you anticipate in your family situation if the requested services are not received;

(4) Estimate the length of time your family will need the requested services; and

(5) Propose funding review dates.

[99-19-104, recodified as § 388-825-236, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-199, filed 2/1/99, effective 3/4/99.]

WAC 388-825-238 What amount of serious need funding is available to my family? (1) The maximum amount of funding available is four hundred dollars per

month or two thousand four hundred dollars in a six-month period, unless the department determines your family member requires licensed nursing care and the funding is used to pay for nursing care. If licensed care is required, the maximum funding level is two thousand four hundred dollars per month.

(2) **REMEMBER:**

(a) Funding must be available in order to receive serious need services.

(b) Services paid for by serious needs funds will be reviewed by DDD every six months.

[99-19-104, recodified as § 388-825-238, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-200, filed 2/1/99, effective 3/4/99.]

WAC 388-825-240 Who determines what family support services my family can receive? Your family and your case manager determine what services your family needs. The department has final approval over service authorization.

[99-19-104, recodified as § 388-825-240, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-202, filed 2/1/99, effective 3/4/99.]

WAC 388-825-242 What department restrictions apply to family support payments? (1) All family support service payments must be authorized by the department.

(2) The department may contract directly with:

(a) A service provider, or

(b) A parent for the reimbursement of goods or services purchased by the parent, or

(c) An agency to purchase goods and services on behalf of a client.

(3) The department's authorization period will start when you agree to be in this program. The period will last one year and may be renewed if you continue to need services.

[99-19-104, recodified as § 388-825-242, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-204, filed 2/1/99, effective 3/4/99.]

WAC 388-825-244 What are regional family support advisory councils? (1) Each division of developmental disabilities regional administrator must appoint a family support advisory council which may serve as a subcommittee of the regional advisory council. The membership of the family support advisory council must include at least one parent representative and at least one case manager.

(2) The purpose of these family support advisory councils is to advise the regional administrator regarding:

(a) Family support issues;

(b) Guidelines for approving or denying short term intervention requests;

(c) Community needs; and

(d) Recommendations for community service grants.

(3) Family support advisory councils must meet at least twice a year.

[99-19-104, recodified as § 388-825-244, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-211, filed 2/1/99, effective 3/4/99.]

WAC 388-825-246 What are community service grants? (1) Community service grants are funded by the division of developmental disabilities family support program to promote community oriented projects that benefit families. Community service grants may fund long-term or short-term projects that benefit children and/or adults.

Agencies or individuals may apply for funding. The department will announce the availability of funding.

(2) To qualify for funding, a proposed project must address one or more of the following topics:

- (a) Provider support and development;
- (b) Parent helping parent; or
- (c) Community resource development for inclusion of all.

(3) Goals for community service projects are as follows:

- (a) Enable families to use generic resources;
- (b) Reflect geographic, cultural and other local differences;
- (c) Support families in a variety of noncrisis-oriented ways;
- (d) Prioritize support for unserved families;
- (e) Address the diverse needs of Native Americans, communities of color and limited or non-English speaking groups;
- (f) Be family focused;
- (g) Increase inclusion of persons with developmental disabilities;
- (h) Benefit families who have children or adults eligible for services from DDD; and
- (i) Promote community collaboration, joint funding, planning and decision making.

(4) Decisions to approve or reject community service grant requests are made by DDD regional administrators considering the recommendations of their regional family support advisory councils. The DDD director has the discretion to award community service grants that have statewide significance.

(5) DDD may sponsor two family support conferences in different areas of the state each year. The purpose of these conferences is to discuss areas addressed by community service grants and other issues of importance to families.

[99-19-104, recodified as § 388-825-246, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-212, filed 2/1/99, effective 3/4/99.]

WAC 388-825-248 Who is covered under these rules? These sections (WAC 275-27-180 through 275-27-212) apply to persons enrolled in family support after June 1996. Those enrolled before June 1996 are covered under WAC 275-27-220 through 275-27-223.

[99-19-104, recodified as § 388-825-248, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-213, filed 2/1/99, effective 3/4/99.]

WAC 388-825-250 Continuity of family support services. (1) It is the policy of the department to recognize the dependence of individuals currently receiving family support services at a given level of services, and to avoid disruption of those services at that given level when possible.

(2) In order for the department to maximize the continuity of service while remaining within appropriated funds for family support services, when appropriated funds for family support services do not permit serving new applicants or increasing services to current recipients without reducing services to existing clients, the department may deny requests for new or increased services based on the lack of funds pursuant to WAC 275-27-230.

(3) These requests may be denied even if the service need levels, as described in WAC 275-27-223, of new applicants or current recipients are of a higher priority than those currently receiving services.

[99-19-104, recodified as § 388-825-250, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.040. 92-13-024 (Order 3394), § 275-27-219, filed 6/9/92, effective 7/10/92.]

WAC 388-825-252 Family support services. (1) The purpose of the family support program is to:

(a) Reduce or eliminate the need for out-of-home residential placement of a client where the in-home placement is in the client's best interest;

(b) Allow a client to live in the most independent setting possible; and

(c) Have access to services best suited to a client's needs.

(2) The department's family support services shall include, the following services:

(a) Respite care, including the use of community activities which provide respite;

(b) Attendant care;

(c) Nursing services provided by a registered nurse or licensed practical nurse, that cannot be provided by an unlicensed caregiver, including but not limited to, ventilation, catheterization, insulin injections, etc., when not covered by another resource;

(d) Therapeutic services, provided these therapeutic services are not covered by another resource such as medicaid, private insurance, public schools, or child development services funding, including:

(i) Physical therapy;

(ii) Occupational therapy;

(iii) Behavior management therapy; and

(iv) Communication therapy; or

(v) Counseling for the client relating to a disability.

(3) Up to nine hundred dollars of the service need level amount in WAC 275-27-222 may be used during a one year period for flexible use as follows. The requested service must be necessary as a result of the disability of the client.

(a) Training and supports including parenting classes and disability related support groups;

(b) Specialized equipment and supplies including the purchase, rental, loan or refurbishment of specialized equipment or adaptive equipment not covered by another resource including Medicaid. Mobility devices such as walkers and wheelchairs are included, as well as communication devices and medical supplies such as diapers for those more than three years of age;

(c) Environmental modification including home repairs for damages, and modifications to the home needed because of the disability of the client;

(d) Medical/dental services not covered by any other resource. This may include the payment of insurance premiums and deductibles and is limited to the premiums and deductibles of the client;

(e) Special formulas or specially prepared foods needed because of the disability of the client;

(f) Parent/family counseling dealing with a diagnosis, grief and loss issues, genetic counseling and behavior management;

(g) Specialized clothing adapted for a physical disability, excessive wear clothing, or specialized footwear;

(h) Specialized utility costs including extraordinary supplemental utility costs related to the client's disability or medical condition;

(i) Transportation costs for gas or tickets (ferry fare, transit cost) for a client to get to essential services and appointments, if another resource is not available;

(j) Other services approved by the DDD regional administrator or designee that will replace or reduce ongoing departmental expenditures and will reduce the risk of out-of-home placement. Exemption requests under this section are not subject to appeal.

(4) Recommendations will be made to the regional administrator by a review committee. The regional administrator will approve or disapprove the request and will communicate reasons for denial to the committee.

(5) Payment for services specified in subsection (3), except (3)(a) and (h), shall cover only the portion of cost attributable to the client.

(6) Requests must be received by DDD no later than midway through the service authorization period unless circumstances exist justifying an emergency.

(7) A plan shall be developed jointly by the family and the department for each service authorization period. The department may choose whether to contract directly with the vendor, to authorize purchase by another agency, or may reimburse the parent of the client.

(8) Emergency Services. Emergency funds may be requested for use in response to a single incident or situation or short term crisis such as care giver hospitalization, absence, or incapacity. The request shall include anticipated resolution of the situation. Funds shall be provided for a limited period not to exceed two months. All requests are to be reviewed and approved or denied by the regional administrator or designee.

(9) A departmental service authorization shall state the type, amount, and period (duration) of service. Each department authorization shall constitute a new service for a new period.

(10) If the client becomes eligible and begins to receive Medicaid Personal Care services as defined in WAC 388-15-880 through 388-15-890, the family support funding will be reduced at the beginning of the next month of service. The family will receive notice of the reconfiguration of services at least five working days before the beginning of the month.

(11) If requested family support services are not authorized, such actions shall be deemed a denial of services.

(12) Family support services may be authorized below the amount requested by the family for the period. When, during the authorized service period, family support services

are reduced or terminated below the amount specified in service authorizations, the department shall deem such actions as a reduction or termination of services.

[99-19-104, recodified as § 388-825-252, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-220, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-220, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-220, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-220, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-220, filed 8/29/86.]

WAC 388-825-254 Service need level rates. (1) The department shall base periodic service authorizations on:

(a) Requests for family support services described in WAC 275-27-220(2) of this section;

(b) Service need levels as described in WAC 275-27-220(3) of this chapter. Service need level lid amounts are as follows:

(i) Clients designated for service need level one (WAC 275-27-223) may receive up to nine hundred fifty-one dollars per month or two thousand three hundred forty-one dollars per month if the client requires licensed nursing care in the home:

(A) If a client is receiving funding through Medicaid Personal Care or other DSHS in-home residential support, the maximum payable through family support shall be four hundred twenty-one dollars per month;

(B) If the combined total of family support services at this maximum plus in-home support is less than nine hundred fifty-one dollars additional family support can be authorized to bring the total to nine hundred fifty-one dollars.

(ii) Clients designated for service need level two may receive up to three hundred seventy-six per month if not receiving funding through Medicaid personal care:

(A) If a client is receiving funds through Medicaid personal care or other DSHS in-home residential support service, the maximum receivable through family support shall be two hundred eleven dollars per month;

(B) If the combined total of family support services at this maximum plus in-home support is less than three hundred seventy-six dollars, additional family support can be authorized to bring the total to three hundred seventy-six dollars.

(iii) Clients designated for service need level three may receive up to two hundred eleven dollars per month provided the client is not receiving Medicaid personal care. If the client is receiving Medicaid personal care or other DSHS in-home residential support service, the maximum receivable through family support shall be one hundred six dollars per month; and

(iv) Clients designated for service level four may receive up to one hundred six dollars per month family support services.

(c) Availability of family support funding;

(d) Authorization by a review committee, in each regional office, which reviews each request for service;

(e) The amounts designated in subsection (1)(b)(i) through (iv) of this section are subject to periodic increase if vendor rate increases are mandated by the legislature.

(2) The department shall authorize family support services contingent upon the applicant providing accurate and complete information on disability-related requests.

(3) The department shall ensure service authorizations do not exceed maximum amounts for each service need level based on the availability of funds.

(4) The department shall not authorize a birth parent, adoptive parent, or stepparent living in the same household as the client as the direct care provider for respite, attendant, nursing, therapy, or counseling services for a child seventeen years of age or younger.

[99-19-104, recodified as § 388-825-254, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-222, filed 6/13/97, effective 7/14/97.]

WAC 388-825-256 Service need levels. (1) The department shall use service need levels to determine periodic family support service authorizations.

(2) The department shall determine service need levels in order of priority for funding as follows:

(a) Service need level 1: Client is at immediate risk of out-of-home placement without the provision of family support services. The client needs intensive residential support to assist the client's family to care for the family's child or adult requiring nursing services, attendant care, or support due to difficult behaviors. A client shall:

(i) Have received, over the past three months, at least ten days or eighty hours of service; or

(ii) Requires at least ten days or eighty hours per month of service to prevent immediate out-of-home placement, based upon an assessment conducted by the department;

(b) Service need level 2: Client is at high risk of out-of-home placement without the provision of family support services and has one or more of the following documented in writing:

(i) The client:

(A) Currently receives adult protective services or division of children and family services as an active:

(I) Child protective service client;

(II) Child welfare service client; or

(III) Family reconciliation service client.

(B) Has returned home from foster care or group care placement within the last six months;

(C) Has a serious medical problem requiring close and ongoing monitoring and/or specialized treatment, such as:

(I) Apnea monitor;

(II) Tracheotomy;

(III) Heart monitor;

(IV) Ventilator;

(V) Constant monitoring due to continuous seizures;

(VI) Immediate life-saving intervention due to life threatening seizures;

(VII) Short bowel syndrome; or

(VIII) Brittle bone syndrome.

(D) Has a dual diagnosis based on current mental health DSM Axis I diagnosis;

(E) Has an extreme behavioral challenge resulting in health and safety issues for self and/or others which:

(I) Resulted in serious physical injury to self or others within the last year;

(II) For a client who is two years of age or older, requires constant monitoring when awake for personal safety reasons; or

(III) Is of imminent danger to self or others as determined by a psychiatrist, psychologist, or other qualified professional.

(F) Is ten years of age or older or weighs forty pounds or more, requires lifting, and needs direct physical assistance in three or more of the following areas:

(I) Bathing;

(II) Toileting;

(III) Feeding;

(IV) Mobility; or

(V) Dressing.

(ii) The caregiver:

(A) Is a division of developmental disabilities client;

(B) Has a physical or medical problem that interferes with providing care; or

(C) Has serious mental health or substance abuse problems and:

(I) Is receiving counseling for these problems; or

(II) Has received or applied for counseling within the past six months.

(c) Service need level 3: The family is at risk of significant deterioration which could result in an out-of-home placement of the client without provision of family support services due to the following:

(i) The client requires direct physical assistance, above what is typical for such client's age, in three or more of the following areas:

(A) Bathing;

(B) Toileting;

(C) Feeding;

(D) Mobility; or

(E) Dressing.

(ii) The client has current behavioral episodes resulting in:

(A) Physical injury to the client or others;

(B) Substantial damage to property; and/or

(C) Chronic sleep pattern disturbances or chronic continuous screaming behavior.

(iii) The client has medical problems requiring substantial extra care; and/or

(iv) The family is:

(A) Experiencing acute and/or chronic stress;

(B) Has acute or chronic physical limitations; or

(C) Has acute or chronic mental or emotional limitations.

(d) Service need level 4: Family needs temporary or ongoing services in order to:

(i) Receive support to relieve and/or prevent stress of caregiver/family; or

(ii) Enhance the current functioning of the family.

(3) The department, through regional review committees, shall determine service need level of the client's service request by reviewing information received from the client, family, and other sources about:

(a) Whether client is an active recipient of services from the division of children and family services or adult protective services;

(b) Whether indicators of risk of out-of-home placement exist, and the imminence of such an event. The department's assessment of such risk may include:

- (i) Review of family's requests for placement;
 - (ii) History of family's involvement with children's protective services or adult protective services;
 - (iii) Client's current adjustment;
 - (iv) Parental history of psychiatric hospitalization;
 - (v) Clinical assessment of family's condition; and
 - (vi) Statements from other professionals.
- (c) Caregiver conditions, such as acute and/or chronic:
- (i) Stress;
 - (ii) Physical limitations; and
 - (iii) Mental and/or emotional impairments.
- (d) Client's need for intense medical, physical, or behavioral support;
- (e) Family's ability to use typical community resources;
- (f) Availability of private, local, state, or federal resources to help meet the need for family support;
- (g) Severity and chronicity of family or client problems; and
- (h) Degree to which family support services will:
- (i) Ameliorate or alleviate such problems; and
 - (ii) Reduce the risk of out-of-home placement.

[99-19-104, recodified as § 388-825-256, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW 97-13-051, § 275-27-223, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-223, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-223, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-223, filed 2/5/88.]

WAC 388-825-260 What are qualifications for individual service providers? The following rules establish qualifications for:

- (1) Persons whom DDD pays to provide services to individuals with developmental disabilities including children; and
- (2) Agencies contracted to provide services in the home of the DDD client.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-260, filed 11/9/99, effective 12/10/99.]

WAC 388-825-262 What services do individuals provide for persons with developmental disabilities? Individual providers contract directly with DDD to provide services such as respite care, Medicaid personal care, attendant care, individual alternative living and companion home services.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-262, filed 11/9/99, effective 12/10/99.]

WAC 388-825-264 If I want to provide services to persons with developmental disabilities, what do I do? You must contact your local DDD office and ask for a contract application package.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-264, filed 11/9/99, effective 12/10/99.]

WAC 388-825-266 If I want to provide respite care in my home, what is required? All out-of-home respite care funded through DDD must take place in a DSHS licensed home unless you meet criteria listed in the "exemption" section below (WAC 388-825-270). You must have a child foster care, family day care, or adult family home license.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-266, filed 11/9/99, effective 12/10/99.]

WAC 388-825-268 What is required for agencies wanting to provide care in the home of a person with developmental disabilities? Agencies must be a home care agency or a home health agency licensed through the department of health. If a DDD-certified residential agency wishes to provide Medicaid personal care or respite care in the client's home, the agency must have home care agency certification or a home health license.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-268, filed 11/9/99, effective 12/10/99.]

WAC 388-825-270 Are there exceptions to the licensing requirement? Relatives of a specified degree are exempt from the licensing requirement and may provide out-of-home respite in their home. Relatives of specified degree include parents, grandparents, brother, sister, stepparent, stepbrother, stepsister, uncle, aunt, first cousin, niece or nephew (WAC 388-76-030).

In addition, RCW 70.128.010 defines adult family home as "more than one, not more than six unrelated adults." If the person requiring out-of-home respite or attendant care is an adult, care may be provided in the nonrelative provider's home without an adult family home license when:

- (1) Care is provided for no more than one unrelated person at a time; and
- (2) The person or his/her legal guardian signs a statement saying they have seen the home where care will be provided and think it is an appropriate place for the care of the adult. If the person does not have a legal guardian, the parent or other relative with whom the person resides may sign a statement.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-270, filed 11/9/99, effective 12/10/99.]

WAC 388-825-272 What are the minimum requirements to become an individual provider? (1) Be at least eighteen years of age;

(2) Successfully pass a criminal history background check;

(3) Not be the spouse of the client receiving services or the natural/step/adoptive parent of a child age seventeen or younger;

(4) Have no findings of fact or conclusions of law or agreed orders related to abuse, neglect, financial exploitation or abandonment of a minor or vulnerable adult, as defined in RCW 74.39A.050(8);

(5) Have not had a child foster care, daycare, adult family home or other license issued by the department of social and health services (DSHS) revoked, denied, suspended or terminated for noncompliance with state and federal regula-

tions. Any existing contracts you hold with DDD will be terminated for cause if such an action exists;

(6) Be able to prove you can work in the United States, provide your social security card and official picture identification or by providing other approved documentation of eligibility to work;

(7) Speak in the language of the person served or have a viable means of communication, such as translation services;

(8) Provide three satisfactory references, unless you are a relative or a Medicaid personal care provider. References are checked prior to the issuance of the initial contract; and

(9) At DDD discretion, a waiver of references may be granted under the following conditions:

(a) The service provider is recruited to provide service exclusively to a specific person;

(b) A request to waive references is submitted in writing by the person, his or her parents, or legal guardian.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-272, filed 11/9/99, effective 12/10/99.]

WAC 388-825-276 What are required skills and abilities for this job? You must be able to:

(1) Adequately maintain records of services performed and payments received;

(2) Read and understand the person's service plan. Translation services may be used if needed;

(3) Be kind and caring to the DSHS client for whom services are authorized.

(4) Identify problem situations and take the necessary action;

(5) Respond to emergencies without direct supervision;

(6) Understand the way your employer wants you to do things and carry out instructions;

(7) Work independently;

(8) Be dependable and responsible;

(9) Know when and how to contact the client's representative and the client's case manager;

(10) Participate in any quality assurance reviews required by DSHS.

(11) If you are working with an adult client of DSHS as an individual alternative living, attendant care or individual supportive living provider, you must also:

(a) Be knowledgeable about the person's preferences regarding the care provided;

(b) Know the resources in the community the person prefers to use and enable the person to use them;

(c) Know who the person's friends are and enable the person to see those friends; and

(d) Enable the person to keep in touch with his/her family as preferred by the person.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-276, filed 11/9/99, effective 12/10/99.]

WAC 388-825-278 Are there any educational requirements for individual providers? Training is mandated only for Medicaid personal care providers of adults (WAC 388-15-19650 through 388-15-19680). DSHS retains the authority to require training of any provider.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-278, filed 11/9/99, effective 12/10/99.]

[2000 WAC Supp—page 1804]

WAC 388-825-280 What are the requirements for an individual supportive living service (also known as a companion home) contract? (1) General knowledge of acceptable standards of performance, including the necessity to be dependable, report punctually, maintain flexibility and to demonstrate kindness and caring to any DSHS client for whom services are authorized.

(2) Twenty hours of training approved by DDD must be completed during the first year of the contract; ten hours must be completed during the second year and all subsequent years.

(3) A clean, safe and healthful environment must be available for the client, including:

(a) A telephone the client can use;

(b) A flashlight or other nonelectrical light source in working condition;

(c) Basic first aid supplies;

(d) An evacuation plan;

(e) A safe storage area for flammable and combustible materials;

(f) Unblocked exits;

(g) Accessibility by customary forms of ingress and egress for space used for residential purposes; and

(h) Smoke alarms in the residence.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-280, filed 11/9/99, effective 12/10/99.]

WAC 388-825-282 What is "abandonment of a vulnerable adult"? State law makes it a crime to abandon a vulnerable adult. "Abandon" means leaving a person without the means or ability to obtain any of the basic necessities of life. If you wish to "quit" or terminate your employment, you must give at least two weeks written notice to your employer, their representative (if applicable) and the DDD case manager. You will be expected to continue working until the termination date unless otherwise determined by DSHS.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-282, filed 11/9/99, effective 12/10/99.]

WAC 388-825-284 Are providers expected to report abuse? You are expected to report any abuse or suspected abuse immediately to child protective services, adult protective services or local law enforcement and make a follow-up call to the person's case manager.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-284, filed 11/9/99, effective 12/10/99.]

Chapter 388-830 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES PROGRAM OPTION RULES

(Formerly chapter 275-31 WAC)

WAC

388-830-005

388-830-010

388-830-015

388-830-020

388-830-025

388-830-030

388-830-035

388-830-040

Purpose.

Definitions.

Determination of eligibility.

Notification to potential applicants.

Application for services.

Individual service plan.

Implementation of necessary services.

Criteria for determining costs.

388-830-045 Method of rate determination.

WAC 388-830-005 Purpose. (1) In order for developmentally disabled individuals to live in the most independent settings possible, and in order for these individuals and families to have access to services best suited to their needs, the division of developmental disabilities may approve alternative service plans for individuals.

(2) Measurable outcomes producing a positive result for individuals will be demonstrated as a result of services provided under such alternative plans.

(3) Cost savings will be demonstrated when costs of services under alternative plans are compared with costs of services provided prior to alternative plans.

[99-19-104, recodified as § 388-830-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-005, filed 1/18/84.]

WAC 388-830-010 Definitions. (1) "Department" means the department of social and health services of the state of Washington.

(2) "Division" means the division of developmental disabilities of the department of social and health services.

(3) "Field services" means the section of the division providing case management services and resource management to division clients living in the community.

(4) "Individual" means the person for whom an alternative plan is being developed.

(5) "Individual habilitation plan" means an individual written plan of care prepared by an interdisciplinary team that sets measurable goals or objectives stated in terms of desirable behavior and that prescribes an integrated program of activities, experiences, or therapies necessary for the individual to reach those goals or objectives. The overall purpose of the plan is to help the individual function at the greatest physical, intellectual, social, or vocational level the individual can presently or potentially achieve.

(6) "Individual program plan" means an individual service plan or individual habilitation plan.

(7) "Individual service plan" means the written plan, specifying goals and objectives, developed by division staff, parent or parents and/or guardian, the individual, and others whose participation is relevant to identifying needs of the individual.

(8) "Less dependent program" means an alternative program which will provide increased numbers and variety of community contacts for the individual or will require fewer hours of staff supervision/support for the individual.

(9) "Provider" means the person or agency contracted by the department to provide training, support, or other services as designated in the alternative plan.

(10) "Secretary" means the secretary of the department of social and health services or such officer of the department as the secretary may designate to carry out administration of the provision of these rules.

[99-19-104, recodified as § 388-830-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-010, filed 1/18/84.]

WAC 388-830-015 Determination of eligibility. An individual shall be eligible for services under an alternative plan, provided that the division has determined the individual has a disability as defined in WAC 275-27-030 and the individual is receiving current services from the department.

[99-19-104, recodified as § 388-830-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-020, filed 1/18/84.]

WAC 388-830-020 Notification to potential applicants. (1) Field services shall, prior to March 15, 1984, contact by mail all individuals determined to have a disability as defined in WAC 275-27-030, along with the guardians and agencies entitled to custody of such disabled individuals and parents of disabled individuals who are minors. Thereafter, the aforementioned persons shall be advised once in each calendar year.

(2) Potential applicants shall be informed of the process by which they may develop an alternative plan for services.

[99-19-104, recodified as § 388-830-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-030, filed 1/18/84.]

WAC 388-830-025 Application for services. (1) In the case of a minor individual, an application can be made by the parent or parents, the guardian or limited guardian, or by the person or agency legally entitled to custody.

(2) In the case of an adult, an application can be made by the individual, by the guardian or limited guardian, or by the person or agency legally entitled to custody.

(3) Application will be made on the forms supplied by the department and the applicant will state the following:

(a) The outline of services proposed;

(b) Service providers for each service;

(c) Tasks necessary to the delivery of each service and the person/organization responsible for each task;

(d) All costs of services currently provided for the individual;

(e) The cost of each service component proposed in the alternative plan;

(f) Information explaining why the alternative plan is a less dependent program than the current program; and

(g) Information explaining why the alternative plan is appropriate under the goals and objectives of the individual program plan.

(4) Applicants must be notified within ninety days after the alternative plan has been received by the department of the secretary's approval or denial of the plan.

(5) The notification of the department's decision is subject to appeal rights pursuant to WAC 275-27-400 and 275-27-500.

[99-19-104, recodified as § 388-830-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-040, filed 1/18/84.]

WAC 388-830-030 Individual service plan. The division shall ensure a current individual service plan is available for each individual prior to approval of application.

[99-19-104, recodified as § 388-830-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-050, filed 1/18/84.]

WAC 388-830-035 Implementation of necessary services. (1) Plans meeting all the criteria specified in RCW 72.33.125(5) shall be implemented as soon as reasonable, but not later than one hundred twenty days after the completion of the determination process.

(2) Approval and reasonableness may be reviewed for a new determination if the plan has not been implemented within one hundred twenty days.

[99-19-104, recodified as § 388-830-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-070, filed 1/18/84.]

WAC 388-830-040 Criteria for determining costs. (1) The term "all costs" includes, but is not limited to: Residential support, habilitation, medical care, income grants to the persons, support to assist their families or other caregivers, and nonrecurring start-up expenses. All residential costs will recognize capital investment, using federal or professional accounting conventions. The department will take the following costs into account:

(a) All costs paid by the department, including costs borne by the federal government. Income grants paid by the federal government directly to the person (or payee) will be considered.

(b) All costs of the current or proposed program.

(2) The department will estimate a monthly average cost based on a two-year prospective cost period.

(3) Where costs are paid or records kept for a group of individuals rather than for one individual in question, the department will primarily use average cost for that group, such as all individuals living at the particular group home or particular residential habilitation center, or all the persons supported by the particular day habilitation program. Exceptions will be considered for persons receiving substantial services above the services received by the typical person in the group.

(4) The analysis of the proposed alternative service plan should show that proposed services can be provided at eighty percent of the current service cost. Exceptions will be considered for persons needing substantial services.

[99-19-104, recodified as § 388-830-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-080, filed 1/18/84.]

WAC 388-830-045 Method of rate determination. Prevailing rates for comparable services will ordinarily be utilized in determining reimbursement for cost components of the alternative plan.

[99-19-104, recodified as § 388-830-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-090, filed 1/18/84.]

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Chapter 388-835 WAC ICF/MR PROGRAM AND REIMBURSEMENT SYSTEM

(Formerly chapter 275-38 WAC)

WAC

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WAC 388-835-010 Terms—Definitions. Unless the context clearly requires otherwise, the following terms shall have the meaning set forth in this section when used in this chapter.

(1) "Accrual method of accounting" means a method of accounting where revenues are reported in the period when earned, regardless of when collected, and expenses are reported in the period incurred, regardless of when paid.

(2) "Active treatment" means "active treatment" as defined under 42 CFR 483.440(a) including implementation of an individual program plan for each client as outlined under 42 CFR 483.440 (c) through (f).

(3) "Administration and management" means activities employed to maintain, control, and evaluate the efforts and resources of a facility or organization for the accomplishment of the objectives and policies of that facility or organization.

(4) "Admission" means entering and being authorized to receive services from a state-certified facility.

(5) "Allowable costs" are described under WAC 275-38-680.

(6) "Appraisal" means the process of establishing the fair market value or reconstruction of the historical cost of an asset acquired in a past period as performed by a person professionally designated either by the American Institute of Real Estate Appraisers as a member, appraisal institute (MAI), or by the Society of Real Estate Appraisers as a senior

real estate analyst (SREA) or a senior real property appraiser (SRPA). The process includes a systematic, analytic determination, the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

(7) "Arm's-length transaction" means a transaction resulting from good-faith bargaining between a buyer and seller who have adverse positions in the market place. Sales or exchanges of ICF/MR or nursing home facilities among two or more parties where all parties subsequently continue to own one or more of the facilities involved in the transaction shall not be considered arm's-length transactions. Sale of an ICF/MR facility which is subsequently leased back to the seller within five years of the date of sale shall not be considered an arm's-length transaction for purposes of chapter 275-38 WAC.

(8) "Assets" means economic resources of the contractor, recognized, and measured in conformity with accounting principles. Assets also include deferred charges which are not resources, but recognized and measured in accordance with accounting principles. The value of assets acquired in a change of ownership entered into after September 30, 1984, shall not exceed the acquisition cost of the owner of record as of July 18, 1984.

(9) "Bad debts" means amounts considered uncollectable from accounts and notes receivable.

(10) "Beds" means unless otherwise specified, the number of set-up beds in the ICF/MR facility, not exceeding the number of licensed beds.

(11) "Beneficial owner" means any person:

(a) Directly or indirectly, through any contract, arrangement, understanding, relationship, or otherwise has or shares:

(i) Voting power including the power to vote, or to direct the voting of such ownership interest; and/or

(ii) Investment power including the power to dispose, or to direct the disposition of such ownership interest.

(b) Directly or indirectly, who creates or uses a trust, proxy, power of attorney, pooling arrangement, or any other contract, arrangement, or device with the purpose or effect of divesting to the same person of beneficial ownership of an ownership interest or preventing the vesting of such beneficial ownership as part of a plan or scheme to evade the reporting requirements of this chapter;

(c) Subject to subsection (5) of this section, with the right to acquire beneficial ownership of such ownership interest within sixty days, including but not limited to any right to acquire:

(i) Through the exercise of any option, warrant, or right;

(ii) Through the conversion of an ownership interest;

(iii) Under the power to revoke a trust, discretionary account, or similar arrangement; or

(iv) Under the automatic termination of a trust, discretionary account, or similar arrangement.

Except, any person acquiring an ownership interest or power specified in subsection (11)(c)(i), (ii), or (iii) of this section shall be deemed the beneficial owner of the ownership interest acquired through the exercise or conversion of such ownership interest or power;

(d) Who in the ordinary course of business is a pledgee of ownership interest under a written pledge agreement and

shall not be deemed the beneficial owner of such pledged ownership interest except under the following conditions:

(i) The pledgee shall take all formal steps necessary and be required to:

(A) Declare a default and determine the power to vote; or

(B) Direct the vote; or

(C) Dispose or direct the disposition of how such pledged ownership interest will be exercised.

(ii) The pledge agreement is bona fide and was not entered into with the purpose nor with the effect of changing or influencing the control of the contractor, nor in connection with any transaction having such purpose or effect, including any transaction with persons who meet the conditions set forth in subsection (11)(b) of this section; and

(iii) The pledge agreement, before default, does not grant to the pledgee the power to:

(A) Vote or direct the vote of the pledged ownership interest; or

(B) Dispose or direct the disposition of the pledged ownership interest, other than the grant of such power or powers under a pledge agreement where credit is extended and where the pledgee is a broker or dealer.

(12) "Boarding home" means any home or other institution licensed in accordance with chapter 18.20 RCW.

(13) "Capitalization" means the recording of an expenditure as an asset.

(14) "Capitalized lease" means a lease required to be recorded as an asset and associated liability in accordance with generally accepted accounting principles.

(15) "Cash method of accounting" means a method of accounting where revenues are recognized only when cash is received, and expenditures are expensed, and asset items are not recorded until cash is disbursed.

(16) "Change of ownership" means a change in the individual or legal organization responsible for the daily operation of an ICF/MR facility.

(a) Events changing ownership include but are not limited to:

(i) The form of legal organization of the owner is changed, such as a sole proprietor forms a partnership or corporation;

(ii) Title to the ICF/MR enterprise is transferred by the contractor to another party;

(iii) The ICF/MR facility is leased, or an existing lease is terminated;

(iv) Where the contractor is a partnership, any event occurring dissolving the partnership;

(v) Where the contractor is a corporation, the corporation is dissolved, merges with another corporation which is the survivor, or consolidates with one or more other corporations to form a new corporation.

(b) Ownership does not change when the following occurs:

(i) A party contracts with the contractor to manage the enterprise as the contractor's agent, that is, subject to the contractor's general approval of daily operating decisions;

(ii) If the contractor is a corporation, some or all of its stock is transferred.

(17) "Charity allowances" means reductions in charges made by the contractor because of the indigence or medical indigence of a resident.

(18) "Client or person" means a person the division determines, under RCW 71A.16.040 and WAC 275-27-026, eligible for division-funded services.

(19) "Consent" means the process through which a person's agreement is obtained for procedures and for taking actions affecting that person.

(20) "Contract" means a contract between the department and a contractor for the delivery of ICF/MR services to eligible Medicaid recipients.

(21) "Contractor" means an entity contracting with the department to deliver ICF/MR services to eligible Medicaid recipients.

(22) "Courtesy allowances" means reductions in charges in the form of an allowance to physicians, clergy, and others for services received from the contractor. Employee fringe benefits are not considered courtesy allowances.

(23) "Custody" means immediate physical attendance, shelter, and supervision of a person for purposes of the person's care and welfare.

(24) "DDD" means the division of developmental disabilities of the department.

(25) "Department" means the department of social and health services (DSHS) and its employees.

(26) "Depreciation" means the systematic distribution of the cost or other base of a tangible asset, less any salvage, over the estimated useful life of the asset.

(27) "Discharge" means the resident's leaving the residential facility and the facility's relinquishment of responsibilities acquired by reason of the acceptance for admission of the resident.

(28) "Donated asset" means an asset the contractor acquired without making any payment in the form of cash, property, or services. An asset is not a donated asset if the contractor made even a nominal payment in acquiring the asset. An asset purchased using donated funds is not a donated asset.

(29) "Entity" means an individual, partnership, corporation, public institution established by law, or any other association of individuals, capable of entering enforceable contracts.

(30) "Equity capital" means total tangible and other assets necessary, ordinary, and related to resident care from the most recent provider cost report minus related total long-term debt from the most recent provider cost report plus working capital as defined in this section.

(31) "Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

(32) "Facility" means a residential setting certified as an ICF/MR by the department in accordance with federal regulations. A state facility is a state-owned and operated residential habilitation center or a state-operated living alternative (SOLA). A nonstate facility is a residential setting licensed in accordance with chapter 18.51 RCW as a nursing home or chapter 18.20 RCW as a boarding home.

(33) "Fair market value" means the price the asset would have been purchased for on the date of acquisition in an

arm's-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.

(34) "Financial statements" means statements prepared and presented in conformity with accounting principles and this chapter including, but not limited to, balance sheet, statements of operations, statements of changes in financial position, and related notes.

(35) "Fiscal year" means the operating or business year of a contractor. All contractors report on the basis of a twelve-month fiscal year, but provision is made in this chapter for reports covering abbreviated fiscal periods.

(36) "Funded capacity" for a state facility means the number of beds on file with the office of financial management by the first day of each biennium for operation during each ensuing fiscal year.

(37) "Generally accepted accounting principles" means accounting principles currently approved by the financial accounting standard board (FASB).

(38) "Generally accepted auditing standards" means auditing standards approved by the American Institute of Certified Public Accountants (AICPA).

(39) "Goodwill" means the excess of the price paid for a business over the fair market value of all other identifiable, tangible, and intangible assets acquired. "Goodwill" also means the excess of the price paid for an asset over fair market value.

(40) "Habilitative services" means those services required by the individual habilitation plan provided or directed by qualified therapists.

(41) "Harmful" means situations when the individual is at immediate risk of serious bodily harm.

(42) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies.

(43) "Imprest fund" means a fund:

(a) That is regularly replenished in exactly the amount expended from the fund[; and]

[(b) In which the cash and expended receipts always equal a predetermined amount].

(44) "ICF/MR" means a facility certified as an intermediate care facility for the mentally retarded by Title XIX to provide services to the mentally retarded or persons with related conditions.

(45) "Interest" means the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user.

(46) "Joint facility costs" means any costs representing expenses incurred benefiting more than one facility, or one facility and any other entity.

(47) "Lease agreement" means a contract between two parties for the possession and use of real or personal property or assets for a specified period of time in exchange for specified periodic payments. Elimination or addition of any party to the contract, expiration, or modification of any lease term in effect on January 1, 1980, or termination of the lease by either party by any means shall constitute a termination of the lease agreement. An extension or renewal of a lease agreement, whether or not under a renewal provision in the lease agreement, shall be considered a new lease agreement. A strictly formal change in the lease agreement which modifies the method, frequency, or manner in which the lease pay-

ments are made, but does not increase the total lease payment obligation of the lessee shall not be considered modification of a lease term.

(48) "Medicaid program" means the state medical assistance program provided under RCW 74.09.500 or authorized state medical services.

(49) "Medical assistance recipient" means an individual determined eligible for medical assistance by the department for the services provided in chapter 74.09 RCW.

(50) "Modified accrual method of accounting" means a method of accounting in which revenues are recognized only when cash is received, and expenses are reported in the period in which incurred, regardless of when paid.

(51) "Net book value" means the historical cost of an asset less accumulated depreciation.

(52) "Nonallowable costs" means costs not allowed under WAC 275-38-680.

(53) "Nonrestricted funds" means donated funds not restricted to a specific use by the donor, for example, general operating funds.

(54) "Nursing home" means a home, place, or institution, licensed in accordance with chapter 18.51 RCW, where skilled nursing, intermediate care, and ICF/MR services are delivered.

(55) "Operating lease" means a lease under which rental or lease expenses are included in current expenses in accordance with accounting principles.

(56) "Owner" means a sole proprietor, general or limited partner, or beneficial interest holder of five percent or more of a corporation's outstanding stock.

(57) "Ownership interest" means all interests beneficially owned by a person, calculated in the aggregate, regardless of the form such beneficial ownership takes.

(58) "Per diem (per resident day) costs" means total allowable costs for a fiscal period divided by total resident days for the same period.

(59) "Prospective daily payment rate" means the daily amount the department assigns to each contractor for providing services to ICF/MR residents. The rate is used to compute the maximum participation of the department in the contractor's costs.

(60) "Qualified mental retardation professional (QMRP)" means QMRP as defined under 42 CFR 483.430(a).

(61) "Qualified therapist" means any of the following:

(a) An activities specialist having specialized education, training, or experience as specified by the department;

(b) An audiologist eligible for a certificate of clinical competence in audiology or having the equivalent education and clinical experience;

(c) A dental hygienist as defined by chapter 18.29 RCW;

(d) A dietitian: Eligible for registration by the American Dietetic Association under requirements in effect on January 17, 1974; or having a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management; having one year supervisory experience in the dietetic service of a health care institution; and participating annually in continuing dietetic education;

(e) An occupational therapist being a graduate of a program in occupational therapy, or having the equivalent of

such education or training, and meeting all requirements of state law;

(f) A pharmacist as defined by chapter 18.64 RCW;

(g) A physical therapist as defined by chapter 18.74 RCW;

(h) A physician as defined by chapter 18.71 RCW or an osteopathic physician as defined by chapter 18.57 RCW;

(i) A psychologist as defined by chapter 18.83 RCW;

(j) A qualified mental retardation professional;

(k) A registered nurse as defined by chapter 18.88 RCW;

(l) A social worker who is a graduate of a school of social work.

(m) A speech pathologist eligible for a certificate of clinical competence in speech pathology or having the equivalent education and clinical experience.

(62) "Regression analysis" means a statistical technique through which one can analyze the relationship between a dependent or criterion variable and a set of independent or predictor variables.

(63) "Regional services" means services of a local office of the division of developmental disabilities.

(64) "Related organization" means an entity which is under common ownership and/or control with, or has control of or is controlled by, the contractor. An entity is deemed to "control" another entity if one entity has a five percent or greater ownership interest in the other, or if an entity has capacity, derived from any financial or other relationship, and whether or not exercised, to influence directly or indirectly the activities of the other.

(65) "Relative" means spouse; natural parent, child, or sibling; adopted child or adoptive parent; stepparent, stepchild, stepbrother, stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law; grandparent or grandchild; uncle, aunt, nephew, niece, or cousin.

(66) "Resident day" means a calendar day of resident care. In computing calendar days of care, the day of admission is always counted. The day of discharge is counted only when the resident was admitted on the same day. A person is admitted for purposes of this definition when the person is assigned a bed and a resident record is opened.

(67) "Resident living staff (also known as resident care and training staff)" means staff whose primary responsibility is the care and development of the residents, including:

(a) Resident activity program;

(b) Domiciliary services; and

(c) Habilitative services under the supervision of the QMRP.

(68) "Restricted fund" means a fund where the use of the principal or income is restricted by agreement with or direction by the donor to a specific purpose, in contrast to a fund over which the owner has complete control. These generally fall into three categories:

(a) Funds restricted by the donor to specific operating purposes;

(b) Funds restricted by the donor for additions to property, plant, and equipment; and

(c) Endowment funds.

(69) "Secretary" means the secretary of DSHS.

(70) "Start-up costs" means the one-time preopening costs incurred from the time preparation begins on a newly constructed or purchased building until the first resident is admitted. Start-up costs include administrative and nursing salaries, utility costs, taxes, insurance, repairs and maintenance, training costs, etc. Start-up costs do not include expenditures for capital assets.

(71) "Superintendent" means the superintendent or the superintendent's designee of a residential habilitation center.

(72) "Title XIX" means the 1965 amendments to the Social Security Act, P.L. 89-07, as amended.

(73) "Uniform chart of accounts" means a list of account titles identified by code numbers established by the department for contractors to use in reporting costs.

(74) "Vendor number (also known as provider number)" means a number assigned to each contractor delivering ICF/MR services to ICF/MR Medicaid recipients.

(75) "Working capital" means total current assets necessary, ordinary, and related to resident care as reported in the most recent cost report minus total current liabilities necessary, ordinary, and related to resident care from the most recent cost report.

[99-19-104, recodified as § 388-835-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-001, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-001, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-001, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-001, filed 9/17/84; 82-16-080 (Order 1853), § 275-38-001, filed 8/3/82.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-835-015 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 275-38-001(31) provided an:

(a) Assessment of the exemption request ensures granting the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not adversely effect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

[99-19-104, recodified as § 388-835-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-003, filed 8/9/91, effective 9/9/91.]

WAC 388-835-020 ICF/MR care. (1) The department has the administrative and legal authority to purchase and provide ICF/MR the services for eligible developmentally disabled persons. The department has the responsibility to assure adequate care, service, and protection are provided through licensing and certification procedures.

(2) This chapter establishes standards for habilitative training, health related care, supervision, and residential services to eligible persons.

(3) Each state and nonstate ICF/MR facility shall be certified as a Title XIX ICF/MR facility.

(4) Each nonstate ICF/MR facility with a certified capacity of sixteen beds or more shall be licensed as a nursing home in accordance with chapter 18.51 RCW.

(5) Each nonstate ICF/MR facility with a certified capacity of fifteen beds or less shall be licensed as a boarding home for the aged in accordance with chapter 18.20 RCW.

(6) Facilities certified to provide ICF/MR services must comply with all applicable federal regulations under Title XIX, Section 1905 of the Social Security Act 42 U.S.C. as amended, and nonstate-operated facilities must comply as well with state regulations governing the licensing of nursing homes or boarding homes for the aged, and other relevant state regulations.

(7) Certified facilities shall admit only developmentally disabled persons as residents.

(8) State facilities may not exceed funded capacity, unless otherwise authorized by the secretary in accord with RCW 71A.20.090.

(9) The sections of this chapter will supersede and replace any and all sections affecting ICF/MR facilities or programs in chapters 388-88 and 388-96 WAC except where specifically referenced in this chapter.

[99-19-104, recodified as § 388-835-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-005, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-005, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-005, filed 8/3/82.]

WAC 388-835-025 Name of IMR. The division will recognize only the official name of an IMR as shown on the license.

[99-19-104, recodified as § 388-835-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-015, filed 8/3/82.]

WAC 388-835-030 Closure of an IMR facility. When a facility is due to cease operations, the facility has the responsibility of notifying the department in writing, giving sixty days notice. Upon receipt of notice of closure of a facility, the department shall cease referral of clients to the facility and proceed in the orderly relocation of the residents.

[99-19-104, recodified as § 388-835-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-020, filed 8/3/82.]

WAC 388-835-035 Adequate IMR care. Care and services rendered must be justified as essential to the resident's habilitation and health care needs, with the overall goal of the resident attaining the highest level of independence. Each IMR is obligated to assure the provision of adequate habilitative training and health care to include but not limited to:

(1) Active treatment as defined in WAC 275-38-001.

(2) Services to the resident by or under the supervision of qualified therapists in accordance with the identified needs of the individual resident.

(3) Provide routine items and supplies uniformly used for all residents.

(4) Surgical appliances, prosthetic devices, and aids to mobility required for the exclusive use of an individual resident are available to the recipient pursuant to WAC 388-86-100.

(5) Nonreusable supplies not usually provided for all residents may be individually ordered in accordance with WAC 388-86-005(2). Requests for such supplies must be authorized by a department representative.

(6) Each IMR facility is responsible for providing transportation to and from the day training programs. Responsibility for transportation may include assurance of resident's use of public transportation.

[99-19-104, recodified as § 388-835-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-025, filed 8/3/82.]

WAC 388-835-040 Continuity of resident care. When a resident is transferred from one IMR facility to another, from an IMR facility to the hospital, from the hospital to an IMR facility, or to alternative community placement, essential information concerning the resident, his or her condition, regimen of care and training must be transmitted in writing by the sending facility to the receiving facility at the time of the resident's transfer.

[99-19-104, recodified as § 388-835-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-030, filed 8/3/82.]

WAC 388-835-045 IMR contract—Noncompliance. When a facility is in violation of the terms of the contract, the department may temporarily suspend the referral of residents to the facility. Whenever referral is suspended under this section, the facility will immediately be notified in writing of the suspension and of the basis for the department's action. Suspension may continue until the department determines the infraction has been corrected.

[99-19-104, recodified as § 388-835-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-035, filed 8/3/82.]

WAC 388-835-050 Minimum staff requirements. Each ICF/MR shall provide staff adequate in numbers and qualifications to meet the needs of the residents.

[99-19-104, recodified as § 388-835-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-045, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-045, filed 8/3/82.]

WAC 388-835-055 Placement of client. (1) Placement into an ICF/MR facility is the responsibility of the division of developmental disabilities and shall be accomplished in accordance with the applicable federal and state regulations.

(2) The client's eligibility for ICF/MR services shall be determined by department representatives before payment can be approved, provided a facility may not admit a client requiring services the facility is not able to provide.

[99-19-104, recodified as § 388-835-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-050, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-050, filed 8/3/82.]

WAC 388-835-060 Transfer of client—Relocation. (1) The department is responsible for assuring the client's health care and habilitative training needs are identified and met, as provided by state and federal regulations. The depart-

ment is responsible for assuring each client is placed in a facility certified as capable of meeting the needs of the client. The division's regional services section shall be responsible for authorizing changes in residential services.

(2) A client admitted to a facility may be transferred or discharged only for medical reasons, for the client's welfare, or for the welfare of other residents of the facility. This determination shall be made by the department based on an assessment of the resident, consultation with the service provider, the parent or guardian, and a review of the relevant records.

(3) If the department services provided to a resident are not commensurate with the resident's needs, the department is responsible for initiating and facilitating the resident's relocation. The department shall consider a resident in a state facility eligible for community residential services when such services appropriately meet the person's individual needs.

A circumstance where the department may enforce immediate movement of a resident from an ICF/MR facility is the revocation or suspension of the ICF/MR certification or license.

(4) The department shall notify, in writing, the resident and resident's guardian, next of kin, or responsible party of the facility's certification or contract status when the:

(a) Department or health care financing administration (HCFA) determines a facility no longer meets certification requirements as an ICF/MR; or

(b) Department determines the facility does not meet contract requirements; or

(c) Facility voluntarily terminates the facility's contract or participation in the ICF/MR program.

(5) When the department determines a resident's relocation is necessary, the department shall give the resident and resident's guardian, next of kin, or responsible party twenty-eight days notice, in writing, of the department's intent to relocate the resident as required under WAC 275-38-060.

(6) When the department determines there is a serious and immediate threat to the resident's health or safety, the department shall not be required to give the resident and resident's guardian, next of kin, or responsible party twenty-eight days notice of the resident's relocation.

(7) Decertification, termination, or nonrenewal of contract actions require a stop payment of Title XIX funds. Such actions do not affect the facility's right to operate as a nursing home or boarding home, but does disqualify the facility from operating as an ICF/MR facility and receiving federal funds.

(8) Grounds for the request by a facility to have a resident relocated or discharged are limited to the following:

(a) Medical reasons;

(b) Resident's welfare;

(c) The welfare of the other residents; or

(d) Nonpayment of services provided to the resident during the resident's stay at the facility.

The facility shall follow the following procedure for resident relocation or discharge:

(i) The facility shall send a request in writing to the department, for relocation or discharge of a resident. The facility's request shall include the grounds for the request and substantiation of concurrence by the interdisciplinary team in the development of an appropriate individual habilitation plan;

(ii) The department shall approve or deny the request for relocation or discharge based on an on-site visit with the resident and a review of the resident's records, within fifteen working days following the receipt of the request;

(iii) The facility administrator shall be informed of the department's approval or denial of the request;

(iv) If the facility's request is approved, the department shall notify, in writing, the resident and the resident's guardian, or next-of-kin, or responsible party, of the decision as described under WAC 275-38-060; and

(v) The resident and the department shall be allowed thirty days from the date the resident is notified of relocation or discharge by the department in order to facilitate relocation.

(e) The resident has a right to request relocation and to select the ICF/MR the resident desires for placement. If this selection is available and appropriate to the habilitation and health care needs of the resident, the department shall make all reasonable attempts to accomplish relocation. If the relocation or ICF/MR selection is not appropriate or available, the resident may make another selection.

(i) The resident or the resident's guardian shall request such a move in writing.

(ii) The division of developmental disabilities shall be responsible for arranging the resident's relocation.

[99-19-104, recodified as § 388-835-060, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-055, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-055, filed 8/3/82.]

WAC 388-835-065 Resident rights—Relocation redetermination of eligibility. (1) Except in the cases specified in WAC 275-38-060 [(2)][(3)], the resident, and the resident's guardian, next-of-kin, or responsible party of the resident shall be informed in writing twenty-eight days before any relocation or redetermination of eligibility for ICF/MR services to ensure orderly transfer or discharge. Such resident's notice shall include:

(a) The grounds for the proposed eligibility change and/or transfer;

(b) A statement that the resident or any other individual designated by the resident has a right to a conference with a division of developmental disabilities representative within twenty-eight days of receipt of the notice;

(c) The right to request a fair hearing within twenty-eight days of the notice to contest the department's decision;

(d) The method by which a fair hearing may be obtained;

(e) The right to be represented at the fair hearing by an authorized representative;

(f) The existence and locations of available legal services in the community.

(2) The department shall send a fair hearing request form with the notice of relocation and/or redetermination of eligibility for ICF/MR services.

(a) If the resident requests a fair hearing within the twenty-eight day time period, the department shall not redetermine eligibility or transfer the resident pending fair hearing decision or appeal rights, unless such action is warranted by the health or safety needs of the resident.

(b) If the secretary or the secretary's designee finds the redetermination of eligibility is not appropriate, further action shall not be taken to redetermine eligibility or transfer the resident, unless there is a change in the situation or circumstances at which time the request may be resubmitted.

(c) If the secretary or the secretary's designee affirms the determination to change the resident's eligibility for services and/or transfer, and no judicial review is filed within twenty-eight days of the receipt of notice of determination, the department shall proceed with the planned action.

(d) If the secretary or secretary's designee affirms the determination to change the resident's eligibility for ICF/MR services or transfer and a request for judicial review has been filed, any proposed redetermination of eligibility or transfer shall be delayed pending the outcome of the process, unless such action is warranted by the health or safety needs of the resident.

(3) Advance notice is not required:

(a) If the resident or the resident's guardian requests a transfer in writing and waives the right to a period notice; or

(b) In the event of an immediate threat to the resident's life or health, or life or health of others.

(4) Advance notice and planning shall not include a right to a fair hearing for a resident when the department judges the facility where the resident resides is not able to provide Title XIX services due to:

(a) Termination of the facility's contract;

(b) Decertification of the facility;

(c) Nonrenewal of the facility's contract;

(d) Revocation of the facility's license; or

(e) Emergency license suspension.

[99-19-104, recodified as § 388-835-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-060, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-060, filed 8/3/82.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-835-070 Transfer or discharge planning.

The division of developmental disabilities (DDD) shall prepare a suitable written discharge or transfer plan for each resident to be transferred or discharged. DDD's plan shall include the location of available settings providing the appropriate services consistent with the needs of the resident. The plan shall include:

(1) Coordination of communication between the staffs of the old and new facilities;

(2) Pretransfer visit, when the resident's condition permits, to the new facility, familiarizing the resident with the new surroundings, and other residents;

(3) Coordination of active participation by the resident's guardian or family in the transfer preparation;

(4) Coordination with staffs of the old and new facilities to discuss expectations and provide consultation on request; and

(5) Posttransfer follow-up by the division of developmental disabilities to monitor the effects of the change.

[99-19-104, recodified as § 388-835-070, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order

3230), § 275-38-065, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-065, filed 8/3/82.]

WAC 388-835-075 Discharge, readmission, and incident reporting. (1) A certified ICF/MR facility having an ICF/MR contract with the department shall contact the regional services office, division of developmental disabilities giving immediate notification of unauthorized leave, disappearance, serious accident, or other traumatic incident effecting a resident or the resident's health or welfare.

(2) The department shall require discharge and readmission for residents admitted as hospital inpatients.

[99-19-104, recodified as § 388-835-075, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-075, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-075, filed 8/3/82.]

WAC 388-835-080 Social leave for IMR residents. (1) Social leaves should be consistent with goals and objectives of the resident's individual habilitation plan.

(2) Facility vacancies due to social leave of a resident will be reimbursed if such social leave complies with the individual habilitation plan and the following conditions:

(a) The facility shall notify the director of the division of developmental disabilities or his or her designee, of social leaves exceeding fifty-three hours.

(b) Social leaves over seven consecutive days require prior written approval by the director, division of developmental disabilities or his or her designee.

(c) Social leave in excess of seventeen days per year requires prior written approval by the director, division of developmental disabilities or his or her designee.

[99-19-104, recodified as § 388-835-080, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-080, filed 8/3/82.]

WAC 388-835-085 Superintendent's limited authority to hold. (1) When a superintendent, acting on behalf of the secretary, receives information that a resident intends to voluntarily discharge himself or herself from the programs and services of the residential habilitation center (RHC), the superintendent shall determine if such a departure would be harmful to the resident.

(2) If, in the superintendent's judgment, the resident's departure is harmful to the resident, the superintendent may hold the resident until the danger passes, not to exceed forty-eight hours. The superintendent may refer the resident to a mental health professional as described under RCW 71.05.150.

(3) When the superintendent detains an RHC resident as required under this section, the superintendent or the superintendent's designee shall give notification of such hold to the resident and the legal representative of the resident as provided under RCW 71A.10.070. If the legal representative is not available, the superintendent shall also notify one or more persons in the following order of priority:

(a) A parent of a person with a developmental disability eighteen years of age or older;

(b) Other kin of the person with a developmental disability with a preference to persons with closest kinship;

(c) The Washington protection and advocacy agency for the rights of a person with a developmental disability, appointed in compliance with 42 USC section 6042; or

(d) A person who is not an employee of the department nor a contractor under this title nor an employee of such contractor who, in the opinion of the superintendent is concerned with the person's welfare.

(4) This section shall not prohibit the superintendent of an RHC from notifying:

- (a) A mental health professional;
- (b) Local law enforcement;
- (c) Adult protective services;
- (d) Child protective services; or
- (e) Other agencies as appropriate.

(5) At the end of the forty-eight-hour hold, the superintendent shall not continue to detain a resident.

(6) If the provisions of the section are invoked a second time within six months, the superintendent or superintendent's designee shall make a referral to a mental health professional within eight hours. In this situation, the resident may only be held until the mental health professional:

(a) Investigates and evaluates the specific facts surrounding the situation; and

(b) Determines the further detention of the resident in accord with RCW 71.05.150.

(7) This section shall not prohibit the superintendent of an RHC or designee from allowing a resident to leave the center for prescribed periods under such conditions as may be appropriate for the resident's habilitation or care.

(8) When a resident has voluntarily left the programs and services of the RHC, under the provision of this section, except as provided in subsection (7), the superintendent shall initiate discharge proceeding.

[99-19-104, recodified as § 388-835-085, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-090, filed 8/9/91, effective 9/9/91.]

WAC 388-835-090 Prospective cost-related reimbursement. The prospective cost-related reimbursement system is the system used by the department to pay for IMR services provided to IMR residents. Reimbursement rates for such services will be determined in accordance with the principles, methods, and standards contained in this chapter.

[99-19-104, recodified as § 388-835-090, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-510, filed 8/3/82.]

WAC 388-835-095 Conditions of participation. In order to participate in the prospective cost-related reimbursement system, the person or legal organization responsible for operation of an IMR facility shall:

(1) Obtain a state certificate of need as required, pursuant to chapter 70.38 RCW;

(2) Hold the appropriate current license (e.g., nursing home, boarding home);

(3) Hold current Title XIX certification to provide IMR services;

(4) Hold a current contract to provide IMR services; and

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(5) Comply with all provisions of the contract and all applicable regulations, including but not limited to the provisions of chapter 275-38 WAC.

[99-19-104, recodified as § 388-835-095, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-515, filed 8/3/82.]

WAC 388-835-100 Projected budget for new contractors. (1) Unless a shorter period is approved by the division director, each new contractor shall submit a one-year projected budget to the department at least sixty days before the contract will become effective. For purposes of this section, a "new contractor" is one:

(a) Operating a new facility;

(b) Acquiring or assuming responsibility for operating an existing facility;

(c) Obtaining a certificate of need approval due to an addition to or renovation of a facility.

(2) The projected budget shall cover the twelve months immediately following the date the contractor will enter the program. The projected budget shall be prepared on forms and in accordance with instructions provided by the department, and shall include all earnest money, purchase, and lease agreements involved in the transaction.

[99-19-104, recodified as § 388-835-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-520, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-520, filed 8/3/82.]

WAC 388-835-105 Change of ownership. (1) On the effective date of a change of ownership, as defined in WAC 275-38-001, the department's contract with the former owner shall be terminated. The former owner shall give the department sixty days written notice of such termination in accordance with the terms of the contract. When certificate of need is required for the new owner to acquire the facility, and the new owner wishes to continue to provide service to recipients without interruption, certificate of need shall be obtained before the former owner submits a notice of termination.

(2) If the new contractor desires to participate in the cost-related reimbursement system, the contractor shall meet the conditions specified in WAC 275-38-515, and shall submit a projected budget in accordance with WAC 275-38-520. The IMR contract with the new owner shall be effective as of the date of the change of ownership.

(3) A new contractor shall submit the following as a part of the projected budget:

(a) A statement disclosing the identity of all individuals and organizations having beneficial ownership interest in the current operating entity or in the land, building, or equipment of the facility; and

(b) The identity of individuals or organizations having beneficial ownership in the purchasing or leasing entity.

[99-19-104, recodified as § 388-835-105, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-525, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-525, filed 8/3/82.]

WAC 388-835-110 Termination of contract. (1) When a contract is terminated for any reason, the former contractor shall give the department sixty days written notice of such termination in accordance with the terms of the contract.

(2) When a contractor terminates for any reason, the former contractor shall submit final reports in accordance with WAC 275-38-546.

(3) Upon notification of a contract termination, the department shall determine by preliminary or final settlement calculations the amount of any overpayments made to the contractor, including overpayments disputed by the contractor. If preliminary or final settlements are unavailable for any period up to the date of contract termination, the department shall make a reasonable estimate of any overpayment or underpayments for such periods. The department shall base a reasonable estimate upon prior period settlements, available audit findings, the projected impact of prospective rates, and other information available to the department.

(4) Payments for one or more months for care provided under a contract will be held until the former contractor has filed a properly completed final annual cost report, and the final settlement has been determined. In lieu of the withheld payments, the former contractor may provide security, in a form acceptable to the department, in the amount of determined and estimated overpayments, whether or not the overpayments are the subject of good-faith dispute. Security shall consist of:

(a) A surety bond issued by a bonding company acceptable to the department; or

(b) An assignment of funds to the department; or

(c) Collateral acceptable to the department; or

(d) A purchaser's assumption of liability for the prior contractor's overpayment; or

(e) Any combination of (4)(a), (b), (c), or (d) of this subsection.

(5) A surety bond or assignment of funds shall:

(a) Be at least equal in amount to determined or estimated overpayments, whether or not the subject of good-faith dispute, minus withheld payments;

(b) Be issued or accepted by a bonding company or financial institution licensed to transact business in Washington state;

(c) Be for a term sufficient to ensure effectiveness after final settlement and the exhaustion of administrative and judicial remedies: Provided, That the bond or assignment shall initially be for a term of five years, and shall be forfeited if not renewed thereafter in an amount equal to any remaining overpayment in dispute;

(d) Provide the full amount of the bond or assignment, or both, shall be paid to the department if a properly completed final cost report is not filed in accordance with this chapter, or if financial records supporting this report are not preserved and made available to the auditor; and

(e) Provide an amount equal to any recovery the department determines is due from the contractor at settlement, but not exceeding the amount of the bond and assignment. The bond or assignment or both shall be paid to the department if the contractor does not pay the refund within sixty days following receipt of written demand or the conclusion of administrative or judicial proceedings to contest settlement issues.

(6) The department shall release any payment withheld as security if alternate security, acceptable to the department, is provided under subsection (4) of this section in an amount equivalent to determined and estimated overpayments.

(7) If the total of withheld payments, bonds, and assignments is less than the total of determined and estimated overpayments, the unsecured amount of such overpayments shall be a debt due the state. The debt shall become a lien against the real and personal property of the contractor from the time of filing by the department with the county auditor of the county where the contractor resides or owns property. Such a lien claim has preference over the claims of all unsecured creditors.

(8) The contractor shall file a properly completed final cost report in accordance with the requirements of chapter 275-38 WAC, which may be audited by the department. A final settlement shall be determined within ninety days following completion of the audit process (including any administrative review of the audit requested by the contractor) or within twelve months if audit is not performed.

(9) Following determination of settlement for all periods, security held pursuant to this section shall be released to the contractor after overpayments determined in connection with final settlement have been paid by the contractor. If the contractor contests the settlement determination in accordance with WAC 275-38-886, the department shall hold the security, not to exceed the amount of estimated unrecovered overpayments being contested, pending completion of the administrative appeal process.

(10) If, after calculation of settlements for any periods, it is determined that overpayments exist in excess of the value of security held by the state, the department may seek recovery of these additional overpayments as provided by law.

(11) The department may accept an assignment of funds if the assignment meets the requirements of subsection (4) of this section.

(12) When a contract is terminated, any accumulated liabilities assumed by a new owner shall be reversed against the appropriate accounts by the contractor.

[99-19-104, recodified as § 388-835-110, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-530, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-530, filed 8/3/82.]

WAC 388-835-115 Due dates for reports. (1) Nonstate facilities' annual cost reports for a calendar year shall be submitted by March 31 of the following year.

(2) State facilities' annual cost reports for a fiscal year shall be submitted by December 31 of that year.

(3) If a contract is terminated for any reason, the former owner shall submit a final cost report, in addition to any reports due under subsection (1) of this section, within one hundred twenty days after the effective date of termination for the period January 1 of the year of termination through the effective date of termination.

(4) A new contractor shall submit, by March 31 of the following year, a cost report for the period from the effective date of the contract through December 31 of the year the contract was made effective, unless an exception is granted by the division director.

[99-19-104, recodified as § 388-835-115, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-535, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-535, filed 9/17/84; 82-16-080 (Order 1853), § 275-38-535, filed 8/3/82.]

WAC 388-835-120 Requests for extensions. (1) The department, upon a written request setting forth reasons for the necessity of an extension, may grant two extensions of up to thirty days each for filing any required report, if the written request is received at least ten days prior to the due dates of the reports.

(2) Extensions shall be granted only if the circumstances stated clearly indicate the due date cannot be met and the circumstances were not foreseeable by the contractor.

[99-19-104, recodified as § 388-835-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-540, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-540, filed 8/3/82.]

WAC 388-835-125 Reports. (1) Each nonstate contractor shall submit to the department an annual cost report for the period from January 1 through December 31 of the preceding year.

(2) Each state facility shall submit to the department an annual cost report for the period from July 1 of the preceding year through June 30 of the current year, i.e., state fiscal year.

[99-19-104, recodified as § 388-835-125, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-545, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-545, filed 8/3/82.]

WAC 388-835-130 Failure to submit final reports.

(1) If a contract is terminated, the former contractor shall submit a final report as required by WAC 275-38-530(2) and 275-38-535(3). The former contractor shall submit final reports to the department within one hundred twenty days after the contract is terminated or prior to the expiration of any department-approved extension granted pursuant to WAC 388-96-107. When the contractor fails to submit a final report, all payments made to the contractor relating to the period for which a report has not been received shall be a debt owed to the department. The contractor shall refund the amount due to the department within thirty days after receiving written demand from the department.

(2) Effective thirty days after written demand for the payment is received by the contractor, interest will begin to accrue on any unpaid balance at the rate of one percent per month.

[99-19-104, recodified as § 388-835-130, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-546, filed 6/1/88.]

WAC 388-835-135 Improperly completed or late reports. (1) For 1981 and subsequent annual cost reporting periods, contractors shall submit an annual report, including the proposed settlement computed by cost center pursuant to WAC 275-38-886, in accordance with chapter 275-38 WAC, departmental regulations and instructions. The department may return an annual cost report deficient in any of these respects in whole or in part to the contractor for proper completion. Submit annual reports by the due date determined in accordance with WAC 275-38-535.

(2) If a the department does not receive properly completed report on or before the due date of the report, including any approved extensions, all or a part of any payments due under the contract may be held by the department until the

improperly completed or delinquent report is properly completed and received by the department.

[99-19-104, recodified as § 388-835-135, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-550, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-550, filed 8/3/82.]

WAC 388-835-140 Completing reports and maintaining records. (1) All reports shall be legible and reproducible. All entries shall be in black or dark blue ink or provided in an acceptable, indelible copy.

(2) Contractors shall complete reports in accordance with instructions provided by the department. If no specific instruction covers a situation, follow generally accepted accounting principles.

(3) Contractors shall use the accrual method of accounting, except for governmental institutions operated on a modified accrual method of accounting. Reverse all revenue and expense accruals against the appropriate accounts if not received or paid within one hundred twenty days after the accrual is made, unless special circumstances are documented justifying continuing to carry all or part of the accrual (e.g., contested billings). Accruals for vacation, holiday, sick pay, and taxes may be carried for longer periods, provided the contractor's usual policy and generally accepted accounting principles are followed.

(4) Contractor shall consistently apply methods of allocating costs [shall be consistently applied], including indirect or overhead costs. Contractors operating multiservice facilities or facilities incurring joint facility costs shall allocate costs in accordance with benefits received from the resources represented by those costs.

(5) The contractor shall maintain records relating to an IMR so reported data can be audited for compliance with generally accepted accounting principles and the department's reimbursement principles and reporting instructions. If a contractor maintains records utilizing a chart of accounts other than that established by the department, the contractor shall provide to the department a written schedule specifying the way in which the contractor's individual account numbers correspond to the department's chart of accounts. Contractors shall make records available for review by authorized personnel of the department and of the United States Department of Health and Human Services during normal business hours at a location in the state of Washington specified by the contractor.

(6) If a contractor fails to maintain records adequate for audit purposes or fails to allow inspection of such records by authorized personnel as provided in the contractor's IMR contract, the department may suspend all or part of subsequent reimbursement payments due under the contract until compliance is forthcoming. Upon compliance, the department shall resume current contract payments and shall release payments suspended pursuant to the contractor's IMR contract.

[99-19-104, recodified as § 388-835-140, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-555, filed 6/1/88; 86-18-002 (Order 2412), § 275-38-555, filed 8/21/86; 82-16-080 (Order 1853), § 275-38-555, filed 8/3/82.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffec-

tual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-835-145 Certification requirement. Each required report shall be accompanied by a certification signed on behalf of the contractor responsible to the department during the report period. If the contractor files a federal income tax return, the certification shall be executed by the person normally signing this return. The certification shall also be signed by the administrator of the IMR facility. If the report is prepared by someone other than an employee of the contractor, include a separate statement with the certification signed by the individual preparing the report and indicating his or her status with the contractor. Submit only the original signature of the certification of the cost report.

[99-19-104, recodified as § 388-835-145, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-560, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-560, filed 8/3/82.]

WAC 388-835-150 Reports—False information. (1) If a contractor knowingly or with reason to know files a report containing false information, such action constitutes cause for termination of the contractor's contract with the department.

(2) Adjustments to reimbursement rates required because a false report was filed will be made in accordance with WAC 275-38-900.

(3) Contractors filing false reports may be referred for prosecution under applicable statutes.

[99-19-104, recodified as § 388-835-150, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-565, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-565, filed 8/3/82.]

WAC 388-835-155 Amendments to reports. (1) For purposes of determining allowable costs for computing a final settlement, the department shall consider an amendment to an annual report only if filed by the contractor before receipt of notification scheduling the department's field audit. If no audit is conducted by the department and the preliminary settlement report becomes the final settlement report, the department shall consider an amendment to an annual report only if filed within thirty days after the contractor receives the final settlement report for which no audit has been conducted. For only the purpose of adjusting reimbursement rates for errors or omissions, the contractor may file an amendment subsequent to notification scheduling the department's field audit pursuant to the provision of WAC 275-38-900. A contractor may file an amendment and the department can consider it only if the errors or omissions are significant. Errors or omissions shall be deemed "significant" if errors or omissions would mean a net difference of two cents or more per resident day or one thousand dollars or more in reported costs, whichever is higher, in any cost area. To file an amendment, only pages where changes are required need to be filed, together with the certification required by WAC 275-38-560. Adjustments to reimbursement rates resulting from an amended report will be made in accordance with WAC 275-38-885.

(2) If an amendment is filed, a contractor shall also submit with the amendment an account of the circumstances

relating to and the reasons for the amendment, along with supporting documentation. The department may refuse to consider an amendment resulting in a more favorable settlement or rate to a contractor if the amendment is:

(a) Not the result of circumstances beyond the control of the contractor; or

(b) The result of good-faith error under the system of cost allocation and accounting in effect during the reporting period in question.

(3) Acceptance or use by the department of an amendment to a cost report shall in no way be construed as a release of applicable civil or criminal liability.

[99-19-104, recodified as § 388-835-155, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-570, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-570, filed 8/3/82.]

WAC 388-835-160 Requirement for retention of reports by the department. The department shall retain each required report for a period of five years following the date the report was submitted. If at the end of five years there are unresolved audit questions, the department shall retain the report until such questions are resolved.

[99-19-104, recodified as § 388-835-160, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-585, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-585, filed 8/3/82.]

WAC 388-835-165 Requirements for retention of records by the contractor. The contractor shall retain all records supporting the required reports for a period of five years subsequent to filing at a location in the state of Washington specified by the contractor. If at the end of five years there are unresolved audit questions, the records shall be retained until these questions are resolved. All such data shall be made available upon demand to authorized representatives of the department and of the United States Department of Health and Human Services. When a contract is terminated, final settlement shall not be made until accessibility to and preservation of the records within the state of Washington are assured.

[99-19-104, recodified as § 388-835-165, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-586, filed 6/1/88.]

WAC 388-835-170 Disclosure of IMR facility reports. Pursuant to chapter 388-320 WAC, all required financial and statistical reports submitted by IMR facilities to the department will be available for public disclosure.

[99-19-104, recodified as § 388-835-170, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-590, filed 8/3/82.]

WAC 388-835-175 Desk review. (1) The department will analyze each annual cost report within six months after the annual cost is properly completed and filed.

(2) If it appears from the analysis a contractor has not correctly determined or reported costs, the department may request additional information from the contractor. If the department deems it necessary in order to ensure correct reporting, the department may schedule a special field audit of the contractor.

[99-19-104, recodified as § 388-835-175, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-595, filed 8/3/82.]

WAC 388-835-180 Field audits. (1) The department shall field audit all cost reports for calendar year 1983.

(2) The department may field audit cost reports for years subsequent to 1983 by auditors employed by or under contract with the department. The department shall notify facilities selected for audit within one hundred twenty days after submission of a complete and correct cost report of the department's intent to audit. The department shall complete such audits within one year after notification of the department's intent to audit unless the contractor fails to allow access to records and documentation or otherwise prevents the audit from being completed in a timely manner.

[99-19-104, recodified as § 388-835-180, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-600, filed 6/1/88; 84-09-018 (Order 2091), § 275-38-600, filed 4/10/84; 82-16-080 (Order 1853), § 275-38-600, filed 8/3/82.]

WAC 388-835-185 Preparation for audit by the contractor. (1) The department shall normally notify the contractor at least ten working days in advance of a field audit.

(2) The contractor shall provide the auditors with access to the IMR and to all financial and statistical records. These financial and statistical records shall include income tax returns relating to the cost report directly or indirectly, and work papers supporting the data in the cost report or relating to resident trust funds. Such records shall be made available at a location in the state of Washington specified by the contractor.

(3) The contractor shall reconcile reported data with applicable federal income and payroll tax returns and with the financial statement as of the end of the period covered by the report. Such reconciliation shall be in suitable form for verification by the auditors.

(4) The contractor shall designate and make available one or more individuals familiar with the internal operations of a facility being audited in order to respond to questions and requests for information and documentation from the auditors. If the individual or individuals designated cannot answer all questions and respond to all requests, an alternative individual with sufficient knowledge and access to records and information must be provided by the contractor.

[99-19-104, recodified as § 388-835-185, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-605, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-605, filed 8/3/82.]

WAC 388-835-190 Scope of field audits. (1) Auditors shall review the contractor's recordkeeping and accounting practices and, where appropriate, make written recommendations for improvements.

(2) Auditors shall examine the contractor's financial and statistical records to verify:

(a) Supporting records are in agreement with reported data; and

(b) Only assets, liabilities, and revenue and expense items the department has specified as allowable costs have been included by the contractor in computing the costs of services provided under the contract; and

(c) Allowable costs have been accurately determined and are necessary, ordinary, and related to resident care; and

(d) Related organizations and beneficial ownerships or interests have been correctly disclosed; and

(e) Resident trust funds have been properly maintained.

(3) Auditors shall prepare and provide draft audit narratives and summaries to the contractor before final narratives and summaries are prepared.

[99-19-104, recodified as § 388-835-190, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-610, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-610, filed 8/3/82.]

WAC 388-835-195 Inadequate documentation. The auditors shall disallow any assets, liabilities, revenues, or expenses reported as allowable which are not supported by adequate documentation in the contractor's financial records. Documentation must show:

(1) The costs were incurred during the period covered by the report and were related to resident care and training; and

(2) Assets reported were used in the provision of resident care and training.

[99-19-104, recodified as § 388-835-195, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-615, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-615, filed 8/3/82.]

WAC 388-835-200 Deadline for completion of audits.

(1) The department shall complete field audits within one year after a properly completed annual cost report is received or within one year after an IMR facility is notified it has been selected for audit, provided field auditors are given timely access to the IMR facility and to all records necessary to audit the report.

(2) For state IMRs, the department shall complete field audits within three years after a properly completed cost report is received by the department, provided field auditors are given timely access to the facility and all records necessary to audit the report.

(3) The department shall give priority to any field audits of final annual reports and whenever possible shall begin such field audits within ninety days after a properly completed final annual report is received.

[99-19-104, recodified as § 388-835-200, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-620, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-620, filed 8/3/82.]

WAC 388-835-205 Disclosure of audit narratives and summaries. Final audit narratives and summaries prepared by the auditor will be available for public disclosure.

[99-19-104, recodified as § 388-835-205, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-625, filed 8/3/82.]

WAC 388-835-210 Resident trust accounts. (1) The provider shall establish and maintain, as a service to the recipient, a bookkeeping system, incorporated in the business records, adequate for audit, for all resident moneys entrusted to and received by the facility for the resident.

(2) The system will apply to the resident:

(a) Incapable of handling his or her own money and whose guardian, relative, developmental disabilities regional

service office administrator, or physician makes written request of the facility to accept this responsibility; if the Social Security Form SSA-780, "certificate of applicant for benefits on behalf of another," is utilized as documentation, the form must be signed by one of the persons designated in this subsection.

(b) Capable of handling his or her own money, but requests the facility in writing to accept this responsibility.

(3) It shall be the responsibility of the provider to maintain such written authorization in the resident's file.

(4) The resident must be given at least a quarterly reporting of all financial transactions in his or her trust account. The representative payee, the guardian and/or other designated agents of the recipient must be sent a copy of the quarterly accounting report.

[99-19-104, recodified as § 388-835-210, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-645, filed 8/3/82.]

WAC 388-835-215 Accounting procedures for resident trust accounts. (1) The provider shall maintain a subsidiary ledger with an account for each resident for whom the provider holds money in trust. Each account and related supporting information shall:

(a) Be maintained at the facility;

(b) Be kept current;

(c) Be balanced each month, and;

(d) Show in detail, with supporting verification, all moneys received on behalf of the individual resident and the disposition of all moneys so received.

(2) The contractor shall make each account available for audit and inspection by a department representative and be maintain such accounts for a minimum of five years. The provider further agrees to notify the division of developmental disabilities, regional services office of the department when:

(a) The account of any individual certified on or before December 31, 1973, having an award letter limit of two hundred dollars cash, reaches the sum of one hundred seventy-five dollars.

The regional services office shall reevaluate the status of each recipient certified under the eligibility criteria prior to January 1, 1974, having an award letter specifying a two hundred dollar cash limit.

(b) The account of any individual certified on or after January 1, 1974, whose resources are within one hundred dollars of the amount listed on the award letter.

(c) The accumulation toward the limit under subsection (2)(a) or (b) of this section, after admission to the facility, is permitted only from savings from the clothing and personal incidentals allowance and other income the department specifically designates as exempt income from time to time.

(d) No resident may overdraw his or her account (show a debit balance). If a resident wants to spend an amount greater than in his or her trust account, the IMR may provide money from its own funds. The IMR can collect the debt by installments from that portion of the resident's allowance remaining at the end of each month. No interest may be charged to residents for such loans.

(3) Resident trust accounts may not be charged for services provided under the Title XIX program. Any charge for

medical services otherwise properly made to a resident's trust account must be supported by a written denial from the department.

(a) A request for additional equipment such as a walker, wheelchair or crutches must have a written denial from the department of social and health services before a resident's trust account can be charged.

(b) Except as otherwise provided below, a request for physical therapy, drugs, or other medical services must have a written denial from the department before a resident trust account can be charged.

A written denial from the department is not required when the pharmacist verifies a drug is not covered by the program (e.g., items on the FDA list of ineffective or possible effective drugs, nonformulary over-the-counter (OTC) medications such as vitamins, nose drops, etc.). The pharmacist's notation to this effect is sufficient.

[99-19-104, recodified as § 388-835-215, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-650, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-650, filed 8/3/82.]

WAC 388-835-220 Trust moneys—Imprest fund. (1) The provider may maintain a petty cash fund originating from trust moneys of an amount reasonable and necessary for the size of the facility and the needs of the residents, not to exceed five hundred dollars. This petty cash fund shall be an imprest fund. The contractor shall deposit all moneys over and above the trust fund petty cash amount intact in a trust fund checking account, separate and apart from any other bank account(s) of the facility or other facilities.

(2) Cash deposits of resident allowances shall be made intact to the trust account within one week from the time payment is received from the department, social security administration, or other payor.

(3) The contractor shall make any related bankbooks, bank statements, checkbook, check register, and all voided and cancelled checks, available for audit and inspection by a department representative, and shall be maintained by the IMR for not less than five years.

(4) No service charges for such checking account shall be paid by resident trust moneys.

(5) The trust account per bank shall be reconciled monthly to the trust account per resident ledgers.

[99-19-104, recodified as § 388-835-220, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-655, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-655, filed 8/3/82.]

WAC 388-835-225 Trust moneys control or disbursement. The contractor shall hold trust moneys and not to be turned over to anyone other than:

(a) The resident or his or her guardian without the written consent of the resident,

(b) His or her designated agent as appointed by power of attorney, or

(c) Appropriate department of social and health services personnel as designated by the DDD regional services administrator.

(1) Complete a receipt in duplicate when moneys are received; give one copy to the person making payment or

deposit, and retain the other copy in the receipt book for easy reference.

(2) Residents shall endorse any checks received. Each resident receiving a check or state warrant is responsible for endorsement by his or her own signature. Only when the resident is incapable of signing his or her name may the provider assume the responsibility of securing the resident's mark "X" followed by the name of the resident and the signature of two witnesses.

(3) If both the general fund account and the trust fund account are at the same bank, deposit the trust portion of checks including care payments can be deposited directly to trust by including a trust account deposit slip for the correct amount with the checks and the general account deposit slip.

(4) The contractor shall credit the resident's trust account ledger sheet with the allowance received. This should be referenced with the receipt number and must be supported by a copy of the deposit slip (one copy for all deposits made).

[99-19-104, recodified as § 388-835-225, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-660, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-660, filed 8/3/82.]

WAC 388-835-230 Trust moneys availability. Monies so held in trust for any resident shall be available for his or her personal and incidental needs when requested by the resident or one of the individuals designated in WAC 275-38-660.

[99-19-104, recodified as § 388-835-230, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-665, filed 8/3/82.]

WAC 388-835-235 Accounting upon change of ownership. (1) Upon sale of the facility or other transfer of ownership, the former contractor shall provide the new contractor with a written accounting, in accordance with generally accepted auditing standards, of all resident funds being transferred, and obtain a written receipt for the funds from the new contractor.

(2) The facility shall give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.

(3) In the event of a disagreement with the accounting provided by the former contractor, the resident retains all rights and remedies provided under state law.

[99-19-104, recodified as § 388-835-235, filed 9/20/99, effective 9/20/99. Statutory Authority: 74.09.120. 88-12-087 (Order 2629), § 275-38-667, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-667, filed 8/3/82.]

WAC 388-835-240 Procedure for refunding trust money. When a recipient is discharged and/or transferred, the balance of the resident's trust account will be returned to the individual designated in WAC 275-38-660, within thirty days, and a receipt obtained. In certain cases it may be advisable to mail the refund to the resident's new residence.

[99-19-104, recodified as § 388-835-240, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-670, filed 8/3/82.]

WAC 388-835-245 Liquidation of trust fund. (1) Expired resident. The provider will obtain a receipt from

next-of-kin, guardian, or duly qualified agent when releasing the balance of money held in trust. If there is no identified next-of-kin, guardian, or duly qualified agent, the DDD regional service office is to be contacted in writing within seven days for assistance in the release of the money held in trust. A check or other document showing payment to such next-of-kin, guardian, or duly qualified agent will serve as a receipt.

(2) Resident, unable to locate. In situations where the resident leaves the IMR facility without authorization and his or her whereabouts are unknown:

(a) The IMR will make a reasonable attempt to locate the missing resident. This includes: Contacting friends, relatives, police, the guardian, and the DDD in the area.

(b) If the resident cannot be located after ninety days, the IMR must notify the department of revenue of the existence of "abandoned property," outlined in chapter 63.28 RCW. The IMR will be required to deliver to the department of revenue the balance of the resident's trust fund account within twenty days following such notification.

[99-19-104, recodified as § 388-835-245, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-675, filed 8/3/82.]

WAC 388-835-250 Resident property records. (1) The facility must maintain a current, written record for each resident including written receipts for all personal possessions deposited with the facility by the resident.

(2) The property record must be available to the resident and resident representative as designated in WAC 275-38-645 (2)(a).

[99-19-104, recodified as § 388-835-250, filed 9/20/99, effective 9/20/99. Statutory Authority: 74.09.120. 82-16-080 (Order 1853), § 275-38-678, filed 8/3/82.]

WAC 388-835-255 Allowable costs. (1) Allowable costs are documented costs which are necessary, ordinary, and related to the provision of IMR services to IMR residents, and are not expressly declared nonallowable by applicable statutes or regulations. Costs are ordinary if costs are of the nature and magnitude which prudent and cost-conscious management would pay.

(2) Upon a request for a rate adjustment pursuant to WAC 275-38-900 or 275-38-906, costs previously audited and not disallowed are subject to review by the department pursuant to subsection (1) of this section.

[99-19-104, recodified as § 388-835-255, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-680, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-680, filed 8/3/82.]

WAC 388-835-260 Substance prevails over form. (1) In determining allowable costs, the substance of a transaction shall prevail over the transaction's form. Accordingly, allowable costs shall not include increased costs resulting from transactions or the application of accounting methods which circumvent the principles of the prospective cost-related reimbursement system.

(2) The department shall not allow increased costs resulting from a series of transactions between the same parties and

involving the same assets (e.g., sale and leaseback, successive sales or leases of a single facility or piece of equipment).

[99-19-104, recodified as § 388-835-260, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-685, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-685, filed 8/3/82.]

WAC 388-835-265 Offset of miscellaneous revenues.

(1) The contractor shall reduce allowable costs whenever the item, service, or activity covered by such costs generates revenue or financial benefits (e.g., purchase discounts or rebates) other than through the contractor's normal billing for IMR services. The contractor shall not deduct unrestricted grants, gifts, endowments, and interest therefrom, from the allowable costs of a nonprofit facility.

(2) Where goods or services are sold, the amount of the reduction shall be the actual cost relating to the item, service, or activity. In the absence of adequate documentation of cost, the amount of the reduction shall be the full amount of the revenue received. Where financial benefits such as purchase discounts or rebates are received, the amount of the reduction shall be the amount of the discount or rebate.

(3) The department shall recover only allowable costs under this section. Costs allocable to activities or services not included in IMR services (e.g., costs of vending machines and services specified in chapter 388-86 WAC which are not included in IMR services) are nonallowable costs.

[99-19-104, recodified as § 388-835-265, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-690, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-690, filed 8/3/82.]

WAC 388-835-270 Costs of meeting standards. All necessary and ordinary expenses a contractor incurs in providing IMR services meeting all applicable standards will be allowable costs. The expenses include necessary and ordinary costs of:

- (1) Meeting licensing and certification standards;
- (2) Fulfilling accounting and reporting requirements imposed by chapter 275-38 WAC; and
- (3) Performing any resident assessment activity required by the department.

[99-19-104, recodified as § 388-835-270, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-695, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-695, filed 8/3/82.]

WAC 388-835-275 Limit on costs to related organizations. (1) The department shall allow costs applicable to services, facilities, and supplies furnished by organizations related to the contractor only to the extent:

- (a) The costs do not exceed the lower of the cost to the related organization; or
- (b) The price of comparable services, facilities, or supplies are purchased elsewhere. The term "related organization" is defined in WAC 275-38-001.

(2) Nonstate facilities shall make documentation of costs to related organizations available to the auditors at the time and place the financial records relating to the entity are audited. State facilities shall make documentation of costs to related organizations available to the auditors at the time the facility is audited at the department's offices of accounting services, financial recovery, or budget. The department shall

disallow payments to or for the benefit of the related organization where the cost to the related organization cannot be documented.

[99-19-104, recodified as § 388-835-275, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-700, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-700, filed 8/3/82.]

WAC 388-835-280 Start-up costs. The department shall allow necessary and ordinary start-up costs, as defined in WAC 275-38-001, in the administration and operations rate component. Start-up costs shall be amortized over not less than sixty consecutive months beginning with the month the first resident is admitted for care.

[99-19-104, recodified as § 388-835-280, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-705, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-705, filed 8/3/82.]

WAC 388-835-285 Organization costs. (1) The department shall allow necessary and ordinary costs directly incident to the creation of a corporation or other form of business of the contractor and that are incurred prior to the admission of the first resident. The department will allow these costs in the administration and operations cost area if they are amortized over not less than sixty consecutive months beginning with the month in which the first resident is admitted for care.

(2) Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization and fees paid to states for incorporation. Organization costs do not include costs relating to the issuance and sale of shares of stock or other securities.

[99-19-104, recodified as § 388-835-285, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-706, filed 6/1/88.]

WAC 388-835-290 Education and training. (1) The department shall allow ordinary expenses of on-the-job training and in-service training required for employee orientation and certification training when directly related to the performance of duties assigned.

(2) Ordinary expenses of resident life staff training pursuant to chapter 18.52A RCW shall be allowable costs.

(3) Necessary and ordinary expenses of recreational and social activity training conducted by the contractor for volunteers shall be allowable costs. Expenses of training programs for other nonemployees shall not be allowable costs, except training provided to employees of a county-contracted training program which is provided by an IMR as a condition of their agreement with the county-contracted training program.

(4) The department shall allow expenses for travel in the states of Idaho, Oregon, and Washington and the Province of British Columbia associated with education and training if the expenses meet the requirements of chapter 275-38 WAC.

[99-19-104, recodified as § 388-835-290, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-715, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-715, filed 8/3/82.]

WAC 388-835-295 Total compensation—Owners, relatives, and certain administrative personnel. For purposes of the tests in WAC 275-38-725 and 275-38-730, total compensation shall be as provided in the employment con-

tract, including benefits, whether such contract is written, verbal, or inferred from the acts of the parties. In the absence of a contract, total compensation shall include gross salary or wages and fringe benefits (e.g., health insurance) made available to all employees but excludes payroll taxes paid by the contractor.

[99-19-104, recodified as § 388-835-295, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-720, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-720, filed 8/3/82.]

WAC 388-835-300 Owner or relative—Compensation. (1) The department shall limit total compensation of an owner or relative of an owner to the ordinary compensation for necessary services actually performed.

(a) Compensation is ordinary if it is the amount usually paid for comparable services in a comparable facility to an unrelated employee, and does not exceed limits set out in this chapter.

(b) A service is necessary if the service is related to resident care and training and would have had to be performed by another person if the owner or relative had not performed the service.

(2) The contractor, in maintaining customary time records adequate for audit, shall include such records for owners and relatives receiving compensation. Such records shall document compensated time was spent in provision of necessary services actually performed.

(3) For purposes of this section, if the contractor with the department is a corporation, "owner" includes all corporate officers and directors.

[99-19-104, recodified as § 388-835-300, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-725, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-725, filed 8/3/82.]

WAC 388-835-305 Allowable interest. (1) The department shall allow the contractor's necessary and ordinary interest for working capital and capital indebtedness.

(a) To be necessary, interest must be incurred in connection with a loan satisfying a financial need of the contractor and be for a purpose related to resident care and training. Interest expense relating to business opportunity or goodwill will not be allowed.

(b) To be ordinary, interest must be at a rate not in excess of what a prudent borrower would have to pay at the time of the loan in an arm's-length transaction in the money market.

(c) Interest expense shall include amortization of bond discounts and expenses related to the bond issue. Amortization shall be over the period from the date of sale to the date of maturity or, if earlier, the date of extinguishment of the bonds.

(d) Interest expense for assets acquired in a change of ownership entered into after September 30, 1984, shall be disallowed in proportion to the amount by which the loan principal for the acquired assets exceeds the original depreciation base of the owner of the assets as of July 18, 1984.

(2) Interest paid to or for the benefit of a related organization shall be allowed only to the extent the actual interest does not exceed the cost to the related organization of obtaining the use of the funds.

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(3) The contractor shall capitalize interest expense and loan origination fees relating to construction incurred during the period of construction. Such costs shall be amortized over the life of the asset from the date the first resident is admitted or the asset is put into service for resident care and training.

[99-19-104, recodified as § 388-835-305, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-745, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-745, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-745, filed 8/3/82.]

WAC 388-835-310 Offset of interest income. (1) In computing allowable costs, the contractor shall deduct interest income from the investment or lending of nonrestricted funds from allowable interest expense, except for a nonprofit facility.

(2) Interest income from the investment or lending of restricted funds shall not be deducted from allowable interest expense.

[99-19-104, recodified as § 388-835-310, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-750, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-750, filed 8/3/82.]

WAC 388-835-315 Operating leases of facilities and equipment. Rental or lease costs under arm's-length operating leases of facilities and/or equipment shall be allowable to the extent the cost is not in excess of arm's-length rental or lease costs of comparable facilities or equipment.

[99-19-104, recodified as § 388-835-315, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-760, filed 8/3/82.]

WAC 388-835-320 Rental expense paid to related organizations. The expense of renting facilities or equipment from a related organization shall be allowable to the extent the rental does not exceed the related organization's costs of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with this chapter.

[99-19-104, recodified as § 388-835-320, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-765, filed 8/3/82.]

WAC 388-835-325 Capitalization. The contractor shall capitalize the following costs:

(1) Expenditures and costs for equipment including furniture and furnishings, with historical cost in excess of one hundred fifty dollars per unit and a useful life of more than one year from the date of purchase.

(2) Expenditures and costs for equipment including furniture and furnishings, with historical cost of one hundred fifty dollars or less per unit if either:

(a) The item was acquired in a group purchase where the total cost exceeded one hundred fifty dollars; or

(b) The item was part of the initial equipment or stock of the IMR facility.

(3) Effective January 1, 1981, for settlement purposes for periods subsequent to that date, and for purposes of setting rates for periods beginning July 1, 1982, and subsequently, subsection (1) of this section shall be applied with the sum five hundred dollars replacing the sum one hundred fifty dollars.

(4) Effective January 1, 1990, for settlement purposes for periods subsequent to that date, and for purposes of setting rates for periods beginning July 1, 1990, and subsequently, subsection (1) of this section shall be applied with the sum one thousand dollars replacing the sum five hundred dollars.

(5) Expenditures for and costs of building, and other real property items, components, and improvements and leasehold improvements, if required or authorized by the lease agreement, in excess of one thousand dollars and involving one or more of the following:

- (a) Increase the interior floor space of the structure;
- (b) Increase or renewal of paved areas outside the structure adjacent to or providing access to the structure;
- (c) Modification of the exterior or interior walls of the structure;
- (d) Installation of additional heating, cooling, electrical water-related, or similar fixed equipment;
- (e) Landscaping or redecorating;
- (f) Increase the useful life of the structure by two years or more;

(g) For a leasehold improvement, the asset shall be amortized over the asset's useful life in accordance with American hospital association guidelines.

[99-19-104, recodified as § 388-835-325, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 90-15-017 (Order 3037), § 275-38-770, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-770, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-770, filed 8/3/82.]

WAC 388-835-330 Depreciation expense. Depreciation expense on depreciable assets required in the regular course of providing resident care and training shall be an allowable cost. The depreciation expense shall be:

- (1) Identifiable and recorded in the contractor's accounting records, and
- (2) Computed using the depreciation base, lives and methods specified in chapter 275-38 WAC.

[99-19-104, recodified as § 388-835-330, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-775, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-775, filed 8/3/82.]

WAC 388-835-335 Depreciable assets. (1) Tangible assets of the following types where a contractor has an economic interest through ownership are subject to depreciation:

- (a) Building - The basic structure or shell and additions thereto.
- (b) Building fixed equipment - Attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, and air conditioning system. The general characteristics of this equipment are:
 - (i) Affixed to the building and not subject to transfer; and
 - (ii) A fairly long life, but shorter than the life of the building where affixed.
- (c) Major movable equipment - Such items as beds, wheelchairs, desks, and x-ray machines. The general characteristics of this equipment are:
 - (i) A relatively fixed location in the building;
 - (ii) Capable of being moved as distinguished from building equipment;
 - (iii) A unit cost sufficient to justify ledger control;

(iv) Sufficient size and identity to make control feasible by means of identification tags; and

(v) A minimum life of approximately three years. Effective January 1, 1981, for settlement purposes for periods subsequent to that date, and for purposes of setting rates for periods beginning July 1, 1982, and subsequently, this equipment shall be characterized by a minimum life of greater than one year.

(d) Minor equipment - Such items as waste baskets, bed pans, syringes, catheters, silverware, mops, and buckets properly capitalized. No depreciation shall be taken on items not properly capitalized (see WAC 275-38-770). The general characteristics of minor equipment are:

- (i) In general, no fixed location and subject to use by various departments;
- (ii) Small in size and unit cost;
- (iii) Subject to inventory control;
- (iv) Fairly large number in use; and
- (v) Generally, a useful life of one to three years.

(e) Land improvements - Such items as paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc., where replacement is the responsibility of the contractor.

(f) Leasehold improvements - Betterments and additions made by the lessee to the leased property, which become the property of the lessor after the expiration of the lease.

(2) Land is not depreciable. The cost of land includes the cost of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a nondepreciable nature, and the cost of curbs and sidewalks, replacement of which is not the responsibility of the contractor.

[99-19-104, recodified as § 388-835-335, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-780, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-780, filed 8/3/82.]

WAC 388-835-340 Depreciation base. (1) The depreciation base shall be the historical cost of the contractor in acquiring the asset from an unrelated organization and preparing depreciation base for use, less goodwill and less accumulated depreciation incurred during periods the assets have been used in or as a facility by the contractor, such accumulated depreciation to be measured in accordance with subsection (4) of this section and WAC 275-38-790, 275-38-795, and 275-38-800. If the department challenges the historical cost of an asset or a contractor is not able to provide adequate documentation of the historical cost of an asset, the department may have the fair market value of the asset at the time of purchase established by appraisal. The fair market value of items of equipment will be established by appraisals performed by vendors of the particular type of equipment. When these appraisals are conducted, the depreciation base of the asset will not exceed fair market value. Estimated salvage value, if any, shall be deducted from historical cost where the straight-line or sum-of-the-years digits method of depreciation is used.

(2) Effective January 1, 1981, for purposes of setting rates for rate periods beginning July 1, 1982, and subsequently, subsection (1) of this section shall be applied with

the phrase "in an arm's-length transaction" replacing the phrase "from an unrelated organization."

(3) Effective July 1, 1982, in all cases subsection (1) of this section shall be applied with the phrase "in an arm's-length transaction" replacing the phrase "from an unrelated organization."

(4) Where depreciable assets are acquired from a related organization, the contractor's depreciation base shall not exceed the base the related organization had or would have had under a contract with the department.

(5) Effective October 1, 1984, the depreciation base for assets acquired in a change of ownership entered into on or after July 18, 1984, shall not exceed the lower of the purchase price of the new owner or the acquisition cost base of the owner of the assets on or after July 18, 1984. Costs (including legal fees, accounting and administrative costs, travel costs, and the cost of feasibility studies) attributable to the negotiation or settlement of the assets acquired in the change of ownership, where any payment has previously been made by Title XIX, shall not be allowed.

[99-19-104, recodified as § 388-835-340, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-785, filed 6/1/88; 86-01-008 (Order 2312), § 275-38-785, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-785, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-785, filed 8/3/82.]

WAC 388-835-345 Depreciation base—Donated or inherited assets. (1) The depreciation base of donated assets, as defined in WAC 275-38-001, or of assets received through testate or intestate distribution, shall be the lesser of:

(a) Fair market value at the date of donation or death, less goodwill. Estimated salvage value, if any, shall be deducted from fair market value where the straight-line or sum-of-the-years digits method of depreciation is used; or

(b) The historical cost of the owner last contracting with the department, if any.

(2) If the donation or distribution is between related organizations, the base shall be the lesser of:

(a) Fair market value, less goodwill and, where appropriate, salvage value, or

(b) The depreciation base the related organization had or would have had for the asset under a contract with the department.

[99-19-104, recodified as § 388-835-345, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-790, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-790, filed 8/3/82.]

WAC 388-835-350 Lives. (1) The contractor shall use lives no shorter than guideline lives contained in the Internal Revenue Service class life ADR system or published by the American Hospital Association in computing allowable depreciation except the building. The shortest life which may be used for buildings is thirty years.

(2) Lives shall be measured from the date of the most recent arm's-length acquisition of the asset.

(3) Building improvements shall be depreciated over the remaining useful life of the building, as modified by the improvement, but not less than fifteen years, except as follows: For boarding home licensed facility building improvements required by the Fire Safety Evaluation System (FSES)

of the Life Safety Code of 1984, the improvements shall be depreciated over a period of not less than five years. This exception shall require prior approval by the department.

(4) Improvements to leased property which are the responsibility of the contractor under the terms of the lease shall be depreciated over the useful life of the improvement, except as follows: For boarding home licensed facility building improvements required by the Fire Safety Evaluation System (FSES) of the Life Safety Code of 1984, the improvements shall be depreciated over a period of not less than five years. This exception shall require prior approval by the department.

(5) A contractor may change the estimate of an asset's useful life to a longer life for purposes of depreciation.

[99-19-104, recodified as § 388-835-350, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-795, filed 12/5/85; 82-16-080 (Order 1853), § 275-38-795, filed 8/3/82.]

WAC 388-835-355 Methods of depreciation. (1) Buildings, building improvements, land improvements, leasehold improvements, and fixed equipment shall be depreciated using the straight-line method. Major-minor equipment shall be depreciated using either the straight-line method, the sum-of-the-years digits method, or declining balance method not to exceed one hundred fifty percent of the straight-line rate. Contractors electing to take either the sum-of-the-years digits method or the declining balance method of depreciation on major-minor equipment may change to the straight-line method without permission of the department.

(2) The annual provision for depreciation shall be reduced by the portion allocable to use of the asset for purposes not both necessary and related to resident care and training.

(3) No further depreciation shall be claimed after an asset has been fully depreciated unless a new depreciation base is established pursuant to WAC 275-38-785.

[99-19-104, recodified as § 388-835-355, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-800, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-800, filed 8/3/82.]

WAC 388-835-360 Retirement of depreciable assets. (1) Where depreciable assets are disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, or fire or other casualty, depreciation shall no longer be taken on the assets. No further depreciation shall be taken on permanently abandoned assets.

(2) Where an asset has been retired from active use but is being held for stand-by or emergency service, and the department has determined that the asset is needed and can be effectively used in the future, depreciation may be taken, as prescribed in WAC 275-38-775 through 275-38-800.

[99-19-104, recodified as § 388-835-360, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-805, filed 8/3/82.]

WAC 388-835-365 Handling of gains and losses upon retirement of depreciable assets. Settlement periods prior to January 1, 1981, and rate periods prior to July 1, 1982.

(1) For settlement purposes for periods prior to January 1, 1981, and for rate-setting purposes for periods prior to July

1, 1982, gains and losses on the retirement of depreciable assets either during the period of participation in the program or within twelve months following termination, shall be treated in accordance with this section.

(2) A gain or loss on the retirement of an asset shall be the difference between the remaining undepreciated base and any proceeds received for, or to compensate for loss of, the asset. For purposes of subsections (3) and (4) of this section, the total gain shall be reduced by one percent for each month of ownership of an asset with an expected useful life of one hundred months or longer. For an asset with an expected useful life of less than one hundred months, total gain shall be reduced by the portion thereof equal to the ratio of the actual life of the asset from the most recent arm's-length acquisition up to the date of retirement to the assets expected useful life.

(3) If the retired asset is replaced, the gain or loss shall be applied against or added to the cost of the replacement asset, provided a loss will only be so applied if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset.

(4) If the retired asset is not replaced, or if the contractor is terminating the contract, the gain or loss shall be spread over the actual life of the asset up to the date of retirement, provided a loss will only be so spread if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset. The difference between reimbursement actually paid for depreciation in any period beginning on or after January 1, 1978, and the reimbursement for depreciation having been paid with the base adjusted to reflect the gain or loss, will be computed. Where the difference results from a gain, the difference shall be recovered by the department. Where the difference results from a loss, the difference will be added to allowable costs for purposes of determining settlement.

[99-19-104, recodified as § 388-835-365, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-810, filed 8/3/82.]

WAC 388-835-370 Handling of gains and losses upon retirement of depreciable assets—Other periods. (1) This section shall apply in the place of WAC 275-38-810 effective January 1, 1981, for purposes of settlement for settlement periods subsequent to that date, and for purposes of setting rates for rate periods beginning July 1, 1982, and subsequently.

(2) A gain or loss on the retirement of an asset shall be the difference between the remaining undepreciated base and any proceeds received for, or to compensate for loss of, the asset.

(3) If the retired asset is replaced, the gain or loss shall be applied against or added to the cost of the replacement asset, provided a loss will only be so applied if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset.

[99-19-104, recodified as § 388-835-370, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-812, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-812, filed 8/3/82.]

WAC 388-835-375 Handling of gains and losses upon retirement of depreciable assets. This section shall apply in

the place of WAC 275-38-812 effective October 1, 1984. Effective October 1, 1984, assets acquired in a change of ownership entered into on or after July 18, 1984, shall be subject to the following depreciation recapture provisions.

(1) A gain or loss on the retirement of an asset shall be the difference between the remaining undepreciated base and any proceeds received for, or to compensate for loss of, the asset.

(2) If the retired asset is replaced, the gain or loss shall be applied against or added to the cost of the replacement asset, provided a loss will only be so applied if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset.

(3) If the retired asset is not replaced, or if the contractor is terminating the contract, the gain or loss shall be spread over the actual life of the asset up to the date of retirement, provided a loss will only be so spread if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset. The difference between reimbursement actually paid for depreciation and the reimbursement for depreciation having been paid with the base adjusted to reflect the gain or loss, will be computed. Where the difference results from a gain, the difference shall be recovered by the department.

[99-19-104, recodified as § 388-835-375, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-813, filed 12/5/85.]

WAC 388-835-380 Recovery of excess over straight-line depreciation. If a contractor terminates the contract without selling or otherwise retiring equipment which was depreciated using an accelerated method, depreciation schedules relating to these assets for periods the contractor participated in the IMR program shall be adjusted. The difference between reimbursement actually paid for depreciation in any period beginning on or after January 1, 1978, and the reimbursement which would have been paid for depreciation if the straight-line method had been used, shall be recovered by the department.

[99-19-104, recodified as § 388-835-380, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-815, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-815, filed 8/3/82.]

WAC 388-835-385 Unallowable costs. (1) Costs shall be unallowable if not documented, necessary, ordinary, and related to the provision of services to IMR residents.

(2) Unallowable costs include, but are not limited to, the following:

(a) Costs of items or services not covered by the Medicaid program. Costs of nonprogram items or services will be unallowable even if indirectly reimbursed by the department as the result of an authorized reduction in resident contribution.

(b) Costs of services and items provided to IMR residents covered by the department's medical care program but not included in IMR services respectively. Items and services covered by the medical care program are listed in chapter 388-86 WAC.

(c) Costs associated with a capital expenditure subject to Section 1122 approval (part 100, Title 42 CFR) if the depart-

ment found the capital expenditure was not consistent with applicable standards, criteria or plans. If the department was not given timely notice of a proposed capital expenditure, all associated costs will be nonallowable as of the date the costs are determined not to be reimbursable under applicable federal regulations.

(d) Costs associated with a construction or acquisition project requiring certificate of need approval pursuant to chapter 70.38 RCW if such approval was not obtained.

(e) Costs of outside activities (e.g., costs allocable to the use of a vehicle for personal purposes, or related to the part of a facility leased out for office space).

(f) Salaries or other compensation of officers, directors, stockholders, and others associated with the contractor or home office, except compensation paid for service related to resident care and training.

(g) Costs in excess of limits or violating principles set forth in this chapter.

(h) Costs resulting from transactions or the application of accounting methods circumventing the principles of the prospective cost-related reimbursement system.

(i) Costs applicable to services, facilities, and supplies furnished by a related organization in excess of the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere.

(j) Bad debts.

(k) Charity and courtesy allowances.

(l) Cash, assessments, or other contributions, excluding dues, to charitable organizations, professional organizations, trade associations, or political parties, and cost incurred to improve community or public relations.

(i) Any portion of trade association dues attributable to legal and consultant fees and costs in connection with lawsuits, or other legal action against the department.

(ii) Travel expenses for members of trade association boards of directors, otherwise meeting the requirements of chapter 275-38 WAC, for more than twelve meetings per year.

(m) Vending machine expenses.

(n) Expenses for barber or beautician services not included in routine care.

(o) Funeral and burial expenses.

(p) Costs of gift shop operations and inventory.

(q) Personal items such as cosmetics, smoking materials, newspapers and magazines, and clothing, except items used in resident activity programs or in IMR programs where clothing is a part of routine care.

(r) Fund-raising expenses, except those directly related to the resident activity program.

(s) Penalties and fines.

(t) Expenses related to telephones, televisions, radios, and similar appliances in residents' private accommodations.

(u) Federal, state, and other income taxes.

(v) Costs of special care services, except where authorized by the department.

(w) Expenses of key-man insurance and other insurance or retirement plans not in fact made available to all employees.

(x) Expenses of profit-sharing plans.

(y) Expenses related to the purchase and/or use of private or commercial airplanes in excess of what a prudent contractor would expend for the ordinary and economic provision of such a transportation need related to resident care.

(z) Personal expenses and allowances of owners or relatives.

(aa) All expenses of maintaining professional licenses or membership in professional organizations.

(bb) Costs related to agreements not to compete.

(cc) Goodwill and amortization of goodwill.

(dd) Expenses related to vehicles in excess of what a prudent contractor would expend for the ordinary and economic provision of transportation needs related to resident care.

(ee) Legal and consultant fees in connection with a fair hearing against the department, including but not limited to accounting services in preparation of administrative or judicial review, where the final administrative decision is rendered in favor of the department or where otherwise the determination of the department stands at the termination of administrative review.

(ff) Legal and consultant fees in connection with a lawsuit against the department, including appeals of administrative decision suits.

(gg) Lease acquisition costs and other intangibles not related to resident care and training.

(hh) Interest charges assessed by the state of Washington for failure to make timely refund of overpayments and interest expenses incurred for loans obtained to make such refunds.

(ii) Travel expenses outside the states of Idaho, Oregon, and Washington and the Province of British Columbia. However, travel to and from the home and central office of a chain organization operation will be allowed outside those areas if such travel is necessary, ordinary, and related to resident care and training.

(jj) Moving expenses of employees in the absence of a demonstrated, good-faith effort to recruit within the states of Idaho, Oregon, and Washington and the Province of British Columbia.

(3) If a contractor provides goods or services not reimbursable under chapter 275-38 WAC, any material indirect or overhead costs must be allocated to such goods or services and not be reported as an allowable cost.

[99-19-104, recodified as § 388-835-385, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-820, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-820, filed 8/3/82.]

WAC 388-835-390 Reimbursement principles. (1) Medicaid program reimbursement rates established under the provisions of this chapter shall be only for facilities holding appropriate state licenses and certified to provide IMR services in accordance with applicable state and federal laws and regulations.

(2) Rates established shall be reasonable and adequate to meet the costs that must be incurred by economically and efficiently operated facilities to provide services in conformity with applicable state and federal laws and regulations.

(3) For nonstate facilities, final payment shall be the lower of their prospective rate or allowable costs.

(a) Prospective rates for nonstate facilities shall be determined in accordance with WAC 275-38-845, 275-38-846, 275-38-850, 275-38-860, 275-38-863, 275-38-865, 275-38-868, 275-38-869, 275-38-870, 275-38-875, and 275-38-880.

(b) Final payments for nonstate facilities shall be determined in accordance with WAC 275-38-886.

(4) For state facilities, final payment shall be their allowable costs.

(a) Interim rates for state facilities shall be determined in accordance with WAC 275-38-846 and 275-38-890.

(b) Final payments for state facilities shall be determined in accordance with WAC 275-38-892.

[99-19-104, recodified as § 388-835-390, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-831, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-831, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-831, filed 8/19/83.]

WAC 388-835-395 Program services not covered by the reimbursement rate. Medical services which are part of the department's medical care program but not included in IMR services are not covered by the prospective reimbursement rate. Payment is made directly to the provider of service in accordance with chapter 388-87 WAC. Items and services covered by the medical care program are listed in chapter 388-86 WAC.

[99-19-104, recodified as § 388-835-395, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-835, filed 8/3/82.]

WAC 388-835-400 Prospective reimbursement rate for new contractors. (1) A prospective reimbursement rate for a new contractor shall be established within sixty days following receipt by the department of a properly completed projected budget (see WAC 275-38-520). The reimbursement rate shall be effective as of the effective date of the contract.

(2) The prospective reimbursement rate shall be based on the contractor's projected cost of operations, and on costs and payment rates of the prior contractor, if any, and/or of other contractors in comparable circumstances taking into account applicable lids or maximums.

(3) If a properly completed projected budget is not received at least sixty days prior to the effective date of the contract, the department shall establish a preliminary rate based on the other factors specified in subsection (2) of this section. The preliminary prospective rate shall remain in effect until an initial prospective rate can be set.

(4) Where a change of ownership is involved which is not an arm's-length transaction as defined in WAC 275-38-001, the new contractor's prospective rates in the administration and operation and property cost areas shall be no higher than the rates of the old contractor, adjusted if necessary to take into account economic trends.

[99-19-104, recodified as § 388-835-400, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-840, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-840, filed 8/3/82.]

WAC 388-835-405 Rate determination. (1) Each contractor's reimbursement rate shall be determined prospectively once each calendar year to be effective July 1. Rates

may be adjusted to take into consideration legislative inflation adjustments or pursuant to WAC 275-38-900 or 275-38-906.

(2) If the contractor participated in the program for at least six months of the prior calendar year, its rates shall be based on the contractor's allowable costs in the prior period. If the contractor participated in the program for less than six months of the prior calendar year, its rates shall be based on its rate determined per WAC 275-38-840.

(3) Contractors submitting correct and complete cost reports by March 31, shall be notified of their rates by July 1, unless circumstances beyond the control of the department interfere.

(4) The department shall take data used in determining rates from the most recent, complete, desk-reviewed cost report submitted by the contractor.

(5) Data containing obvious errors shall be excluded from the determination of predicted costs, cost averages, and rate upper limits for WAC 275-38-870.

(6) Inflation factor adjustments shall be specified in division policy Directive 406.

[99-19-104, recodified as § 388-835-405, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-845, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-845, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-845, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-845, filed 8/3/82.]

WAC 388-835-410 Desk review for rate determination. (1) The department shall analyze each cost report to determine if the information is correct, complete, and reported in conformity with generally accepted accounting principles, the requirements of chapter 275-38 WAC, and such rules and instructions issued by the department. An analysis by the department to determine whether reported information is correct and complete may include, but is not limited to:

(a) An examination of reported costs for prior years;

(b) An examination of desk review adjustments made in prior years and their final disposition; and

(c) An examination of findings, if any, from field audits of cost reports from prior years and findings, if any, from the field audit of the cost report under analysis.

(2) If it appears from the analysis a contractor has not correctly determined or reported its costs, the department may make adjustments to the reported information for purposes of establishing reimbursement rates. The department shall provide a schedule of such adjustments to contractors and shall include an explanation for the adjustment and the dollar amount for each adjustment made. Adjustments shall be subject to review and appeal as provided in subsection (2)(a) or (b) below.

(a) If a contractor believes an adjustment is in error, the adjustment shall be subject to review pursuant to WAC 275-38-900; and

(b) If a satisfactory resolution of issues is not reached between the contractor and the department, the adjustment shall be subject to further review pursuant to WAC 275-38-950 and 275-38-960.

(3) The department may accumulate data from properly completed cost reports for use in exception profiling and establishing rates.

(4) The department may further utilize such accumulated data for analytical, statistical, or informational purposes as deemed necessary by the department.

[99-19-104, recodified as § 388-835-410, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-846, filed 6/1/88; 83-17-074 (Order 2012), § 275-38-846, filed 8/19/83.]

WAC 388-835-415 Cost centers. (1) A contractor's overall reimbursement rate for IMR residents consists of the total of three component rates, each covering one cost center. The five cost centers are: Resident care and habilitative services; food; administration and operations; property; and return on equity;

(2) Effective January 1, 1985, a contractor's reimbursement rate for IMR residents consists of the total of three component rates, each covering one cost center. The three cost centers are: Resident care and habilitation; administration, operations, and property; and return on equity.

[99-19-104, recodified as § 388-835-415, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-850, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-850, filed 8/3/82.]

WAC 388-835-420 Resident care and habilitation cost center rate. (1) For C and D level facilities, the resident care and habilitation cost center shall reimburse for resident living services, habilitative and training services, recreation services, and nursing services in accordance with applicable federal and state regulation.

(2) For E level facilities, the resident care and habilitation cost center shall reimburse for resident living services, habilitative and training services, recreation services, and nursing services in accordance with applicable federal and state regulation. The cost center shall reimburse for resident care and training staff performing administration and operations functions specified in WAC 275-38-870.

(3) A facility's resident care and habilitation cost center rate shall be the facility's most recent desk-reviewed costs per resident day adjusted for inflation.

[99-19-104, recodified as § 388-835-420, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 93-17-034 (Order 3616), § 275-38-860, filed 8/11/93, effective 9/11/93; 90-15-017 (Order 3037), § 275-38-860, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-860, filed 6/1/88; 86-18-002 (Order 2412), § 275-38-860, filed 8/21/86; 86-01-008 (Order 2312), § 275-38-860, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-860, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-860, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-860, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-860, filed 8/3/82.]

WAC 388-835-425 Administration, operations, and property cost center rate. Effective October 1, 1985, the administration, operations, and property cost center rate shall consist of the sum of three rate components: Food, administration and operations, and property. The food rate component shall be established pursuant to WAC 275-38-865. The administration and operations rate component shall be established pursuant to WAC 275-38-870. The property rate component shall be established pursuant to WAC 275-38-875.

[2000 WAC Supp—page 1828]

[99-19-104, recodified as § 388-835-425, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-863, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-863, filed 3/6/85.]

WAC 388-835-430 Food rate component. (1) The food rate component will reimburse for the necessary and ordinary costs of bulk and raw food, dietary supplements, and beverages for meals and between-meal nourishment for residents.

(2) A facility's food rate component shall be set at the July 1, 1983, IMR food rate component, adjusted for inflation.

[99-19-104, recodified as § 388-835-430, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-865, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-865, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-865, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-865, filed 8/3/82.]

WAC 388-835-435 Maximum allowable compensation of certain administrative personnel. (1) Compensation for administrative personnel shall be an allowable cost, subject to the limits contained in this section.

(2) Total compensation of the licensed administrator for services actually rendered to an IMR facility on a full-time basis (at least forty hours per week, including reasonable vacation, holiday, and sick time) will be allowable at the lower of:

(a) Actual compensation received; or

(b) The amount specified in division policy Directive 403 corresponding to the number of set-up beds in the IMR facility. Compensation of the licensed administrator will only be allowable if the department is given written notice of his or her employment within ten days after the employment begins.

(3) Total compensation of not more than one full-time licensed assistant administrator will be allowable if there are at least eighty set-up beds in the IMR, at the lower of:

(a) Actual compensation received; or

(b) Seventy-five percent of the amount specified in division policy Directive 403.

(4) Total compensation of not more than one full-time registered administrator-in-training will be allowable at the lower of:

(a) Actual compensation received; or

(b) Sixty percent of the amount specified in division policy Directive 403.

(5) The cost of a licensed administrator, assistant administrator, or administrator-in-training is not an allowable expense in IMR facilities of fifteen beds or less. Administrative services will be provided by the QMRP in these facilities. Total compensation of wages and salaries for the QMRP will be allowable at the lower of:

(a) Actual compensation received; or

(b) The amount specified in division policy Directive 403.

(6) If the licensed administrator, licensed assistant administrator, registered administrator-in-training, or QMRP regularly works fewer than forty hours per week, allowable compensation shall be the lower of:

(a) Actual compensation received, or

(b) The maximum amount allowed multiplied by the percentage derived by dividing actual hours worked by forty hours. Further discounting is required if the person was licensed or registered and/or worked for less than the entire report period.

(7) The contractor shall maintain time records for the licensed administrator and for an assistant administrator, administrator-in-training, or QMRP, if any.

[99-19-104, recodified as § 388-835-435, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 84-19-042 (Order 2150), § 275-38-868, filed 9/17/84. Formerly WAC 275-38-730.]

WAC 388-835-440 Management agreements, management fees, central office services, and board of directors.

(1) If a contractor intends to enter into a management agreement with an individual or firm which will manage the IMR facility as agent of the contractor, a copy of the agreement must be submitted by the contractor at least sixty days before the agreement is to become effective. A copy of any amendment to a management agreement must also be received by the department at least thirty days in advance of the date the amendment is to become effective. No management fees for periods prior to the time the department receives a copy of the applicable agreement shall be allowable. When necessary for the health and safety of facility residents, the sixty-day notice requirement may be waived, in writing, by the department.

(2) Management fees shall be allowed only if:

(a) A written management agreement both creates a principal and/or agent relationship between the contractor and the manager, and sets forth the items, services, and activities to be provided by the manager; and

(b) Documentation demonstrates the services contracted for were actually delivered.

(c) To be allowable, fees must be for necessary, nonduplicative services.

(3) The contractor shall limit allowable fees for general management services, including corporate or business entity management and board of director's fees and including the overhead and indirect costs associated with providing general management services to:

(a) The maximum allowable compensation under WAC 275-38-868 of the licensed administrator and, if the facility has at least eighty set-up beds, of an assistant administrator; less

(b) Actual compensation received by the licensed administrator and by the assistant administrator, if any. In computing maximum allowable compensation under WAC 275-38-868 for a facility with at least eighty set-up beds, include the maximum compensation of an assistant administrator even if no assistant administrator is employed;

(c) For IMR facilities of fifteen or fewer beds, the maximum allowable compensation under WAC 275-38-868, less the actual compensation received by the QMRP.

(4) A management fee paid to or for the benefit of a related organization shall be allowable to the extent the fee does not exceed the lesser of:

(a) The limits set out in subsection (3) of this section; or

(b) The lower of the actual cost to the related organization of providing necessary services related to resident care

and training under the agreement, or the cost of comparable services purchased elsewhere.

Where costs to the related organization represents joint facility costs, the measurement of such costs shall comply with WAC 275-38-868.

(5) Central office costs, owner's compensation, and other fees or compensation, including joint facility costs, for general administrative and management services, shall include the overhead and indirect costs associated with providing general management expense not allocated to specific services. Such costs shall be subject to the management fee limits determined in subsections (3) and (4) of this section.

(6) Necessary travel and housing expenses of nonresident staff working at a contractor's IMR facility are allowable costs if the visit does not exceed three weeks. Such costs in excess of three weeks shall be subject to the management fee limits determined in subsections (3) and (4) of this section.

(7) Bonuses paid to employees at a contractor's IMR facility are compensation. Bonuses paid to employees at a contractor's central office or otherwise not employed at the IMR facility, who are not engaged in nonmanagerial services such as accounting, are management costs and shall be subject to the management fee limits determined in subsections (3) and (4) of this section.

(8) Fees paid to members of the board of directors of corporations operating IMR facilities shall be subject to the management fee limits determined in subsection (3) and (4) of this section.

[99-19-104, recodified as § 388-835-440, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-869, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-869, filed 9/17/84. Formerly WAC 275-38-740.]

WAC 388-835-445 Administration and operations rate component.

(1) The administration and operations rate component will include reimbursement for the necessary and ordinary costs of overall administration and management of the facility, operation and maintenance of the physical plant, resident transportation, dietary service (other than the cost of food and beverages), laundry service, medical and habitative supplies, taxes, and insurance.

(2) A facility's administration and operations rate component shall be the lesser of:

(a) The facility's most recent desk-reviewed cost per resident day, adjusted for inflation; or

(b) The eighty-fifth percentile ranking of state and non-state facilities' most recent desk-reviewed cost per resident day, adjusted for inflation. The ranking shall be based on cost reports used for rate determination for facilities having an occupancy level of at least eighty-five percent for the cost report period.

[99-19-104, recodified as § 388-835-445, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 85-06-063 (Order 2213), § 275-38-870, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-870, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-870, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-870, filed 8/3/82.]

WAC 388-835-450 Property rate component. The property rate component will reimburse for the necessary and ordinary costs of leases, depreciation, and interest. A facil-

ity's property rate component shall be the facility's most recent desk-reviewed cost per resident day.

[99-19-104, recodified as § 388-835-450, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-875, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-875, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-875, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-875, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-875, filed 8/3/82.]

WAC 388-835-455 Return on equity. (1) The department will pay a return on equity to proprietary contractors.

(2) A contractor's net equity will be calculated using the appropriate items from the contractor's most recent desk-reviewed cost report utilizing the definition of equity capital in WAC 275-38-001 and applying relevant Medicare rules and regulations, except that goodwill is not includable in the determination of net equity and monthly equity calculations will not be used.

(3) The contractor's net equity will be multiplied by the prior calendar year's December 31 Medicare rate of return for the twelve-month period ending on the date of the closing date of the contractor's cost report. The amount will be divided by the contractor's annual resident days for the cost report period to determine a rate per resident day. Where a contractor's cost report covers less than a twelve-month period, annual resident days will be estimated using the contractor's reported resident days. The contractor shall be paid a prospective rate which is the lesser of the amount calculated pursuant to this section or two dollars per resident day.

(4) The information on which the return on equity is calculated is subject to field audit. Field audit shall determine whether the desk-reviewed reported equity exceeds the equity documented and calculated in conformance with Medicare rules and regulations as modified by this section. Using the determinations of field audit, the department shall recalculate the contractor's return on equity rate for the rate period using the report. Any payments in excess of the rate shall be refunded to the department as part of the settlement procedure established by WAC 275-38-886.

[99-19-104, recodified as § 388-835-455, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-880, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-880, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-880, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-880, filed 8/3/82.]

WAC 388-835-460 Upper limits to reimbursement rate. The reimbursement rate shall not exceed the contractor's customary charges to the general public for the services covered by the rate, except that public facilities rendering such services free of charge or at a nominal charge will be reimbursed according to the methods and standards set out in this chapter. The contractor shall immediately inform the department if the department's reimbursement rate does exceed customary charges for comparable services. If necessary, the rate will be adjusted in accordance with WAC 275-38-900. Rates will not exceed the limits set in 42 CFR 447.316.

[99-19-104, recodified as § 388-835-460, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-885, filed 8/3/82.]

[2000 WAC Supp—page 1830]

WAC 388-835-465 Principles of settlement. (1) Settlement shall be calculated at the lower of prospective reimbursement rate or audited allowable costs, except as otherwise provided in this chapter.

(2) Each contractor shall complete a proposed preliminary settlement as part of the annual cost report and submit it by the due date of the annual cost report. After review of the proposed preliminary settlement, the department shall issue a preliminary settlement report to the contractor.

(3) If a field audit is conducted, the department shall evaluate the audit findings after completion of the audit and shall issue a final settlement which takes account of such findings and evaluations.

(4) Pursuant to preliminary or final settlement and the procedures set forth in chapter 275-38 WAC[, the contractor shall refund overpayments to the department and the department shall pay underpayments to the contractor].

(5) When payment for services is first made following preliminary or final settlement for the period during which the services were provided, payment shall be at the most recent available settlement rate.

[99-19-104, recodified as § 388-835-465, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-886, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-886, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-886, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-886, filed 8/19/83.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-835-470 Procedures for overpayments and underpayments. (1) The department shall make payment of underpayments determined by preliminary or final settlement within thirty days after the preliminary or final settlement report is submitted to the contractor.

(2) A contractor found to have received overpayments or payments in error as determined by preliminary or final settlement shall refund such payments to the department within thirty days after receipt of the preliminary or final settlement report as applicable.

(3) If a contractor fails to comply with subsection (2) of this section, the department shall:

(a) Deduct from current monthly amounts due the contractor the refund due the department and interest on the unpaid balance at the rate of one percent per month; or

(b) If the contract has been terminated:

(i) Deduct from any amounts due the contractor the refund due the department and interest on the unpaid balance at the rate of one percent per month; or

(ii) Pursue, as authorized by law and regulation, recovery of the refund due and interest on the unpaid balance at the rate of one percent per month.

(4) If a facility is pursuing timely filed administrative or judicial remedies in good faith regarding settlement report, the contractor need not refund. The department shall not withhold any refund or interest from current amounts due the facility if the refund is specifically disputed by the contractor on review or appeal. The department may recover portions of refunds not specifically disputed by the contractor on review

or appeal and assess interest as provided in subsection (3) of this section. If the administrative or judicial remedy sought by the facility is not granted or is granted only in part after exhaustion or mutual termination of all appeals, the facility shall refund all amounts due the department within sixty days after the date of decision or termination plus interest as payable on judgments from the date the review was requested pursuant to WAC 275-38-950 and 275-38-960 to the date the repayment is made.

[99-19-104, recodified as § 388-835-470, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-887, filed 6/1/88.]

WAC 388-835-475 Preliminary settlement. (1) Effective January 1, 1985, the proposed preliminary settlement submitted by a contractor pursuant to WAC 275-38-886 shall use the prospective rate for the resident care and habilitation cost center at which the contractor was paid during the report period, including any client specific payment adjustments made for the resident care and habilitation cost center. Such payments shall be weighted by the number of paid resident days reported for the period each rate was in effect. These payments shall be compared to the contractor's allowable costs for the resident care and habilitation cost center divided by total resident days.

(2) A contractor's administration, operations, and property cost center settlement rate shall be its prospective rate for the report period weighted by the number of paid resident days reported for the period each rate was in effect.

(3) A contractor's return on equity settlement rate shall be its prospective rate for the report period weighted by the number of paid resident days reported for the period each rate was in effect.

(4) Within one hundred twenty days after a proposed preliminary settlement is received, the department shall review it for accuracy and either accept or reject the proposal of the contractor. If accepted, the proposed preliminary settlement shall become the preliminary settlement report. If rejected, the department shall issue a preliminary settlement report by cost center which shall fully substantiate disallowed costs, refunds, or underpayments due and adjustments to the proposed preliminary settlement.

(5) A contractor shall have thirty days after receipt of a preliminary settlement report to contest such report pursuant to WAC 275-38-950 and 275-38-960. Upon expiration of the thirty-day period, a preliminary settlement report shall not be subject to review.

[99-19-104, recodified as § 388-835-475, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-888, filed 6/1/88.]

WAC 388-835-480 Final settlement. (1) If an audit is conducted, the department shall issue a final settlement report to the contractor after completion of the audit process, including exhaustion or mutual termination of reviews and appeals of audit findings or determinations.

(2) The final settlement shall be by cost center and shall fully substantiate disallowed costs, refunds, underpayments, or adjustments to the cost reports and financial statements, reports, and schedules submitted by the contractor.

(a) The final settlement report shall use the prospective rate at which the contractor was paid during the report period, including any client specific payment adjustments made for resident care and training cost center. Such payments shall be weighted by the number of paid resident days reported for the period each rate was in effect. The department shall compare these payments to the contractor's audited allowable costs for the period.

(b) A contractor's administration operations and property cost center settlement rate shall be its prospective rate for the period weighted by the number of paid resident days reported for the period each rate was in effect.

(c) A contractor's return on equity rate shall be its prospective rate for the report period weighted by the number of paid resident days reported for the period each rate was in effect.

(3) If the contractor is pursuing an administrative or judicial review or appeal in good faith regarding audit findings or determinations, the department may issue a partial final settlement report in order to recover overpayments based on audit findings or determinations not in dispute on review or appeal.

(4) A contractor shall have thirty days after receipt of a final settlement report to contest such report pursuant to WAC 275-38-950 and 275-38-960. Upon expiration of the thirty-day period, a final settlement report shall not be subject to review.

[99-19-104, recodified as § 388-835-480, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-889, filed 6/1/88.]

WAC 388-835-485 Interim rate. (1) A state facility's interim rate shall be determined utilizing the most recent desk-reviewed costs per resident day. These costs may be adjusted to incorporate federal, state, or department changes in program standards or services.

(2) A facility's interim rate may be adjusted for federal, state, or department changes in program standards or services.

[99-19-104, recodified as § 388-835-485, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-890, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-890, filed 9/17/84.]

WAC 388-835-490 Final payment. (1) A settlement shall be determined to establish a state facility's final payment. A settlement shall be calculated as follows:

(a) If the state facility's allowable costs for the report period are greater than their interim payment, the amount owed to the facility shall be the difference of cost minus interim payment.

(b) If the state facility's allowable costs for the report period are less than their interim payments, the amount owed by the department shall be the difference of interim payment minus cost.

(2) The settlement process shall consist of a preliminary settlement and a final settlement.

(3) The preliminary settlement process shall be as follows:

(a) State facilities shall submit a proposed settlement report with their cost report.

(b) Within one hundred twenty days after receipt of the proposed settlement, the department shall verify the accuracy of the proposal and shall issue a preliminary settlement substantiating the settlement amount.

(4) The final settlement process shall be as follows:

(a) After completion of the audit process, the department shall submit a final settlement report to the state facility substantiating disallowed costs, refunds, underpayments, or adjustments to the contractor's financial statements, cost report, and final settlement.

(b) A preliminary settlement as issued by the department shall become the final settlement if an audit is not to be conducted pursuant to WAC 275-38-620.

[99-19-104, recodified as § 388-835-490, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-892, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-892, filed 9/17/84.]

WAC 388-835-495 Notification of rates. The department will notify each contractor in writing of the department's prospective reimbursement rate. Unless otherwise specified at the time the reimbursement rate is issued, the rate will be effective from the first day of the month the rate is issued until a new rate becomes effective. If a rate is changed as the result of an appeal in accordance with WAC 275-38-960, the rate will be effective as of the date the rate appealed from became effective.

[99-19-104, recodified as § 388-835-495, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-895, filed 8/3/82.]

WAC 388-835-500 Adjustments required due to errors or omissions. (1) The department may adjust prospective rates in accordance with subsection (1) of this section and WAC 275-38-570, as a result of cost report or computational errors or omissions by the department or by the contractor. The department shall notify the contractor in writing of each adjustment and of the effective date, and of any amount due to the department or to the contractor as a result of the rate adjustment. Rates adjusted in accordance with this section shall be effective as of the effective date of the original rate, whether the adjustment is solely for computing a preliminary or final settlement or for the purpose of modifying past or future rate payments as well.

(2) If a contractor claims an error or omission based upon incorrect cost reporting, the contractor shall submit amended cost report pages. Amended pages shall be accompanied by the certification required by WAC 275-38-560 and a written justification explaining why the amendment is necessary. Such amendments shall not be accepted unless the amendments meet the requirements of WAC 275-38-570. If the department determines the changes made by such amendments are material, the amended pages shall be subject to field audit. If the department determines the amendments are incorrect or otherwise unacceptable from a field audit, or other information available to the department, any rate adjustment based on the amendment shall be null and void. Future rate payment increases, if any, scheduled as a result of such an amendment shall be cancelled immediately. Payments based upon the rate adjustment shall be subject to repayment as provided in subsection (3) of this section.

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(3) The contractor shall pay or commence repayment for an amount he or she owes the department resulting from an error or omission within sixty days after receipt of notification of the rate adjustment or in accordance with a schedule determined by the department. If the determination is contested in accordance with WAC 275-38-950 and 275-38-960, the contractor shall pay or commence repayment within sixty days after completion of these proceedings. If a refund is not paid when due, the amount thereof may be deducted from current payments by the department.

(4) The department shall pay any amount owed the contractor as a result of a rate adjustment within thirty days after the department notifies the contractor of the rate adjustment.

(5) No adjustments for any purpose shall be made to a rate more than one hundred twenty days after the final audit narrative and summary is sent to the contractor or more than one hundred twenty days after the preliminary settlement becomes the final settlement.

(a) A final settlement within this one hundred twenty day time limit may be reopened for the sole purpose of making an adjustment to a prospective rate in accordance with WAC 275-38-900.

(b) Only such an adjustment to a prospective rate and its related computation shall be subject to review if timely contested pursuant to WAC 275-38-950 and 275-38-960. Other actions relating to settlement reopened shall not be subject to review unless previously contested in a timely manner.

[99-19-104, recodified as § 388-835-500, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-900, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-900, filed 8/3/82.]

WAC 388-835-505 Receivership. (1) If the IMR facility is providing care to recipients of state medical assistance is placed under receivership pursuant to chapter 388-98 WAC, the receiver shall:

(a) Become the Medicaid contractor for the duration of the receivership period;

(b) Assume all reporting responsibilities for new contractors;

(c) Assume all other responsibilities for new contractors set forth in chapter 275-38 WAC; and

(d) Be responsible for the refund of Medicaid rate payments pursuant to chapter 275-38 WAC in excess of costs during the period of receivership.

(2) In establishing the prospective rate during receivership, the department shall consider:

(a) Compensation, if any, ordered by the court for the receiver. Such compensation may already be available to the receiver through the rate as follows:

(i) The return on equity cost center rate, or

(ii) The administrator's salary in the case of facilities where the receiver is also the administrator.

If these existing sources of compensation are less than what was ordered by the court, additional costs may be allowed in the rate up to the compensation amount ordered by the court;

(b) Start-up costs and costs of repairs, replacements, and additional staff needed for resident health, training, security, and welfare. To the extent such costs can be covered through

the return on equity cost center rate, if any, no additional money will be added to the rate; and

(c) Any other allowable costs as set forth in chapter 275-38 WAC.

(3)(a) Upon order of the court, the department shall provide emergency or transitional financial assistance to a receiver not to exceed thirty thousand dollars.

(b) The department shall recover any emergency or transitional expenditure from revenue generated by the facility which is not obligated to the operation of the facility.

(c) If the department has not fully recovered any emergency or transitional expenditure at the termination of receivership, the department may:

(i) File an action against the former licensee or owner to recover such expenditure; or

(ii) File a lien on the facility or on the proceeds of the sale of the facility.

(4) If recommendations on receiver's compensation are solicited from the department by the court, the department shall consider the following:

(a) The range of compensation for nonstate IMR facility managers;

(b) Experience and training of the receiver;

(c) The size, location, and current condition of the facility;

(d) Any additional factors deemed appropriate by the department.

(5) When the receivership terminates, the department may revise the facility's Medicaid reimbursement as follows:

(a) The Medicaid reimbursement rate for the former owner or licensee shall be what it was prior to receivership. Unless the former owner or licensee may request prospective rate revisions from the department as set forth in chapter 275-38 WAC;

(b) The Medicaid reimbursement rate for licensed replacement operators shall be determined consistent with rules governing prospective reimbursement rates for new contractors as set forth in chapter 275-38 WAC.

[99-19-104, recodified as § 388-835-505, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-903, filed 6/1/88.]

WAC 388-835-510 Adjustments to prospective rates.

(1) Prospective rates shall be maximum payment rates for contractors for the periods to which they apply, except as otherwise provided in WAC 275-38-906. The department shall not grant rate adjustments for cost increases which are or were subject to management control or negotiation including, but not limited to, all lease cost increases, or for cost increases not expressly authorized in subsections (2) and (3) of this section.

(2) The department shall adjust rates for any capitalized additions or replacements made as a condition for licensure or certification.

(3) The department shall adjust rates for increased costs that must be incurred and which cannot be otherwise met through the contractor's prospective rate, for the following:

(a) Program changes required by the department;

(b) Changes in staffing levels or consultants at a facility required by the department; and

(c) Changes required by survey; and

(d) Changes in assessments related to revenue as required by the state legislature.

(4) Contractors requesting an adjustment shall submit:

(a) A financial analysis showing the increased cost and an estimate of the rate increase, computed according to allowable methods, necessary to fund the cost;

(b) A written justification for granting the rate increase; and

(c) A certification and supporting documentation which shows the changes in staffing, or other improvements, have been commenced or completed.

(5) Contractors receiving prospective rate increases under WAC 275-38-906 shall submit quarterly reports, beginning the first day of the month following the date the increase is granted, showing how the additional rate funds were spent. If the funds were not spent for change or improvements approved by the department in granting the adjustment, they may be subject to immediate recovery by the department unless the department finds the facility gave written notice of its intent to close by a date certain and recovery jeopardizes the facility's ability to provide for resident health, safety, and welfare.

(6) A contractor requesting an adjustment under subsection (3)(c) of this section shall submit a written plan specifying additional staff to be added and the resident needs the facility has been unable to meet due to lack of sufficient staff.

(7) In reviewing a request made under subsection (3) of this section, the department shall consider:

(a) Whether additional staff requested by a contractor is appropriate in meeting resident needs;

(b) Comparisons of staffing levels of facilities having similar characteristics;

(c) The physical layout of the facility;

(d) Supervision and management of current staff;

(e) Historic trends in under-spending of a facility's resident care and habilitation;

(f) Numbers and positions of existing staff; and

(g) Other resources available to the contractor under subsection (3) of this section.

[99-19-104, recodified as § 388-835-510, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 93-17-034 (Order 3616), § 275-38-906, filed 8/11/93, effective 9/11/93; 90-15-017 (Order 3037), § 275-38-906, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-906, filed 6/1/88.]

WAC 388-835-515 Public review of rate-setting methods and standards. The department will provide all interested members of the public with an opportunity to review and comment on proposed rate-setting methods and standards each year before setting rates.

[99-19-104, recodified as § 388-835-515, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-910, filed 8/3/82.]

WAC 388-835-520 Public disclosure of rate-setting methodology. Without identifying individual IMR facilities, the department will make available to the public full information regarding the department's rate-setting methodology.

[99-19-104, recodified as § 388-835-520, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 82-16-080 (Order 1853), § 275-38-915, filed 8/3/82.]

WAC 388-835-525 Billing period. A contractor shall bill the department for care provided to medical care recipients from the first through the last day of each calendar month.

[99-19-104, recodified as § 388-835-525, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 82-16-080 (Order 1853), § 275-38-920, filed 8/3/82.]

WAC 388-835-530 Billing procedures. (1) A contractor shall bill the department each month by completing and returning the IMR statement provided by the department. The IMR statement shall be completed and filed in accordance with instructions issued by the department.

(2) A contractor shall not bill the department for service provided to a resident until a department award letter relating to the resident has been received. At that time the contractor may bill for service provided back through the date the resident was admitted or became eligible.

(3) Billing shall not cover the day of a resident's death, discharge, or transfer from the IMR facility.

[99-19-104, recodified as § 388-835-530, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-925, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-925, filed 8/3/82.]

WAC 388-835-535 Charges to residents. (1) The department will notify a contractor of the amount each resident is required to pay for care provided under the contract and the effective date of such required contribution. It is the contractor's responsibility to collect that portion of the cost of care from the resident, and to account for any authorized reduction from his or her contribution in accordance with procedures established by the department.

(2) If a contractor receives documentation showing a change in the income or resources of a resident which will mean a change in his or her contribution toward the cost of care, this shall be reported in writing to the regional services office, DDD, within seventy-two hours. If necessary, appropriate corrections shall be made in the next IMR statement, and a copy of documentation supporting the change shall be attached. If increased funds for a resident are received by a contractor, the normal amount shall be allowed for clothing, personal, and incidental expense, and the balance applied to the cost of care.

(3) The contractor shall accept the reimbursement rate established by the department as full compensation for all services the contractor is obligated to provide under the contract. The contractor shall not seek or accept additional compensation from or on behalf of a resident for any or all such services.

[99-19-104, recodified as § 388-835-535, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 82-16-080 (Order 1853), § 275-38-930, filed 8/3/82.]

WAC 388-835-540 Payment. (1) The department will reimburse a contractor for service rendered under the IMR contract and billed for in accordance with WAC 275-38-925.

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(2) The amount paid will be computed using the appropriate rate assigned to the contractor.

(3) For each resident, the department will pay an amount equal to the appropriate rate or rates, multiplied by the number of resident days each rate was in effect, less the amount the resident is required to pay for his or her care (see WAC 275-38-930).

[99-19-104, recodified as § 388-835-540, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 82-16-080 (Order 1853), § 275-38-935, filed 8/3/82.]

WAC 388-835-545 Suspension of payment. (1) Payments to a contractor may be withheld by the department in each of the following circumstances:

(a) A required report is not properly completed and filed by the contractor within the appropriate time period, including any approved extensions. Payments shall be released as soon as a properly completed report is received.

(b) Auditors or other authorized department personnel in the course of his or her duties are refused access to an IMR or are not provided with existing appropriate records. Payments shall be released as soon as such access or records are provided.

(c) A refund in connection with a settlement or rate adjustment is not paid by the contractor when due. The amount withheld shall be limited to the unpaid amount of the refund.

(d) Payments for the final service under a contract, pursuant to WAC 275-38-530, shall be held pending final settlement when the contract is terminated.

(2) No payment shall be withheld until written notification of the suspension is given to the contractor, stating the reason therefor.

[99-19-104, recodified as § 388-835-545, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-940, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-940, filed 8/3/82.]

WAC 388-835-550 Termination of payments. All Medicaid Title XIX payments to a contractor shall end no later than sixty days after any of the following occurs:

- (1) A contract expires, is terminated or is not renewed;
- (2) A facility license is revoked; or
- (3) A facility is decertified as a Title XIX facility.

[99-19-104, recodified as § 388-835-550, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-945, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-945, filed 8/3/82.]

WAC 388-835-555 Disputes. (1) If a contractor wishes to contest the way a rule, contract provision, or policy statement relating to the prospective cost-related reimbursement system was applied to the contractor by the department, (e.g., in setting a reimbursement rate or determining a disallowance at audit), the contractor shall first pursue the administrative review process set out in WAC 275-38-960.

(2) The administrative review process in WAC 275-38-960 need not be exhausted if a contractor wishes to challenge the legal validity of a statute, rule, contract provision or policy statement.

[99-19-104, recodified as § 388-835-555, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 82-16-080 (Order 1853), § 275-38-950, filed 8/3/82.]

WAC 388-835-560 Recoupment of undisputed overpayments. The department is authorized to withhold from the IMR current payment all amounts found by preliminary or final settlement to be overpayments not identified by the IMR and challenged as overpayments as part of a good-faith administrative or judicial review. Contested amounts retained by the IMR pursuant to this section may be subject to recoupment by the department from the IMR current payment upon completion of judicial and administrative review procedures to the extent the department's position or claims are upheld.

[99-19-104, recodified as § 388-835-560, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-955, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-955, filed 8/3/82.]

WAC 388-835-565 Administrative review—Adjudicative proceeding. (1) A contractor has the right to an administrative review to challenge an audit finding (adjusting journal entries or AJEs) or other audit determination, or a rate, desk review, or other settlement determination. A contractor challenging an audit or settlement determination shall within twenty-eight days of receipt of the determination:

(i) File a written request for an administrative review with the:

(A) Office of vendor services when the challenge pertains to an audit finding (adjusting journal entries or AJEs) or other audit determination; or

(B) Director, division of developmental disabilities, for a rate, desk review, or other settlement determination.

(ii) Sign the request or have the facility administrator sign the request;

(iii) Identify the challenged determination and the date thereof;

(iv) State as specifically as practicable the issues and regulations involved and the grounds for contending the determination was erroneous;

(v) Attach to the request copies of any documentation the contractor intends to rely on to support the contractor's position.

(2) After receiving a timely request meeting the criteria of this section, the department shall:

(a) Contact the contractor to schedule a conference for the earliest mutually convenient time; and

(b) Schedule the conference for no earlier than fourteen days after the contractor was notified of the conference and no later than ninety days after a properly completed request is received, unless both parties agree, in writing, to a specific later date.

The department may conduct the conference by telephone unless either the department or the contractor requests, in writing, the conference be held in person.

(3) The contractor and appropriate representatives of the department shall participate in the conference. The contractor shall bring to the conference, or provide to the department in advance of the conference:

(a) Any documentation requested by the department which the contractor is required to maintain for audit purposes under WAC 275-38-555; and

(b) Any documentation the contractor intends to rely on to support the contractor's contentions. The parties shall clarify and attempt to resolve the issues at the conference.

If additional documentation is needed to resolve the issues, a second session of the conference shall be scheduled for not later than thirty days after the initial session unless both parties agree, in writing, to a specific later date.

(4) Regardless of whether agreement is reached at the conference, the department shall furnish a written decision to the contractor within sixty days after the conclusion of the conference.

(5) A contractor shall have the right to an adjudicative proceeding to contest an administrative review decision.

(a) A contractor contesting an administrative review decision shall within twenty-eight days of receipt of the decision:

(i) File a written application for an adjudicative proceeding with the office of appeals;

(ii) Sign the application or have the administrator of the facility sign the application;

(iii) State as specifically as practicable the issues and regulations involved;

(iv) State the grounds for contesting the administrative review decision; and

(v) Attach to the application a copy of the administrative review decision being contested and copies of any documentation the contractor intends to rely on to support the contractor's position.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), this chapter, and chapter 388-08 WAC. If any provision in this chapter conflicts with chapter 388-08 WAC, the provision in this chapter governs.

[99-19-104, recodified as § 388-835-565, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030], 90-04-074 (Order 2997), § 275-38-960, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.09.120, 88-12-087 (Order 2629), § 275-38-960, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-960, filed 8/3/82.]

Chapter 388-840 WAC

WORK PROGRAMS FOR RESIDENTS OF RESIDENTIAL HABILITATION CENTERS IN THE DIVISION OF DEVELOPMENTAL DISABILITIES

(Formerly chapter 275-41 WAC)

WAC

388-840-005	Purpose.
388-840-010	Definition.
388-840-015	Establishment of new work programs.
388-840-020	Protection of residents.
388-840-025	Compensation for persons participating in work programs.

WAC 388-840-005 Purpose. The regulations provide guidelines for the operation of work programs at residential habilitation centers or for programs contracted on behalf of residents of residential habilitation centers within the division of developmental disabilities as required under RCW 43.20A.445.

[99-19-104, recodified as § 388-840-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-005, filed 8/9/91, effective 9/9/91.]

WAC 388-840-010 Definition. (1) "Compensate" means the resident's receipt of money for work done at a work program.

(2) "Department" means the Washington state department of social and health services.

(3) "Division" means the developmental disabilities division of the department of social and health services.

(4) "Prevailing wage" means the amount paid to a non-disabled worker in a nearby industry or surrounding community for essentially the same type, quality, and quantity of work or work requiring comparable skills.

(5) "Residential habilitation center (RHC)" means a residential habilitation center operated by the developmental disabilities division.

(6) "Work program" means a directed vocational activity or series of related activities provided on a systematic, organized basis for developing and maintaining individual resident work skills, and providing remuneration to resident employees. Work programs must result in:

- (a) Benefit to the economy of the facility; or
- (b) A contribution to the facility's maintenance; or
- (c) Produce articles or services for sale.

[99-19-104, recodified as § 388-840-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-010, filed 8/9/91, effective 9/9/91.]

WAC 388-840-015 Establishment of new work programs. The requirements of RCW 43.20A.445 shall be followed before the department establishes new residential habilitation center work programs.

[99-19-104, recodified as § 388-840-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-015, filed 8/9/91, effective 9/9/91.]

WAC 388-840-020 Protection of residents. (1) When a resident participates in a work program, the resident shall be employed in work and subjected to work conditions where reasonable precautions are taken to ensure the resident's health and safety.

(2) Resident work programs shall be consistent with the resident's individual habilitation plan objectives.

[99-19-104, recodified as § 388-840-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-020, filed 8/9/91, effective 9/9/91.]

WAC 388-840-025 Compensation for persons participating in work programs. (1) The department shall compensate a person participating in a work program at the prevailing minimum wage except when an appropriate certificate has been obtained by the RHC or contract program in accordance with current regulations and guidelines issued under the Fair Labor Standards Act (29 CFR Ch. V, 525 and 529) as amended.

(2) The department shall not be required to compensate a person participating in the shared domiciliary activities of

maintaining the person's own immediate household or residence.

[99-19-104, recodified as § 388-840-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-025, filed 8/9/91, effective 9/9/91.]

Chapter 388-850 WAC

COUNTY PLAN FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES

(Formerly chapter 275-25 WAC)

WAC

388-850-010	Definitions.
388-850-015	Exemptions.
388-850-020	Plan development and submission.
388-850-025	Program operation—General provisions.
388-850-030	Appeal procedure.
388-850-035	Services—Developmental disabilities.
388-850-040	Rights—Health and safety assured.
388-850-045	Funding formula—Developmental disabilities.
388-850-050	Client rights—Notification of client.

WAC 388-850-010 Definitions. (1) All terms used in this chapter not defined herein shall have the same meaning as indicated in the act.

(2) "Act" means local funds for community services chapter 71.20 RCW, State services chapter 71A.12 RCW, and Local services chapter 71A.14 RCW as now existing or hereafter amended.

(3) "County" means each county or two or more counties acting jointly.

(4) "Department" means the department of social and health services.

(5) "Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

(6) "Indian" shall mean any:

(a) Person enrolled in or eligible for enrollment in a recognized Indian tribe; any person determined to be or eligible to be found to be an Indian by the secretary of the interior; and any Eskimo, Aleut or other Alaskan native;

(b) Canadian Indian person who is a member of a treaty tribe, Metis community, or other nonstatus Indian community from Canada;

(c) Unenrolled Indian person considered an Indian by a federally or nonfederally recognized Indian tribe or by an urban Indian/Alaska community organization.

(7) "Plan" means the application a county submits to the secretary for review and approval under the act(s); or revision of an existing plan.

(8) "Population" means the most recent estimate of the aggregate number of persons located in the designated county as computed by the office of financial management.

(9) "Secretary" means the secretary of the department or such employee or such unit of the department as the secretary may designate.

[99-19-104, recodified as § 388-850-010, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 70.96A and 34.05 RCW and P.L. 102-234. 93-15-013 (Order 3591), § 275-25-010, filed 7/8/93, effective 8/8/93. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-010, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-010, filed 1/12/83; Order 1142, § 275-25-010, filed 8/12/76. Formerly chapters 275-12, 275-13 and 275-29 WAC.]

WAC 388-850-015 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 275-25-010(5) provided an:

(a) Assessment of the exemption request ensures granting the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not adversely affect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

[99-19-104, recodified as § 388-850-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030, 91-17-005 (Order 3230), § 275-25-015, filed 8/9/91, effective 9/9/91.]

WAC 388-850-020 Plan development and submission. (1) All dates in this section refer to the twenty-four-month period prior to the start of the state fiscal biennium.

(2) Before July 1, in the odd year of each biennium, the department shall negotiate with and submit to counties the biennial plan guidelines.

(3) Before July 1, the department shall submit to counties needs assessment data, and before December 31, updated needs assessment data in the odd year of each biennium.

(4) Before April 1, of the even year of each biennium, each county shall submit to the department a written plan for developmental disabilities services for the subsequent state fiscal biennium. The county's written plan shall be in the form and manner prescribed by the department in the written guidelines.

(5) Within sixty days of receipt of the county's written plan, the department shall acknowledge receipt, review the plan, and notify the county of errors and omissions in meeting minimum plan requirements.

(6) Within thirty days after receipt, each county shall submit a response to the department's review when errors and omissions have been identified within the review.

(7) Before December 15 of the even year of each biennium, the department shall announce the amount of funds included in the department's biennial budget request to each county. The department shall announce the actual amount of funds appropriated and available to each county as soon as possible after final passage of the Biennial Appropriations Act.

(8) Each county shall submit to the department a contract proposal within sixty days of the announcement by the department of the actual amount of funds appropriated and available.

(9) The department may modify deadlines for submission of county plans and responses to reviews or contract proposals when, in the department's judgment, the modification enables the county to improve the program or planning process.

(10) The department may authorize the county to continue providing services in accordance with the previous plan and contract, and reimburse at the average level of the previous contract, in order to continue services until the new contract is executed.

[99-19-104, recodified as § 388-850-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030 and 71A.16.020, 92-09-115 (Order 3373), § 275-25-020, filed 4/21/92, effective 5/21/92. Statutory Authority: RCW 69.54.040 and 71.24.190, 83-03-011 (Order 1936), § 275-25-020, filed 1/12/83. Statutory Authority: RCW 69.54.040, 78-08-086 (Order 1322), § 275-25-020, filed 7/28/78; Order 1142, § 275-25-020, filed 8/12/76.]

WAC 388-850-025 Program operation—General provisions. (1) The provisions of this section shall apply to all programs operated under authority of the acts.

(2) The county and all contractors and subcontractors must comply with all applicable law or rule governing the department's approval of payment of funds for the programs. Verification may be in the manner and to the extent requested by the secretary.

(3) State funds shall not be paid to a county for costs of services provided by the county or other person or organization who or which was not licensed, certified, and approved as required by law or by rule whether or not the plan was approved by the secretary.

(4) The secretary may impose such reasonable fiscal and program reporting requirements as the secretary deems necessary for effective program management.

(5) Funding.

(a) The department and county shall negotiate and execute a contract before the department provides reimbursement for services under contract, except as provided under WAC 275-25-020(10).

(b) Payments to counties shall be made on the basis of vouchers submitted to the department for costs incurred under the contract. The department shall specify the form and content of the vouchers.

(c) The secretary may make advance payments to counties, where such payments would facilitate sound program management. The secretary shall withhold advance payments from counties failing to meet the requirements of WAC 275-25-020 until such requirements are met. Any county failing to meet the requirements of WAC 275-25-020 after advance payments have been made shall repay said advance payment within thirty days of notice by the department that the county is not in compliance.

(d) If the department receives evidence a county or subcontractor performing under the contract is:

(i) Not in compliance with applicable state law or rule; or

(ii) Not in substantial compliance with the contract; or

(iii) Unable or unwilling to provide such records or data as the secretary may require, then the secretary may withhold all or part of subsequent monthly disbursement to the county until such time as satisfactory evidence of corrective action is forthcoming. Such withholding or denial of funds shall be subject to appeal under the Administrative Procedure Act (chapter 34.05 RCW).

(6) Subcontracting. A county may subcontract for the performance of any of the services specified in the contract. The county's subcontracts shall include:

(a) A precise and definitive work statement including a description of the services provided;

(b) The subcontractor's specific agreement to abide by the acts and the rules;

(c) Specific authority for the secretary and the state auditor to inspect all records and other material the secretary

deems pertinent to the subcontract; and agreements by the subcontractor that such records will be made available for inspection;

(d) Specific authority for the secretary to make periodic inspection of the subcontractor's program or premises in order to evaluate performance under the contract between the department and the county; and

(e) Specific agreement by the subcontractor to provide such program and fiscal data as the secretary may require.

(7) **Records: Maintenance.** Client records shall be maintained for every client for whom services are provided and shall document:

(a) Client demographic data;

(b) Diagnosis or problem statement;

(c) Treatment or service plan; and

(d) Treatment or services provided including medications prescribed.

(8) **Liability.**

(a) The promulgation of these rules or anything contained in these rules shall not be construed as affecting the relative status or civil rights or liabilities between:

(i) The county and community agency; or

(ii) Any other person, partnership, corporation, association, or other organization performing services under a contract or required herein and their employees, persons receiving services, or the public.

(b) The use or implied use herein of the word "duty" or "responsibility" or both shall not import or imply liability other than provided for by the statutes or general laws of the state of Washington, to any person for injuries due to negligence predicated upon failure to perform on the part of an applicant, or a board established under the acts, or an agency, or said agency's employees, or persons performing services on said agency's behalf.

(c) Failure to comply with any compulsory rules shall be cause for the department to refuse to provide the county and community agency funds under the contract.

[99-19-104, recodified as § 388-850-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030, 91-17-005 (Order 3230), § 275-25-030, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 69.54.040 and 71.24.190, 83-03-011 (Order 1936), § 275-25-030, filed 1/12/83; Order 1142, § 275-25-030, filed 8/12/76.]

WAC 388-850-030 Appeal procedure. (1) Any agency making application to participate in a county program operated under authority of the act(s), which is dissatisfied with the disposition of its application, or the community board(s) as defined in the act(s) or the community social services board, which is dissatisfied with any aspect of the plan, may appeal for a hearing before the county governing body. The county governing body shall review the appeal and notify the agency or board of its disposition within thirty days after the appeal has been received.

(2) A county which is dissatisfied with the department's disposition of its plan may request an administrative review.

(3) All requests for administrative reviews shall:

(a) Be made in writing to the appropriate program office within the department;

(b) Specify the date of the decision being appealed;

(c) Specify clearly the issue to be resolved by the review;

(d) Be signed by, and include the address of the county or its representative;

(e) Be made within thirty days of notification of the decision which is being appealed.

(4) An administrative review and redetermination shall be provided by the department within thirty days of the submission of the request for review, with written confirmation of the findings and the reasons for the findings to be forwarded to the county as soon as possible.

(5) Any county dissatisfied with the finding of an administrative review or who chooses not to request an administrative review may initiate proceedings pursuant to the Administrative Procedure Act (chapter 34.05 RCW).

[99-19-104, recodified as § 388-850-030, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 70.96A and 34.05 RCW and P.L. 102-234, 93-15-013 (Order 3591), § 275-25-040, filed 7/8/93, effective 8/8/93; Order 1142, § 275-25-040, filed 8/12/76.]

WAC 388-850-035 Services—Developmental disabilities. (1) A county may purchase and provide services listed under chapter 71A.14 RCW. The department shall pay a county for department authorized services provided to an eligible developmentally disabled person.

(2) A county may purchase or provide authorized services. Authorized services may include, but are not limited to:

(a) Early childhood intervention services;

(b) Employment services;

(c) Community access services;

(d) Residential services;

(e) Individual evaluation;

(f) Program evaluation;

(g) County planning and administration; and

(h) Consultation and staff development.

[99-19-104, recodified as § 388-850-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030, 91-17-005 (Order 3230), § 275-25-520, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850, 82-06-034 (Order 1771), § 275-25-520, filed 3/1/82. Statutory Authority: RCW 71.20.030, 71.20.050, and 71.20.070, 78-04-002 (Order 1278), § 275-25-520, filed 3/2/78; Order 1142, § 275-25-520, filed 8/12/76.]

WAC 388-850-040 Rights—Health and safety assured. A county, when contracting for specific services, must assure that client rights and client health and safety are protected.

[99-19-104, recodified as § 388-850-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850, 82-06-034 (Order 1771), § 275-25-527, filed 3/1/82.]

WAC 388-850-045 Funding formula—Developmental disabilities. (1) For the purposes of this section, "county" shall mean the legal subdivision of the state, regardless of any agreement with another county to provide developmental disabilities services jointly.

(2) The allocation of funds to counties shall be based on the following criteria:

(a) Each county shall receive a base amount of funds. The amount shall be based on the prior biennial allocation, including any funds from budget provisos from the prior

biennium, and subject to the availability of state and federal funds;

(b) The distribution of any additional funds provided by the legislature or other sources shall be based on a distribution formula which best meets the needs of the population to be served as follows:

(i) On a basis which takes into consideration minimum grant amounts, requirements of clients residing in an ICF/MR or clients on one of the division's Title XIX home and community-based waivers, and the general population of the county, and special education enrollment as well as the population eligible for county-funded developmental disabilities services;

(ii) On a basis that takes into consideration the population numbers of minority groups residing within the county;

(iii) A biennial adjustment shall be made after these factors are considered; and

(iv) Counties not receiving any portion of additional funds pursuant to this formula shall not have their base allocation reduced due to application of this formula.

(c) Funding appropriated through legislative proviso, including vendor rate increases, shall be distributed to the population directed by the legislature utilizing a formula as directed by the legislature or using a formula specific to that population or distributed to identified people;

(d) The ability of the community to provide funds for the developmental disability program provided in chapter 71A.14 RCW may be considered with any or all of the above.

(3) A county may utilize seven or less percent of the county's allocated funds for county administrative expenses. A county may utilize more than seven percent for county administration with approval of the division director. A county electing to provide all services directly, in addition to county administration, is exempt from this requirement.

(4) The department may withhold five or less percent of allocated funds for new programs, for state-wide priority programs, and for emergency needs.

[99-19-104, recodified as § 388-850-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.040, 92-13-032 (Order 3404), § 275-25-530, filed 6/10/92, effective 7/11/92. Statutory Authority: RCW 71A.14.030, 91-17-005 and 91-17-025 (Orders 3230 and 3230A), § 275-25-530, filed 8/9/91 and 8/14/91, effective 9/9/91 and 9/14/91. Statutory Authority: RCW 69.54.040 and 71.24.190, 83-03-011 (Order 1936), § 275-25-530, filed 1/12/83; Order 1142, § 275-25-530, filed 8/12/76.]

WAC 388-850-050 Client rights—Notification of client.

(1) All agencies providing services under the act shall post a statement of client rights. Such statement shall inform the client of the client's right to:

- (a) Be treated with dignity;
- (b) Be protected from invasion of privacy;
- (c) Have information about him/her treated confidentially;

(d) Actively participate in the development or modification of his/her treatment program;

(e) Be provided treatment in accordance with accepted quality-of-care standards and which is responsive to his/her best interests and particular needs;

(f) Review his/her treatment records with the therapist at least bimonthly: Provided, That information confidential to other individuals shall not be reviewed by the client;

(g) Be fully informed regarding fees to be charged and methods for payment.

(2) Clients shall be informed of their rights pursuant to WAC 275-55-170 upon admission to inpatient service.

[99-19-104, recodified as § 388-850-050, filed 9/20/99, effective 9/20/99; Order 1142, § 275-25-755, filed 8/12/76.]

Chapter 388-880 WAC

SEXUAL PREDATOR PROGRAM—SPECIAL COMMITMENT—ESCORTED LEAVE

(Formerly chapter 275-155 WAC)

WAC

388-880-005	Special commitment of sexually violent predators—Legal basis.
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WAC 388-880-005 Special commitment of sexually violent predators—Legal basis.

(1) Chapter 71.09 RCW authorizes the department to develop a sexual predator program (SPP) for a person the court determines is a sexually violent predator.

(2) Beginning July 1, 1990, the department's SPP shall provide:

(a) Evaluation of a person court-ordered to the SPP to determine if the person meets the definition of a sexually violent predator under this chapter; and

(b) Control, care, and treatment services to a person court-committed as a sexually violent predator.

[99-21-001, recodified as § 388-880-005, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230, 97-24-054, § 275-155-005, filed 12/1/97, effective 1/1/98. Statutory Authority: 1990 c 3, 90-17-120 (Order 3054), § 275-155-005, filed 8/21/90, effective 9/21/90.]

WAC 388-880-010 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Appropriate facility" means a facility the department uses for evaluating and determining if a person meets the definition of a sexually violent predator as defined in this section.

(2) "Care" means a service the department provides during a person's commitment to the SPP to sustain adequate health, shelter, and physical sustenance.

(3) "Control" means a restraint, restriction, or confinement the department applies protecting a person from endangering self, others, or property during a commitment under this chapter.

(4) "Department" means the department of social and health services.

(5) "Escorted leave" means a leave of absence from a facility housing persons detained or committed under chapter 71.09 RCW under the continuous supervision of an escort.

(6) "Evaluation" means an examination, report, or recommendation a professionally qualified person makes determining if a person meets or continues to meet the definition of a sexually violent predator as defined in this section.

(7) "Immediate family" includes a resident's parents, stepparents, parent surrogates, legal guardians, grandparents, spouse, brothers, sisters, half or stepbrothers or sisters, children, stepchildren, and other dependents.

(8) "Indigent" means a resident who has not been credited with twenty-five dollars or more total from any source for deposit to the resident's trust fund account during the thirty days preceding the request for an escorted leave and has less than a twenty-five dollar balance in his/her trust fund account on the day the escorted leave is requested, and together with his/her requesting immediate family member affirm in writing that they cannot afford to pay the costs of the escorted leave without undue hardship. A declaration of indigency shall be signed by the resident and the resident's requesting immediate family member on forms provided by the department.

(9) "Individual treatment plan (ITP)" means an outline the SPP staff persons develop detailing how control, care, and treatment services are provided to a SPP-committed person.

(10) "Mental abnormality" means a congenital or acquired condition affecting a person's emotional or volitional capacity, including personality disorders, predisposing the person to commit criminal acts of sexual violence placing other persons in danger.

(11) "Predatory" means acts a person directs toward strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization.

(12) "Professionally qualified person" includes:

(a) "Mental health counselor" means a person certified as a mental health counselor under chapter 18.19 RCW;

(b) "Psychiatric nurse" means a person licensed as a registered nurse under chapter 18.88 RCW and having two or more years supervised clinical experience;

(c) "Psychiatrist" means a person licensed as a physician under chapters 18.71 and 18.57 RCW. In addition, the person shall:

(i) Have completed three years of graduate training in a psychiatry program approved by the American Medical Association or the American Osteopathic Association; and

(ii) Be certified, or eligible to be certified, by the American Board of Psychiatry and Neurology;

(d) "Psychologist" means a person licensed as a doctor of psychology under chapter 18.83 RCW; and

(e) "Social worker" means a person certified as a social worker under chapter 18.19 RCW.

(13) "Resident" means a person detained or committed pursuant to chapter 71.09 RCW.

(14) "Secretary" means the secretary of the department of social and health services.

(15) "Secure facility" means a department-operated facility, not located on the grounds of a state mental facility

or residential habilitation center, with the purpose of confining and treating a person committed to the SPP.

(16) "Sexual predator program (SPP)" means a department-administered and operated program established for:

(a) A court-ordered person's evaluation; or

(b) Control, care, and treatment of a court-committed person defined as a sexually violent predator under this chapter.

(17) "Sexually violent offense" means an act defined under chapter 71.09 RCW and for which a person is charged or convicted on, before, or after July 1, 1990.

(18) "Sexually violent predator" means a person defined under chapter 71.09 RCW who has been convicted or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence.

(19) "Superintendent" means the person delegated by the secretary of the department to be responsible for the facility housing persons detained or committed under chapter 71.09 RCW.

[99-21-001, recodified as § 388-880-010, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230, 97-24-054, § 275-155-010, filed 12/1/97, effective 1/1/98. Statutory Authority: 1990 c 3, 90-17-120 (Order 3054), § 275-155-010, filed 8/21/90, effective 9/21/90.]

WAC 388-880-020 Authorization for indefinite commitment to the sexual predator program. The department shall admit a person to the SPP as a sexually violent predator only when all of the following requirements are met:

(1) Petition. The prosecuting attorney or attorney general if requested by the prosecutor files a petition with the superior court in the county where a person was most recently charged or convicted of a sexually violent offense;

(2) Probable cause. A court determines probable cause exists and orders a person transferred to an appropriate facility for evaluation as to whether the person is a sexually violent predator;

(3) Evaluation. A person is evaluated by one or more professionally qualified persons and is found to have:

(a) Been charged with or convicted of a sexually violent offense;

(b) A mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence; and

(c) A sentence or commitment about to expire or having expired.

(4) Trial. A court commences a trial determining if a person is a sexually violent predator within forty-five days of the petition filing date, not including continuances requested by the alleged sexually violent predator; and

(5) Judgment. A court or jury finds a person, beyond a reasonable doubt, to be a sexually violent predator and the person is committed to the department's custody for control, care, and treatment.

[99-21-001, recodified as § 388-880-020, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.030 and 71.09.050, 93-17-027 (Order 3609), § 275-155-020, filed 8/11/93, effective 9/11/93. Statutory Authority: 1990 c 3, 90-17-120 (Order 3054), § 275-155-020, filed 8/21/90, effective 9/21/90.]

WAC 388-880-030 Sexual predator program evaluation—Reporting. (1) When a court orders a person transferred to an appropriate facility for evaluation, the department shall, within forty-five days of the petition filing date, evaluate and provide a recommendation to the court as to whether the person meets the statutory definition of a sexually violent predator under Laws of 1990, chapter 3, section 1002.

(2) Annually or more often, the department shall provide the committing court an evaluation determining if a committed person continues meeting the definition of a sexually violent predator under this chapter.

[99-21-001, recodified as § 388-880-030, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-030, filed 8/21/90, effective 9/21/90.]

WAC 388-880-040 Individual treatment. (1) When the court commits a person to the SPP as a sexually violent predator, SPP staff persons shall develop an individual treatment plan (ITP). The ITP shall include, but not be limited to:

- (a) A description of a person's specific treatment needs;
- (b) An outline of intermediate and long-range treatment goals, with a projected timetable for reaching the goals;
- (c) The treatment strategies for achieving the treatment goals;
- (d) A description of SPP staff persons' responsibility; and
- (e) Criteria for recommending to the court whether a person should be released from the SPP.

(2) The SPP staff persons shall review a committed person's ITP every six months or more often.

[99-21-001, recodified as § 388-880-040, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-040, filed 8/21/90, effective 9/21/90.]

WAC 388-880-050 Rights of a person committed to the sexual predator program. (1) During a person's commitment to the SPP, the department shall apprise the committed person of the person's right to an attorney and to retain a professionally qualified person to perform an evaluation on the committed person's behalf.

(2) Upon request, the department shall provide to the following persons access to a committed person for an evaluation and all records and reports related to the person's commitment, control, care, and treatment:

- (a) The committed person's attorney;
- (b) The committed person's professionally qualified person, if any;
- (c) The prosecuting attorney, or the attorney general, if requested by the prosecuting attorney; and
- (d) The professionally qualified person approved by the prosecuting attorney or the attorney general.

(3) A person the court commits to the SPP shall:

- (a) Receive adequate care and individualized treatment;
- (b) Be permitted to wear the committed person's own clothes and keep and use the person's personal possessions, except when deprivation of possessions is necessary for the person's protection and safety, the protection and safety of others, or the protection of property within the SPP;

(c) Be permitted to accumulate and spend a reasonable amount of money in the person's SPP account;

(d) Have access to reasonable personal storage space within SPP limitations;

(e) Be permitted to have approved visitors within reasonable limitations;

(f) Have reasonable access to a telephone to make and receive confidential calls within SPP limitations; and

(g) Have reasonable access to letter writing material and to:

(i) Receive and send correspondence through the mail within SPP limitations; and

(ii) Send written communication regarding the fact of the person's commitment.

(4) A person the court commits to the SPP shall have the following procedural rights to:

(a) Have reasonable access to an attorney and be informed of the name and address of the person's designated attorney;

(b) Petition the court for release from the SPP; and

(c) Receive annual written notice of the person's right to petition the committing court for release. The department's written notice and waiver shall:

(i) Include the option to voluntarily waive the right to petition the committing court for release; and

(ii) Annually be forwarded to the committing court by the department.

[99-21-001, recodified as § 388-880-050, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.030 and 71.09.050. 93-17-027 (Order 3609), § 275-155-050, filed 8/11/93, effective 9/11/93. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-050, filed 8/21/90, effective 9/21/90.]

WAC 388-880-060 Sexual predator program reimbursement. (1) The department shall obtain reimbursement under RCW 43.20B.330, 43.20B.335, 43.20B.340, 43.20B.345, 43.20B.350, 43.20B.355, 43.20B.360, and 43.20B.370 for the cost of care of a person committed to a SPP to the extent of the person's ability to pay.

(2) The department shall calculate ability to pay and assess liability under chapter 275-16 WAC.

[99-21-001, recodified as § 388-880-060, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-060, filed 8/21/90, effective 9/21/90.]

WAC 388-880-070 Escorted leave—Purpose. The purpose of WAC 275-155-070 through 275-155-140 is:

(1) To set forth the conditions under which residents will be granted leaves of absence;

(2) To provide for safeguards to prevent escape, the obtaining of contraband, and the commission of new crimes, while on leaves of absence; and

(3) To outline the process for the reimbursement of the state by the resident and the resident's family for the costs of the leave of absence.

[99-21-001, recodified as § 388-880-070, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-070, filed 12/1/97, effective 1/1/98.]

WAC 388-880-080 Reasons allowed. An escorted leave of absence may be granted by the superintendent, or designee, subject to the approval of the secretary, to residents to:

(1) Go to the bedside of a member of the resident's immediate family as defined in WAC 275-155-010, who is seriously ill;

(2) Attend the funeral of a member of the resident's immediate family as defined in WAC 275-155-010; and

(3) Receive necessary medical or dental care which is not available in the institution.

[99-21-001, recodified as § 388-880-080, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-080, filed 12/1/97, effective 1/1/98.]

WAC 388-880-090 Conditions. (1) An escorted leave shall be authorized only for trips within the boundaries of the state of Washington.

(2) The duration of an escorted leave to the bedside of a seriously ill member of the resident's immediate family or attendance at a funeral shall not exceed forty-eight hours unless otherwise approved by the superintendent, or designee.

(3) Other than when housed in a city or county jail or state institution the resident shall be in the visual or auditory contact of an approved escort at all times.

(4) The resident shall be housed in a city or county jail or state institution at all times when not in transit or actually engaged in the activity for which the escorted leave was granted.

(5) Unless indigent, the resident and immediate family member shall, in writing, make arrangements to reimburse the state for the cost of the leave prior to the date of the leave.

(6) The superintendent, or designee, shall notify county and city law enforcement agencies with jurisdiction in the area of the resident's destination before allowing any escorted leave of absence.

[99-21-001, recodified as § 388-880-090, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-090, filed 12/1/97, effective 1/1/98.]

WAC 388-880-100 Application requests and approval for escorted leave. The superintendent, or designee, shall establish a policy and procedures governing the method of handling the requests by individual residents. The superintendent, or designee, shall evaluate each leave request and, in writing, approve or deny the request within forty-eight hours of receiving the request based on:

(1) The nature and length of the escorted leave;

(2) The community risk associated with granting the request based on the resident's history of security or escape risk;

(3) The resident's overall history of stability, cooperative or disruptive behavior, and violence or other acting out behavior;

(4) The resident's degree of trustworthiness as demonstrated by his/her performance in unit assignments, security level, and general cooperativeness with facility staff;

(5) The resident's family's level of involvement and commitment to the escorted leave planning process;

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(6) The rehabilitative or treatment benefits which could be gained by the resident; and

(7) Any other information as may be deemed relevant.

The resident's, and family's, ability to reimburse the state for the cost of the escorted leave shall not be a determining factor in approving or denying a request.

[99-21-001, recodified as § 388-880-100, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-100, filed 12/1/97, effective 1/1/98.]

WAC 388-880-110 Escort procedures. (1) Only persons approved by the superintendent, or designee, will be authorized to serve as escorts. All escorts must be employees of either the department of social and health services or the department of corrections and must have attained permanent employee status. At least one of the escorts must be experienced in the escort procedures.

(2) The superintendent, or designee, shall determine the use and type of restraints necessary for each escorted leave on an individual basis.

(3) Escorted leaves supervised by department of corrections staff shall require the approval of the superintendent of the appropriate facility and be done in accordance with established department of corrections procedures. Correctional officers may wear civilian clothing when escorting a resident to a bedside visit or a funeral.

[99-21-001, recodified as § 388-880-110, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-110, filed 12/1/97, effective 1/1/98.]

WAC 388-880-120 Expenses. (1) Staff assigned escort duties shall be authorized per diem reimbursement for meals, lodging, and transportation at the rate established by the state travel policy.

(2) Staff assigned escort duties shall receive appropriate compensation at regular salary or overtime for all hours spent in actual escort of the resident, but not including hours spent sleeping or not engaged in direct supervision of the resident. The salary shall be paid at the appropriate straight time and overtime rates as provided in the merit system rules.

(3) Cost of housing the resident in a city or county jail shall be charged to the resident in accordance with WAC 275-155-130.

[99-21-001, recodified as § 388-880-120, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-120, filed 12/1/97, effective 1/1/98.]

WAC 388-880-130 Expenses—Paid by resident. (1) The expenses of the escorted leave as enumerated in WAC 275-155-120 shall be reimbursed by the resident or his/her immediate family member unless the superintendent, or designee, has authorized payment at state expense in accordance with WAC 275-155-140.

(2) Payments by the resident, or the resident's immediate family member, shall be made to the facility's business office and applied to the appropriate fund as defined by law, applicable provisions of the Washington Administrative Code, or department policy.

[99-21-001, recodified as § 388-880-130, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-130, filed 12/1/97, effective 1/1/98.]

WAC 388-880-140 Expenses—Paid by department. The expenses of the escorted leave shall be absorbed by the state if:

- (1) The resident and his/her immediate family are indigent as defined in WAC 275-155-010; or
- (2) The expenses were incurred to secure medical care.

[99-21-001, recodified as § 388-880-140, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-140, filed 12/1/97, effective 1/1/98.]

Chapter 388-885 WAC

CIVIL COMMITMENT COST REIMBURSEMENT

(Formerly chapter 275-156 WAC)

WAC

388-885-005	Purpose.
388-885-010	Definitions.
388-885-015	Limitation of funds.
388-885-020	Maximum allowable reimbursement for civil commitment cost.
388-885-025	Billing procedure.
388-885-030	Exceptions.
388-885-035	Effective date.
388-885-040	Audits.

WAC 388-885-005 Purpose. These rules establish the standards and procedures for reimbursing counties for the cost incurred during civil commitment trial, annual evaluation, and review processes and release procedures related to chapter 71.09 RCW. The department's reimbursement to counties is limited to appropriated funds.

[99-21-002, recodified as § 388-885-005, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-005, filed 10/8/91, effective 11/8/91.]

WAC 388-885-010 Definitions. (1) "Attorney cost" means the fully documented fee directly related to the violent sexual predator civil commitment process for:

- (a) A single assigned prosecuting attorney;
- (b) When the person is indigent, a single court-appointed attorney; and
- (c) Additional counsel, when additional counsel is approved by the trial judge for good cause. Said fee includes the cost of paralegal services.

(2) "Department" means the department of social and health services.

(3) "Evaluation by expert cost" means a county-incurred service fee directly resulting from the completion of a comprehensive examination and/or a records review, by a single examiner selected by the county, of a person:

- (a) Investigated for "sexually violent predator" probable cause;
- (b) Alleged to be a "sexually violent predator" and who has had a petition filed; or
- (c) Committed as a "sexually violent predator" and under review for release.

In the case where the person is indigent, "evaluation by expert cost" includes the fee for a comprehensive examina-

tion and/or records review by a single examiner selected by the person examined. When additional examiners are approved by the trial judge for good cause, "evaluation by expert cost" includes the cost of additional examiners.

(4) "Incidental cost" means county-incurred efforts or costs that are not otherwise covered and are exclusively attributable to the trial of a person alleged to be a "sexually violent predator."

(5) "Investigative cost" means a cost incurred by a police agency or other investigative agency in the course of investigating issues specific to:

- (a) Filing or responding to a petition alleging a person is a "sexually violent predator;" or
- (b) Testifying at a hearing to determine if a person is a "sexually violent predator."

(6) "Medical cost" means a county-incurred extraordinary medical expense beyond the routine services of a jail.

(7) "Secretary" means the secretary of the department of social and health services.

(8) "Transportation cost" means the cost a county incurs when transporting a person alleged to be, or having been found to be, a "sexually violent predator," to and from a sexual predator program facility.

(9) "Trial cost" means the costs a county incurs as the result of filing a petition for the civil commitment of a person alleged to be a "sexually violent predator" under chapter 71.09 RCW. This cost is limited to fees for:

- (a) Judges, including court clerk and bailiff services;
- (b) Court reporter services;
- (c) Transcript typing and preparation;
- (d) Expert and nonexpert witnesses;
- (e) Jury; and
- (f) Jail facilities.

[99-21-002, recodified as § 388-885-010, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-010, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-010, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-010, filed 10/8/91, effective 11/8/91.]

WAC 388-885-015 Limitation of funds. The department shall:

- (1) Reimburse funds to a county when funds are available;
- (2) Limit a county's reimbursement to costs of civil commitment trials or hearings as described under this chapter;
- (3) Restrict a county's reimbursement to documented investigation, expert evaluation, attorney, transportation, trial, incidental, and medical costs;
- (4) Not pay a county a cost under the rules of this section when said cost is otherwise reimbursable under law;
- (5) Pay a county's claim for a trial or hearing occurring during each biennium in the order in which the claim is received at the office of accounting services, special commitment center, until the department's biennial appropriation is expended.

[99-21-002, recodified as § 388-885-015, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-015, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-015, filed 10/8/91, effective 11/8/91.]

WAC 388-885-020 Maximum allowable reimbursement for civil commitment cost. The department shall reimburse a county for actual costs incurred up to the maximum allowable rate as specified:

(1) Attorney cost - Up to forty-nine dollars and forty-one cents per hour;

(2) Evaluation by expert cost - Actual costs, within reasonable limits, plus travel and per diem according to state travel policy;

(3) Trial costs:

(a) Judge - Up to forty-six dollars and five cents per hour;

(b) Court reporters - Up to twenty dollars and seventy-one cents per hour;

(c) Transcript typing and preparation services - Up to four dollars and thirteen cents per page;

(d) Expert witnesses - Actual costs within reasonable limits plus travel and per diem according to state travel policy;

(e) Nonexpert witnesses - Actual compensation, travel and per diem paid to witnesses, provided compensation is in accordance with chapter 2.40 RCW and state travel policy;

(f) Jurors - Actual compensation, travel, and per diem paid to jurors provided compensation is in accordance with chapter 2.36 RCW and state travel policy;

(g) Jail facilities - Thirty dollars per day.

(4) Investigative cost - Up to twenty dollars and sixty-six cents per hour. Medical costs - Up to fifty dollars per day, not to exceed five consecutive days; and

(5) Transportation cost - Actual compensation paid to transport staff, plus mileage and per diem at the rate specified in the state travel policy.

[99-21-002, recodified as § 388-885-020, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-020, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-020, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-020, filed 10/8/91, effective 11/8/91.]

WAC 388-885-025 Billing procedure. (1) When a county requests the department reimburse a county's cost, the county shall:

(a) Make a claim using the state of Washington invoice voucher, Form A 19 1-A;

(b) Attach to the claim necessary documentation, support, and justification materials;

(c) Report expenses billed by the hour in one-quarter hour increments unless smaller increments are provided to the county by the vendor; and

(d) Include the name of the person for whom the costs were incurred and the cause number when it exists.

(2) The department may subject a county's claim documentation to periodic audit at the department's discretion.

(3) Only an authorized administrator, or the county administrator's designee, may submit to the department a request for a county's cost reimbursement.

(4) A county shall submit a reimbursement claim to the department within thirty days of final costs incurred to assure proper handling of the claim.

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(5) When a county submits a reimbursement claim, the county shall submit a reimbursement claim to the special commitment center, offices of accounting services.

(6) If the department's reimbursement appropriation becomes exhausted before the end of a biennium, a county may continue to make a claim for reimbursement. The department may use the reimbursement claim to justify a request for adequate department funding during future biennia.

[99-21-002, recodified as § 388-885-025, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-025, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-025, filed 10/8/91, effective 11/8/91.]

WAC 388-885-030 Exceptions. (1) The secretary may grant exceptions to the rules of this chapter.

(2) A county seeking an exception shall request the exception, in writing from the secretary or secretary's designee.

(3) The department shall deny a claim which does not follow the rules of this chapter unless the secretary or secretary's designee granted an exception before the claim was filed.

[99-21-002, recodified as § 388-885-030, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-030, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-030, filed 10/8/91, effective 11/8/91.]

WAC 388-885-035 Effective date. When a county submits a reimbursement claim according to this chapter, the claim shall be only for costs incurred as defined in this chapter, on or after July 1, 1990.

[99-21-002, recodified as § 388-885-035, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-035, filed 10/8/91, effective 11/8/91.]

WAC 388-885-040 Audits. The department may audit county reimbursement claims at the department's discretion.

[99-21-002, recodified as § 388-885-040, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-040, filed 10/8/91, effective 11/8/91.]

Chapter 388-890 WAC

REHABILITATION SERVICES FOR INDIVIDUALS WITH DISABILITIES

(Formerly chapter 490-500 WAC (part))

WAC

388-890-0005	What is the purpose of this chapter?
388-890-0010	What definitions apply to this chapter?
388-890-0015	What is informed choice?
388-890-0020	How does DVR support the informed choice process?
388-890-0025	What decisions can I make using informed choice?
388-890-0030	What if I don't know how to use the informed choice decision making process?
388-890-0035	Who is eligible to receive VR services?
388-890-0040	How does DVR determine whether VR services will enable me to work?
388-890-0045	Am I eligible for VR services if I receive Social Security disability benefits?
388-890-0050	What criteria are not considered in the eligibility decision?

388-890-0055	What information does DVR use to make an eligibility decision?	388-890-0305	What are post-employment services?
388-890-0060	After I submit my application to DVR, how long does it take DVR to make an eligibility decision?	388-890-0310	Under what conditions does DVR provide post-employment services?
388-890-0065	What happens if DVR determines that I am not eligible?	388-890-0315	What are reader services?
388-890-0070	If I am not eligible for DVR services, can DVR help me find other services and programs to meet my needs?	388-890-0320	Under what conditions does DVR provide reader services?
388-890-0071	If I am eligible for or ineligible for VR services, how will I be notified?	388-890-0325	What are referral services?
388-890-0075	Who can apply for vocational rehabilitation services?	388-890-0330	Under what conditions does DVR provide referral services?
388-890-0080	Can I receive VR services if I am not a United States citizen?	388-890-0335	What is rehabilitation engineering?
388-890-0085	Am I required to provide proof of my identity and work status?	388-890-0340	Under what conditions does DVR provide rehabilitation engineering?
388-890-0090	If I don't live in Washington, can I receive VR or IL program services?	388-890-0345	What are self-employment services?
388-890-0095	Can I receive VR services if I am legally blind?	388-890-0350	Under what conditions does DVR provide self-employment services and issue items for self-employment?
388-890-0100	Can I receive VR or IL program services if I am Native American?	388-890-0355	What are services to family members?
388-890-0105	How do I apply for VR services?	388-890-0360	Under what conditions does DVR provide services to my family members?
388-890-0110	Under what general conditions does DVR provide vocational rehabilitation services to individuals?	388-890-0365	What are supported employment services?
388-890-0115	Can I ask for an exception to a rule or a condition relating to VR services?	388-890-0370	What are tools, equipment, initial stocks and supplies?
388-890-0120	How do I ask for an exception to a rule or condition in this chapter?	388-890-0375	Under what conditions does DVR provide and issue tools, equipment, initial stocks and supplies?
388-890-0125	What happens if the service I want exceeds what I need or is more expensive than a similar service?	388-890-0380	What are training services?
388-890-0130	Can a guardian or another representative act on my behalf?	388-890-0385	What is on-the-job training?
388-890-0135	What is the purpose of vocational rehabilitation (VR) services?	388-890-0390	Under what conditions does DVR provide on-the-job training?
388-890-0140	How do I know which VR services are right for me?	388-890-0395	Under what conditions does DVR provide training services and issue items for training?
388-890-0145	What vocational rehabilitation services are available to individuals from DVR?	388-890-0400	Do I have to apply for a student loan to pay for training services?
388-890-0150	What are assessment services?	388-890-0405	Can I receive training services from a private school, an out-of-state training agency or an out-of-state college?
388-890-0155	To determine whether I am eligible for VR services, who decides what assessment services I need and where to get the assessment services?	388-890-0410	What are transition services?
388-890-0160	If I need assessment services to help me choose an employment goal and what VR services I need, who decides what assessment services I need and where to get the assessment services?	388-890-0415	Under what conditions does DVR provide transition services?
388-890-0165	What if I already have assessment information to help me and DVR make the decisions we need to make?	388-890-0420	How does DVR coordinate with public high schools to provide transition services?
388-890-0170	How do I provide needed assessment information to DVR?	388-890-0425	How does DVR help me plan transition services?
388-890-0175	What is an assistive technology device?	388-890-0430	Who decides what transition services I get from DVR?
388-890-0180	Under what conditions does DVR provide and issue assistive technology devices?	388-890-0435	What activities does DVR support after I leave high school?
388-890-0185	Under what conditions does DVR provide vehicle modifications?	388-890-0440	What are transportation services?
388-890-0190	What are assistive technology services?	388-890-0445	Under what conditions does DVR provide transportation services?
388-890-0195	Under what conditions does DVR provide assistive technology services?	388-890-0450	Under what conditions does DVR provide and issue a vehicle?
388-890-0200	What are counseling and guidance services?	388-890-0455	Under what conditions does DVR issue a device, tool, piece of equipment or other item I need to participate in VR services or to get a job?
388-890-0210	Under what conditions does DVR provide counseling and guidance services?	388-890-0460	What conditions apply to the use of a device, tool, piece of equipment or other item that is issued to me?
388-890-0220	What are independent living services?	388-890-0465	What types of devices, tools, pieces of equipment or other items can DVR issue to me?
388-890-0225	Under what conditions does DVR provide independent living services?	388-890-0470	Does DVR issue new or used devices, tools, pieces of equipment, or other items?
388-890-0230	What are interpreter services?	388-890-0475	What happens if I fail to return a device, tool, piece of equipment or other item if requested by DVR?
388-890-0235	Under what conditions can I receive interpreter services?	388-890-0480	What happens to a device, tool, piece of equipment or other item if I need it when my DVR case service record is closed?
388-890-0240	What are job placement and job retention services?	388-890-0485	What is an individualized plan for employment (IPE)?
388-890-0245	Under what conditions can I receive job placement and job retention services?	388-890-0490	How do I develop an IPE?
388-890-0250	What are maintenance services?	388-890-0495	What information does DVR give me to develop my IPE?
388-890-0255	Under what conditions does DVR provide maintenance services?	388-890-0500	Who makes decisions about what to include on my IPE?
388-890-0260	What are occupational licenses?	388-890-0505	Can I include any VR services I want on my IPE?
388-890-0265	Under what conditions can I get an occupational license?	388-890-0510	What if the employment goal I choose is religious in nature?
388-890-0270	What other goods and services does DVR provide?	388-890-0515	What must be included on my IPE?
388-890-0275	Under what conditions does DVR provide and issue other goods and services?	388-890-0520	Who signs the IPE?
388-890-0280	What are personal assistance services?	388-890-0525	Is the IPE reviewed and updated?
388-890-0285	Under what conditions does DVR provide or pay for personal assistance services?	388-890-0530	Why does DVR close a case service record?
388-890-0290	What are the physical and mental restoration services DVR provides?	388-890-0535	Under what conditions does DVR determine that I am working and no longer need VR services?
388-890-0295	Under what conditions does DVR provide physical and mental restoration services?	388-890-0540	Am I involved in the decision to close my case?
388-890-0300	What are the medical treatments DVR does not pay for?	388-890-0545	What is competitive employment?
		388-890-0550	What is extended employment?
		388-890-0555	If the job I get is in extended employment, what follow-up does DVR provide?
		388-890-0560	Under what conditions does DVR follow up with me if I am determined ineligible for VR services?
		388-890-0570	What is supported employment?
		388-890-0575	Who is eligible for supported employment?

388-890-0580	Who decides if I am eligible for supported employment?	388-890-0840	Under what conditions can I get IL program services?
388-890-0585	What is competitive work in supported employment?	388-890-0845	How are my IL program services planned?
388-890-0590	What is an integrated setting in supported employment?	388-890-0850	What is included on a written or verbal IL plan?
388-890-0595	Is my work setting integrated if my interactions at the work site are with nondisabled supported employment service providers?	388-890-0855	Who signs and keeps a written IL plan?
388-890-0600	What is transitional employment?	388-890-0860	How often is my IL plan reviewed?
388-890-0605	What are supported employment services?	388-890-0870	What are IL advocacy services?
388-890-0610	What are ongoing support services?	388-890-0875	What are IL rehabilitation technology services?
388-890-0615	Under what conditions does DVR provide supported employment services?	388-890-0880	What are IL communication services?
388-890-0620	What is included on my individualized plan for supported employment?	388-890-0885	What are IL counseling services?
388-890-0625	What are extended services?	388-890-0890	What are IL housing services?
388-890-0630	Does DVR provide extended services?	388-890-0895	Are IL program payments for home modifications limited?
388-890-0635	Who provides the extended services I need?	388-890-1000	What is IL skills training?
388-890-0640	What is natural support?	388-890-1005	What are IL information and referral services?
388-890-0645	Are supported employment services time-limited?	388-890-1010	What is IL peer counseling?
388-890-0650	What is required for me to change from supported employment services to extended services?	388-890-1015	What is IL mobility training?
388-890-0655	What happens if my VR counselor and I do not find a source for extended services and/or we cannot establish natural supports during the initial eighteen months of my individualized plan for employment?	388-890-1020	What is IL personal assistance training?
388-890-0660	Under what conditions does DVR close my case service record for supported employment?	388-890-1025	Does the IL program pay for attendant services as part of personal assistance training?
388-890-0665	Under what conditions does DVR provide supported employment services as post-employment services?	388-890-1030	What are IL physical rehabilitation services?
388-890-0670	What is a trial work experience?	388-890-1035	What are IL preventative services?
388-890-0675	What happens during a trial work experience?	388-890-1040	What are IL recreational services?
388-890-0680	Who decides if a trial work experience is needed to determine if I am eligible for DVR services?	388-890-1045	What are IL program services to family members?
388-890-0685	What services does DVR provide during a trial work experience?	388-890-1050	What are IL therapeutic services?
388-890-0690	What if I am too significantly disabled to participate in a trial work experience?	388-890-1055	What are IL transportation services?
388-890-0695	What choices can I make about the trial work experience?	388-890-1060	What other services does the IL program offer?
388-890-0700	Am I evaluated during the trial work experience?	388-890-1065	How long can I receive independent living services?
388-890-0705	When does DVR make an eligibility decision when I am in a trial work experience?	388-890-1070	Why does the IL program stop providing or paying for IL program services?
388-890-0710	Are there any vocational rehabilitation services that can be provided to a group of individuals with disabilities?	388-890-1075	Am I involved in the decision to stop receiving IL program services?
388-890-0715	Under what conditions does DVR provide services to a group of individuals with disabilities to establish, develop or improve a community rehabilitation program?	388-890-1080	How does the IL program notify me that my services are stopping?
388-890-0720	Under what conditions does DVR provide services to a group of individuals with disabilities that cannot be purchased under an individual IPE?	388-890-1085	If the IL program decides I am not eligible for IL program services, is the decision reviewed?
388-890-0725	Under what conditions does DVR provide consulting and/or technical assistance to plan for the transition of students with disabilities?	388-890-1090	Does the IL program keep a record of my IL program services?
388-890-0730	What if DVR does not have funding to serve all eligible individuals?	388-890-1095	Does the IL program keep personal information confidential?
388-890-0745	If DVR has to decide in what category to place me, who decides what assessment services I need and where to get the assessment services?	388-890-1100	How are costs for VR and IL program services paid?
388-890-0750	What categories are used by DVR to determine the priority by which eligible individuals are served and in what order are the categories prioritized?	388-890-1110	What are comparable services and benefits?
388-890-0755	What information does DVR use to determine whether I am in category one?	388-890-1115	What VR or IL program services are provided without a determination of comparable services or benefits?
388-890-0760	What information does DVR use to determine whether I am in category two?	388-890-1120	What if determining the availability of comparable services and benefits would result in a delay or interrupt my progress?
388-890-0765	What information does DVR use to determine whether I am in category three?	388-890-1125	What is extreme medical risk?
388-890-0780	What is the independent living (IL) program?	388-890-1130	Does DVR pay for a service if comparable services and benefits are available, but I don't want to use them?
388-890-0785	What types of services does the IL program offer?	388-890-1135	Are awards and scholarships based on merit considered comparable services and benefits?
388-890-0790	Who is eligible for Title VII IL program services?	388-890-1140	How do I get comparable services and benefits?
388-890-0795	What is a significant disability?	388-890-1145	How does DVR determine whether I pay for all or part of my VR or IL services using my own financial resources?
388-890-0800	Who provides IL program services?	388-890-1150	Do I have to report my financial status if I receive public assistance or income support from another public program?
388-890-0805	What are my responsibilities in the IL program?	388-890-1155	What financial information does DVR use to decide if I need to help pay for VR services?
388-890-0810	How do I apply for IL program services?	388-890-1160	Are any of my resources not counted in the decision about whether I have to help pay for services?
388-890-0815	What happens after I submit my application for IL program services?	388-890-1165	How does DVR decide whether I have resources to help pay for VR services?
388-890-0820	Who decides if I am eligible for IL program services?	388-890-1170	How is the amount I pay for VR or IL program services determined?
388-890-0825	Where does the IL program get the information needed to decide if I am eligible?	388-890-1175	What VR or IL program services am I not required to help pay for?
388-890-0830	How do I find out if I am eligible for IL program services?	388-890-1180	What if a VR counselor makes a decision about my VR services that I don't agree with?
388-890-0835	What if I disagree with a decision about my eligibility for IL or a decision about IL program services?	388-890-1185	What is the client assistance program (CAP)?
		388-890-1190	What is mediation?
		388-890-1195	When can I ask for mediation?
		388-890-1200	Who arranges and pays for mediation?
		388-890-1205	Is information discussed during mediation confidential?
		388-890-1210	How do I request mediation?
		388-890-1215	After the mediation session, do I receive a written statement of the results?
		388-890-1220	What is a formal hearing?
		388-890-1225	When is a formal hearing available?
		388-890-1230	How do I request a formal hearing?
		388-890-1235	After I submit a request for a formal hearing, when is it held?
		388-890-1240	Do I receive a written formal hearing decision?

388-890-1245	Is the decision after a formal hearing final?
388-890-1250	Can DVR suspend, reduce or terminate my services while waiting for a formal hearing decision?
388-890-1255	How do I know what personal information I must give DVR and how it is used?
388-890-1260	Does DVR keep a record of my VR services on file?
388-890-1265	Under what conditions does DVR share personal information in my record with another service provider or organization?
388-890-1270	When DVR gets personal information about me from another agency or service provider, is it kept confidential?
388-890-1275	Does DVR change incorrect information in my record?
388-890-1280	How do I receive copies of information from my DVR record?
388-890-1285	Can DVR release personal information without my written consent?
388-890-1290	Under what conditions does DVR release personal information for audit, evaluation or research?
388-890-1295	How does DVR protect personal information about drug, alcohol, HIV/AIDS and sexually transmitted diseases?
388-890-1300	How do I contact DVR if I don't speak English?
388-890-1305	What other methods of communication does DVR use?
388-890-1310	When does DVR communicate with me using methods other than English?

WAC 388-890-0005 What is the purpose of this chapter? This chapter explains the types of vocational rehabilitation services (referred to as "VR services" in this chapter) and independent living (IL) services available to individuals who are eligible through the department of social and health services (DSHS), division of vocational rehabilitation (DVR).

VR services are offered to assist individuals with disabilities to prepare for, get and keep jobs that are consistent with their abilities, capabilities, and interests. This chapter is consistent with the laws included under the Rehabilitation Act of 1973, as amended by the Rehabilitation Act Amendments of 1998 and codified in 34 Code of Federal Regulations, Parts 361, 363 and 364.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0005, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0010 What definitions apply to this chapter? **Client assistance program** is a program that offers free advice and information about your rights when you are receiving services from DVR.

"DSHS" means the Washington state department of social and health services.

"DVR" means the DSHS division of vocational rehabilitation.

"Family member" means a person:

- (1) Who is your relative or legal guardian or someone who lives in the same household as you; and
- (2) Who has a substantial interest in your well-being.

"IL counselor" means an independent living counselor employed by the DSHS division of vocational rehabilitation.

"Impediment to employment" means the physical or mental limitations resulting from a disability that hinder your ability to prepare for a job, find a job, or keep a job that matches your abilities and potential.

"Integrated setting":

(1) for the purpose of receiving services, means a setting commonly found in the community where you would interact with nondisabled people, other than people who are providing VR services to you.

(2) for the purpose of employment, means a setting commonly found in the community in which you interact with nondisabled people to the same extent that a nondisabled person in the same type of job interacts with others.

"VR counselor" means a vocational rehabilitation counselor employed by the DSHS division of vocational rehabilitation.

"You," as used in this chapter, includes your representative or guardian, if a representative or guardian is acting on your behalf or assisting you to make informed decisions about VR or IL program services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0010, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0015 What is informed choice? Informed choice is a way to make reasonable decisions by comparing the meaningful options available to you and choosing one that matches your strengths, needs, capabilities and interests.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0015, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0020 How does DVR support the informed choice process? DVR supports the informed choice process by:

- (1) Helping you understand the options available to you;
- (2) Sharing information to help you make decisions that match your strengths, needs, capabilities, and interests; and
- (3) Discussing the information provided and offering advice.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0020, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0025 What decisions can I make using informed choice? (1) You have the right to make informed choices throughout the rehabilitation process.

- (2) Your informed choices include, but are not limited to:
 - (a) Your employment goal;
 - (b) VR services you need to reach your employment goal;
 - (c) Service provider(s) for each VR service;
 - (d) Whether to get services in an integrated or nonintegrated setting;
 - (e) Using DVR's purchasing methods if DVR is responsible to pay for services or using your choice of purchasing methods for services you agree to pay for.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0025, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0030 What if I don't know how to use the informed choice decision making process? DVR explains to you how to make informed choices in the vocational rehabilitation process, including:

- (1) Any conditions that limit your choices; and

(2) Support and assistance if the type of disability you have makes it difficult for you to understand and use informed choice to make decisions.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0030, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0035 Who is eligible to receive VR services? You are eligible for VR services if you meet all of the following conditions:

(1) You have a physical, mental, or sensory limitation resulting from a disability that hinders your ability to prepare for, get, or keep a job that matches your abilities and potential;

(2) You intend to and can work after receiving VR services; and

(3) You require VR services to prepare for, get or keep a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0035, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0040 How does DVR determine whether VR services will enable me to work? (1) In making an eligibility decision, DVR presumes that VR services will enable you to work, unless, because of the significance of your disability, a VR counselor cannot make such a presumption.

(2) If the significance of your disability prevents a VR counselor from presuming that VR services will enable you to work, you may complete a trial work experience as outlined under WAC 388-890-0670 through 388-890-0705 in order for the counselor to make an eligibility decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0040, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0045 Am I eligible for VR services if I receive Social Security disability benefits? (1) If you receive disability benefits under Title II or Title XVI of the Social Security Act and intend to work, DVR presumes that you are eligible, unless, because of the significance of your disability, a VR counselor cannot presume that VR services will enable you to work.

(2) If the significance of your disability prevents a VR counselor from presuming that VR services will enable you to work, you may complete a trial work experience as outlined in WAC 388-890-0670 through 388-890-0705 in order for the counselor to make an eligibility decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0045, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0050 What criteria are not considered in the eligibility decision? DVR does not base an eligibility decision on your:

(1) Type of disability;

(2) Age, gender, race, color, creed, national origin, or sexual orientation;

(3) Rehabilitation needs;

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(4) Cost of services; or

(5) Income level.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0050, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0055 What information does DVR use to make an eligibility decision? (1) To determine whether you are eligible for VR services, a VR counselor reviews existing records about the current status of your disability.

(2) Information may be provided to DVR by you, your family, or other service providers who have information about your disability, such as your doctor, schools you attended, or the Social Security Administration.

(3) If existing information does not verify whether you are eligible, DVR explains what additional information is needed and the options for getting the information.

(4) DVR provides or pays for medical evaluations, tests, assistive technology services, technology devices, or other services needed to document that you are eligible for VR services.

(5) When enough information is available, a VR counselor reviews the information and makes an eligibility decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0055, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0060 After I submit my application to DVR, how long does it take DVR to make an eligibility decision? DVR makes an eligibility decision as soon as enough information is available, but no longer than sixty days after you complete the application requirements under WAC 388-890-0105.

(1) If DVR does not have enough information to determine your eligibility within sixty days, you and a VR counselor must:

(a) Discuss the reason for the delay and whether other methods to get the information are needed;

(b) Agree to extend the eligibility period, if you agree; or

(c) If the significance of your disability prevents a VR counselor from presuming that VR services will enable you to work, you may complete a trial work experience as outlined under WAC 388-890-0670 through 388-890-0705 in order for the counselor to make an eligibility decision.

(2) If you do not agree to extend the eligibility determination period, DVR must close your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0060, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0065 What happens if DVR determines that I am not eligible? (1) Before making a decision that you are not eligible for VR services, a VR counselor consults with you and gives you an opportunity to discuss the decision.

(2) DVR sends you a notice of ineligibility in writing, or using another method of communication, if needed. The written notice includes:

(a) An explanation of the reasons you are not eligible;

(b) Your rights to appeal the decision as outlined under WAC 388-890-1180; and

(c) An explanation of the services available from the client assistance program as outlined in WAC 388-890-1185.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0065, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0070 If I am not eligible for DVR services, can DVR help me find other services and programs to meet my needs? If DVR determines that you are not eligible for DVR services, DVR provides you with information and refers you to other agencies or organizations that may provide services to meet your needs.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0070, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0071 If I am eligible for or ineligible for VR services, how will I be notified? A VR counselor sends you written explanation of your eligibility or ineligibility for VR services that includes a description of the client assistance program (CAP) and how to contact CAP.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0071, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0075 Who can apply for vocational rehabilitation services? Any individual has the right to apply for VR services, including individuals who:

- (1) Applied before, were determined eligible and received VR services; or
- (2) Were previously determined ineligible or were denied VR services for other reasons.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0075, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0080 Can I receive VR services if I am not a United States citizen? DVR serves individuals who are legally eligible to work in the United States.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0080, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0085 Am I required to provide proof of my identity and work status? If you apply for VR services, you must provide copies of legal documents requested by DVR that verify your identity and that verify you can legally work in the United States before DVR can offer you VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0085, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0090 If I don't live in Washington, can I receive VR or IL program services? (1) The state in which you live has the primary responsibility to provide VR services to you.

(2) You may receive services from DVR if you are present or intend to be present in Washington in a way that you would be counted for census purposes, including but not limited to:

- (a) You pay income taxes;
- (b) You maintain a home; or
- (c) You are registered to vote.

(3) To receive IL program services, you must be able to receive the services in a DVR region where IL program services are offered.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0090, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0095 Can I receive VR services if I am legally blind? The Washington state department of services for the blind, under an agreement with DVR, is the primary agency to provide vocational rehabilitation services to individuals who are blind or have a visual impairment resulting in an impediment to employment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0095, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0100 Can I receive VR or IL program services if I am Native American? DVR serves eligible Native Americans, including Native Americans who belong to an Indian tribe. If you live on an Indian reservation that operates a vocational rehabilitation program, you may apply for VR services from the tribe or from DVR.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0100, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0105 How do I apply for VR services? To complete the application process:

(1) Sign an application form provided by DVR or provide a written request that includes the following information:

- (a) Your name and address;
- (b) The nature of your disability;
- (c) Your age and gender;
- (d) The date of application; and
- (e) Your Social Security Number (optional).

(2) Meet with a DVR representative to:

- (a) Learn about VR services and processes;
- (b) Provide information needed to begin an assessment of your eligibility and VR service needs; and

(c) Make sure you are available to complete the assessment process for determining if you are eligible for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0105, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0110 Under what general conditions does DVR provide vocational rehabilitation services to individuals? (1) DVR provides VR services to individuals under the following general conditions.

- (a) The services are needed to:

- (i) Get and/or keep a job or advance in employment;
- (ii) Determine your eligibility for services;
- (iii) Identify your vocational rehabilitation needs; or
- (iv) Develop or complete your individual plan for employment (IPE).

(b) You have an open case service record and DVR authorizes the services before the services begin;

(c) The services are provided directly by a VR counselor or purchased by DVR from a service provider who meets local, state and/or national standards required to practice in the field and/or do business in the state;

(d) The services are provided in accordance with payment for services requirements under WAC 388-890-1100 through 388-890-1175; and

(e) The services are consistent with your informed choice, including whether to receive services in an integrated or nonintegrated setting.

(2) Unique or additional conditions that apply to a specific service are outlined under WAC 388-890-0150 to 388-890-0450.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0110, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0115 Can I ask for an exception to a rule or a condition relating to VR services? You or a VR counselor may request an exception to any rule or condition relating to VR services in this chapter if the exception is needed to:

- (1) Complete an assessment to determine eligibility;
- (2) Identify the VR services you need; or
- (3) Achieve your employment goal.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0115, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0120 How do I ask for an exception to a rule or condition in this chapter? (1) A request for exception to a rule or condition in this chapter is submitted to the regional administrator in writing, and must include:

- (a) A description of the exception being requested;
- (b) The reason for the exception; and
- (c) The duration of the exception, if applicable.

(2) An exception requesting a medical service that is otherwise not provided by DVR may only be requested on a trial basis or for a short duration to be specified in the request.

(3) After getting your request for an exception, the regional administrator considers:

- (a) The impact of the exception on accountability, efficiency, choice, satisfaction, and quality of services;
- (b) The degree to which your request varies from the rule or condition; and
- (c) Whether the rule or condition is a federal rule or regulation that cannot be waived.

(4) The regional administrator responds to the request for an exception within ten working days of receipt of the request.

(a) If the request is approved, the regional administrator will provide a written approval that includes:

- (i) The specific WAC for which an exception is approved;
- (ii) Any conditions of approval; and
- (iii) Duration of the exception.

(b) If the request is denied, the regional administrator will provide a written explanation of the reasons for the denial.

(5) If the regional administrator makes a decision that you do not agree with, you have the right to appeal the decision as outlined under WAC 388-890-1180.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0120, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0125 What happens if the service I want exceeds what I need or is more expensive than a similar service? (1) DVR pays for services at the level required to meet your needs at the lowest cost possible.

(2) You may select the following service providers without regard to the fees charged:

- (a) Assistive technology service providers;
- (b) Community rehabilitation program service providers; and
- (c) Independent living service providers.

(3) If you and a VR counselor cannot agree on the type or level of services you need, you may ask for a review of the decision as outlined under WAC 388-890-1180.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0125, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0130 Can a guardian or another representative act on my behalf? (1) You may select another person as your representative during the VR or IL program.

(2) If you have a legal guardian or a court-appointed representative, he or she must act as your representative.

(a) A legal guardian or court-appointed representative must provide DVR with documentation of guardianship.

(b) Your legal guardian or court-appointed representative must sign the application and other documents that require your signature.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0130, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0135 What is the purpose of vocational rehabilitation (VR) services? VR services are services provided to you to meet your specific needs to prepare for, get, and keep a job, or to advance in employment if you are working. Vocational rehabilitation services include services listed in WAC 388-890-0145.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0135, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0140 How do I know which VR services are right for me? DVR explains how the different VR services are used and gives you the information and support you need to make decisions about the services you need.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0140, filed 8/27/99, effective 11/1/99.]

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0140, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0145 What vocational rehabilitation services are available to individuals from DVR? The following VR services are available to individuals from DVR:

- (1) Assessment services;
- (2) Assistive technology devices;
- (3) Assistive technology services;
- (4) Counseling and guidance services;
- (5) Independent living services;
- (6) Interpreter services;
- (7) Job placement and job retention services;
- (8) Maintenance services;
- (9) Occupational licenses;
- (10) Other goods and services;
- (11) Personal assistance services;
- (12) Physical and mental restoration services;
- (13) Post-employment services;
- (14) Reader services;
- (15) Referral services;
- (16) Rehabilitation engineering services;
- (17) Self-employment services;
- (18) Services to family members;
- (19) Supported employment services;
- (20) Tools, equipment, initial stocks, and supplies;
- (21) Training services;
- (22) Transition services; and
- (23) Transportation services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0145, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0150 What are assessment services?

(1) Assessment services are used to collect information about you:

- (a) Disability and how it keeps you from working;
- (b) Strengths;
- (c) Resources;
- (d) Priorities;
- (e) Concerns,
- (f) Abilities;
- (g) Capabilities;
- (h) Interests; and
- (i) Needs, including your need for supported employment.

(2) Assessment services include the VR services listed under WAC 388-890-0145.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0150, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0155 To determine whether I am eligible for VR services, who decides what assessment services I need and where to get the assessment services? If enough information is not available to determine whether you are eligible for VR services:

(1) DVR decides what assessment services are needed; and

(2) You use informed choice to choose service providers for assessment services you need.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0155, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0160 If I need assessment services to help me choose an employment goal and what VR services I need, who decides what assessment services I need and where to get the assessment services? If you need assessment services to determine your vocational rehabilitation needs or to develop your individualized plan for employment (IPE), you use informed choice to select the:

- (1) Assessment services; and
- (2) Service providers.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0160, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0165 What if I already have assessment information to help me and DVR make the decisions we need to make? No assessment services are needed if the information you already have is complete and current enough:

(1) For a VR counselor to make a decision about your eligibility; and

(2) To help you make decisions about your vocational rehabilitation needs and the VR services you need on your IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0165, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0170 How do I provide needed assessment information to DVR? You may give information needed for an assessment directly to DVR or you may give written consent to DVR to get the information from other sources including, but not limited to:

- (1) Doctors or other medical service providers;
- (2) Community programs or organizations that have provided services to you;
- (3) Schools you attended.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0170, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0175 What is an assistive technology device? An assistive technology device is any item, piece of equipment or product, either commercially available or custom-designed that is used to increase, maintain or improve your functional capacities. Assistive technology devices include, but are not limited to:

- (1) Telecommunications devices;
- (2) Sensory aids and devices including hearing aids, telephone amplifiers and other hearing devices, real time captioning, captioned videos, taped text;
- (3) Eyeglasses, contact lenses, microscopic lenses, Brailled and large print materials; electronic formats; graphics and other special visual aids;
- (4) Simple language materials;

- (5) Vehicle modifications;
- (6) Computer and computer-related hardware and software;
- (7) Other technological aids and devices.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0175, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0180 Under what conditions does DVR provide and issue assistive technology devices? (1) DVR provides assistive technology devices to you under conditions specified in WAC 388-890-0110.

(2) DVR issues assistive technology devices to you under conditions specified in WAC 388-890-0455 through 388-890-0480.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0180, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0185 Under what conditions does DVR provide vehicle modifications? DVR provides vehicle modifications to you under conditions specified in WAC 388-890-0110, and:

(1) If a used vehicle is to be modified, an inspection from a certified or journey level auto mechanic must be performed and documented to ensure the vehicle is in good condition and capable of being modified.

(2) You, your spouse, or other family member is the registered and/or legal owner of the vehicle.

(3) You agree to pay for and have driver insurance and vehicle insurance adequate to cover the cost of replacement for loss or damage at the time of modification.

(4) A specialist in evaluation and modification of vehicles for individuals with disabilities prescribes and inspects the modification, except prescriptions are not required for:

- (a) Placement of a wheelchair lift, ramp, or scooter lift and tie downs for passenger access only;
- (b) Replacement of hand controls;
- (c) Wheelchair carriers; and
- (d) Other minor driving aids.

(5) If you operate the vehicle:

(a) Your disability must be stable or slowly progressive and not likely to impair your driving ability in the future.

(b) You agree to pay for and have a current driver's license and vehicle license with required endorsements.

(c) Following modification, you are adequately trained to operate the vehicle as modified.

(d) You demonstrate that you can safely operate the vehicle as modified.

(6) If someone else operates the vehicle for you, you agree to pay for and have a current vehicle license with required endorsements.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0185, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0190 What are assistive technology services? Assistive technology services help you to select, get or use an assistive technology device. Assistive technology services include, but are not limited to services that:

(1) Evaluate your needs and how you perform activities in your daily environment;

(2) Select, design, fit, customize, adapt, apply, maintain, repair, or replace an assistive technology device;

(3) Coordinate and use other therapies or services that have assistive technology devices such as existing education and rehabilitation plans and programs;

(4) Train or give technical assistance on the use of assistive technology to you or your family members, guardians, advocates or authorized representatives;

(5) Train or give technical assistance to professionals, employers, or others who provide services to you, hire you, or are involved in your major life activities if they need training on the use of assistive technology to help you get or keep a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0190, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0195 Under what conditions does DVR provide assistive technology services? DVR provides assistive technology services under the conditions outlined in WAC 388-890-0110.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0195, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0200 What are counseling and guidance services? Counseling and guidance services are information and support services provided by a VR counselor to assist you to make informed decisions about your VR services. Counseling and guidance services include, but are not limited to:

- (1) Explaining your responsibilities in a VR program;
- (2) Explaining the nature and scope of VR services;
- (3) Explaining the use of services and resources available from other programs as comparable services and benefits;

(4) Explaining information about your strengths, resources, priorities, interests, and rehabilitation needs;

(5) Explaining your opportunities to make informed choices;

(6) Helping you collect and understand information needed to decide on a employment goal;

(7) Providing you information and support to decide which services and activities you need to reach your employment goal;

(8) Providing support and information to you and someone you choose to develop all or part of your individualized plan for employment;

(9) Explaining how to use services to reach your employment goal;

(10) Providing you support and advice when issues arise during your VR program that relate to health, family, finances, interpersonal relationships, appearance, and other issues that could impact your vocational rehabilitation;

(11) Providing information and support, with your permission, to employers, family members, relatives or others to help you get or keep a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0200, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0210 Under what conditions does DVR provide counseling and guidance services? A VR counselor provides counseling and guidance services as needed throughout the rehabilitation process.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0210, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0220 What are independent living services? Independent living services help you deal with life issues that may prevent you from getting and keeping a job. Independent living services include, but are not limited to:

- (1) An evaluation to help you find out about the:
 - (a) Issues in your life that may present problems for you in vocational rehabilitation and in work;
 - (b) Ways to deal with life issues that present problems for you; and
 - (c) Services you need to help you deal with the issues.
- (2) Self-advocacy to help you find out about and manage the services you need to live independently and to help you find out about benefit rights and responsibilities;
- (3) Independent living counseling to help you set personal goals, learn how to make decisions that relate to life issues and employment and to help your family with issues related to your disability and independence;
- (4) Independent living skills training to help you get skills to manage and balance your life in areas including, but not limited to budgeting, meal preparation and nutrition, shopping, hygiene, time management, recreation, necessary community resources, and attendant management;
- (5) Living arrangement counseling, including helping you to:
 - (a) Find out about housing resources and the qualifications for applying for housing;
 - (b) Make decisions about the living arrangements you want and need; and
 - (c) Make decisions about changing to a more independent living arrangement.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0220, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0225 Under what conditions does DVR provide independent living services? DVR provides independent living services under the conditions outlined in WAC 388-890-0110 and DVR does not pay your family members to provide independent living services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0225, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0230 What are interpreter services? Interpreter services are services to assist deaf, deaf-blind, and hard of hearing individuals who use sign language or another form of communication to express and receive information with other individuals who use speech and hearing to com-

municate. An example of interpreter services is the use of an interpreter by a deaf person who communicates in American Sign Language to express and receive information with a person who speaks English. Interpreter services include:

- (1) Oral interpreting, in which the interpreter mouths (without voice) what the speaker says, using some natural facial expressions;
- (2) Sign interpreting, in which the interpreter signs what the speaker says;
- (3) Tactile interpreting, in which a hands-on interpreting method is used with people who are deaf-blind. The interpreter communicates what the speaker says by signing and/or fingerspelling into the hands of the deaf-blind person; and
- (4) Voice interpreting, in which the interpreter speaks what a deaf person is mouthing or signing.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0230, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0235 Under what conditions can I receive interpreter services? DVR provides interpreter services under the conditions outlined in WAC 388-890-0110.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0235, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0240 What are job placement and job retention services? Job placement and job retention services help you get or keep a job that meets your employment goal.

- (1) Job placement includes job search to help you look for and find a job.
- (2) Job retention includes follow-up services to help you keep a job once you are working.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0240, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0245 Under what conditions can I receive job placement and job retention services? DVR provides job placement and job retention services to you under the conditions listed in WAC 388-890-0110, and:

- (1) A VR counselor provides job placement services to help you conduct a self-directed job search; or
- (2) DVR purchases job placement services only if:
 - (a) You and your VR counselor agree that you are unable to conduct a self-directed job search because of the significance of your disability; or
 - (b) You have tried to conduct a self-directed job search without success.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0245, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0250 What are maintenance services? Maintenance services include financial assistance for food, shelter, and/or clothing expenses that occur in excess of your usual living expenses in order for you to participate in another VR service. The following examples include, but are not limited to, the ways maintenance may be used:

(1) A uniform or other suitable clothing required to look for or get a job;

(2) Short-term lodging and meals required to participate in assessment or training services not within commuting distance of your home;

(3) A security deposit or utility hook-ups on housing you need to relocate for a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0250, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0255 Under what conditions does DVR provide maintenance services? DVR provides maintenance services under the conditions in WAC 388-890-0110, and if you and your VR counselor agree that you need maintenance services to participate in another VR service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0255, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0260 What are occupational licenses? Occupational licenses are licenses, permits or certificates showing you meet certain standards or have accomplished certain achievements and/or have paid dues, fees or otherwise qualify to engage in a business, a specific occupation or trade, or other work related activity.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0260, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0265 Under what conditions can I get an occupational license? DVR pays fees for occupational licenses under the conditions listed in WAC 388-890-0110 and if you meet the requirements to hold the occupational license as established by the licenser.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0265, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0270 What other goods and services does DVR provide? DVR provides other miscellaneous goods and services to meet your specific needs for vocational rehabilitation and employment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0270, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0275 Under what conditions does DVR provide and issue other goods and services? (1) DVR provides other goods and services to you under conditions specified in WAC 388-890-0110.

(2) DVR issues other goods and services to you as outlined under WAC 388-890-0455 through 388-890-0480.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0275, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0280 What are personal assistance services? Personal assistance services increase your ability to perform daily living activities on or off the job to help you get

or keep a job. Personal assistance services include, but are not limited to, bathing, dressing, cooking, eating, and helping you move around.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0280, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0285 Under what conditions does DVR provide or pay for personal assistance services? DVR provides personal assistance services under the conditions listed in WAC 388-890-0110, and:

(1) If needed to help you participate in another VR service.

(2) Your family members cannot be paid to provide personal assistance services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0285, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0290 What are the physical and mental restoration services DVR provides? Physical and mental restoration services are used to diagnose and treat physical and mental impairments for the purposes of correcting, improving, modifying or accommodating a physical or mental condition. Physical and mental restoration services include:

(1) Cognitive rehabilitation services;

(2) Corrective surgery or therapy;

(3) Diagnosis and treatment of mental or emotional disorders by licensed individuals;

(4) Dental treatment if the treatment is directly related to an employment outcome, or in emergency situations involving pain, acute infections, or injury;

(5) Nursing services;

(6) Hospitalization, including surgery or treatment, and clinic services;

(7) Drugs and supplies;

(8) Prosthetic and orthotic devices;

(9) Visual examinations and visual treatment;

(10) Podiatry;

(11) Physical therapy;

(12) Occupational therapy;

(13) Speech or hearing therapy;

(14) Treatment of acute or chronic medical conditions and emergencies that occur when providing physical and mental restoration services, or that are related to the condition being treated;

(15) Special services for the treatment of end-stage renal disease; and

(16) Other medical or medically-related rehabilitation services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0290, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0295 Under what conditions does DVR provide physical and mental restoration services? DVR provides physical and mental restoration services under the conditions in WAC 388-890-0110, and if:

(1) Your disabling condition is stable or slowly progressive; and

(2) The service is expected to substantially modify, correct, or improve a physical or mental impairment that is a substantial impediment to employment for you within a reasonable length of time.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0295, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0300 What are the medical treatments DVR does not pay for? DVR does not pay for the following medical treatments:

(1) Maintenance of your general health including, but not limited to, vitamins, in-patient hospital based weight loss programs or for-profit weight loss programs, exercise programs, health spas, swim programs and athletic fitness clubs;

(2) Facelifts, liposuction, cellulite removal;

(3) Maternity care;

(4) Hysterectomies, elective abortions, sterilization, and contraceptive services as independent procedures;

(5) Drugs not approved by the Federal Drug Administration for general use or by state law;

(6) Life support systems, services, and hospice care;

(7) Transgender services including surgery and medication management;

(8) Homeopathic and herbalist services, Christian Science practitioners or theological healers; and

(9) Treatment that is experimental, obsolete, investigational, or otherwise not established as effective medical treatment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0300, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0305 What are post-employment services? Post employment services are one or more of the vocational rehabilitation services listed in WAC 388-890-0145, provided after DVR determines you have achieved an employment outcome or a supported employment outcome, your case service record is closed, and you need additional services to help you keep, regain or advance in employment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0305, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0310 Under what conditions does DVR provide post-employment services? DVR provides post-employment services under the conditions listed in WAC 388-890-0110, and if:

(1) Your VR case service record was closed because you achieved an employment outcome;

(2) Your VR case service record has been closed less than three years; and

(3) The impediments to employment related to your disability have not changed to the extent that you require more than short term intervention to keep, regain, or advance in employment within the same or closely related occupation.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0310, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0315 What are reader services? Reader services help you get information from printed text if your disability impairs or prevents you from getting information from printed text. An example of reader services is the use of a person to read print materials such as job announcements and letters from possible employers to an individual with dyslexia or an individual who is blind.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0315, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0320 Under what conditions does DVR provide reader services? DVR provides reader services under the conditions listed in WAC 388-890-0110.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0320, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0325 What are referral services? Referral services help you find and get services or benefits from other programs or agencies.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0325, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0330 Under what conditions does DVR provide referral services? DVR provides referral services under the conditions listed in WAC 388-890-0110, and if:

(1) A VR counselor determines you are not eligible for VR services; or

(2) You and a VR counselor identify services or benefits available to you from another agency or organization and you agree to be referred.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0330, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0335 What is rehabilitation engineering? Rehabilitation engineering is a type of rehabilitation technology service. Rehabilitation engineering uses engineering sciences to design, develop, adapt, test, evaluate, and implement new and unique products to help you maintain or improve your ability to move around, communicate, hear, see, and understand things.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0335, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0340 Under what conditions does DVR provide rehabilitation engineering? DVR provides rehabilitation engineering services under the conditions listed in WAC 388-890-0110.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0340, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0345 What are self-employment services? Self-employment services include:

(1) Consultation and technical assistance to help you conduct market analyses, develop business plans, and use other resources to pursue self-employment or to establish a small business to become self-employed;

(2) All services required to help you in self-employment including, but not limited to:

- (a) Planning;
- (b) Consultation;
- (c) Initial stocks and supplies;
- (d) Tools;
- (e) Equipment;
- (f) Business licenses;
- (g) Fees.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0345, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0350 Under what conditions does DVR provide self-employment services and issue items for self-employment? (1) DVR provides self-employment services under the conditions listed in WAC 388-890-0110.

(2) DVR issues items for self-employment under WAC 388-890-0455 through 388-890-0480.

(3) Before DVR supports a self-employment goal, you must complete a business plan that demonstrates that the self-employment you are considering is feasible, sustainable, and results in employment.

(4) DVR does not support hobbies or activities that do not result in an income-producing self-employment outcome.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0350, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0355 What are services to family members? Services to family members are provided to a family member, guardian, or household member with whom you have a close interpersonal relationship. Services to family members include, but are not limited to:

- (1) Family or marital counseling;
- (2) Information and referral services to family members as appropriate;
- (3) Child care.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0355, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0360 Under what conditions does DVR provide services to my family members? DVR provides services to family members under the conditions listed in WAC 388-890-0110 and the following additional conditions for child care:

(1) DVR pays for the following types of licensed child care and child care exempt from licensing in conformance with DSHS children's administration regulations and licensing or certification requirements:

(a) Child day care centers as outlined in WAC 388-150-020 (1)(2) and (4) through (8)(a);

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(b) Family child day care homes as outlined in WAC 388-155-020 (1) through (6)(a); and

(c) School-age child care centers as outlined in WAC 388-151-010 and 388-151-020.

(2) DVR pays for in-home or relative child care including:

(a) Child care provided to your child(ren) in your home by a relative or other person; and

(b) Child care provided to your child(ren) by a relative outside of your home.

(3) For in-home or relative child care, you assume full responsibility for the qualifications of the child care provider and the quality of child care services.

(4) DVR pays the child care provider's usual rates for child care services directly to the child care provider.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0360, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0365 What are supported employment services? See WAC 388-890-0570 through 388-890-0665 for supported employment program and services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0365, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0370 What are tools, equipment, initial stocks and supplies? Tools, equipment, initial stocks and supplies are materials and hardware required to carry out the duties of a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0370, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0375 Under what conditions does DVR provide and issue tools, equipment, initial stocks and supplies? (1) DVR provides tools, equipment, initial stocks and supplies under the conditions listed in WAC 388-890-0110.

(2) DVR issues tools, equipment, initial stocks and supplies under WAC 388-890-0455 through 388-890-0480.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0375, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0380 What are training services? Training services assist you to gain knowledge, skills and abilities needed for employment. Training services, include, but are not limited to:

(1) Training to develop work habits, work behaviors, and work skills;

(2) On-the-job training;

(3) Vocational, technical, trade or business training;

(4) Post-secondary academic training;

(5) Books, tools, fees, and other training supplies;

(6) Independent living training;

(7) Tutoring that supports another training service you are receiving;

(8) Other types of training that strengthen your knowledge, skills and abilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0380, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0385 What is on-the-job training? On-the-job training is a way to gain work skills needed for a specific job after being placed in that job. After you start a job, the employer or the employer's designee provides individualized training to teach you the skills you need to perform the job. DVR may reimburse an employer for training costs that exceed the employer's usual costs to train a new employee.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0385, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0390 Under what conditions does DVR provide on-the-job training? DVR provides on-the-job training as a training service under the conditions in WAC 388-890-0110 and if:

- (1) An employer has hired you;
- (2) The employer or employer's designee has the skills to provide the training you need to learn the job; and
- (3) The employer signs an agreement to include at a minimum:
 - (a) Training to be provided by the employer or designee;
 - (b) Duration or number of hours of training to be provided;
 - (c) How the employer will evaluate and report your progress to DVR;
 - (d) Employer's cost to provide the training; and
 - (e) Agreed-upon fee, including payment criteria.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0390, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0395 Under what conditions does DVR provide training services and issue items for training? (1) DVR provides training services under the conditions listed in WAC 388-890-0110.

(2) DVR issues devices, tools, equipment or other items used for training under WAC 388-890-0455 through 388-890-0480.

(3) Training at an institution of higher education (universities, colleges, community or junior colleges, vocational schools, technical institutes, or hospital schools of nursing) is provided only after you and a VR counselor have made maximum efforts to get and use grant funding, in whole or in part, from other sources to pay for the training.

(4) You must give DVR a copy of your grant funding award or denial form when it is available.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0395, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0400 Do I have to apply for a student loan to pay for training services? You are not required to apply for a student loan to pay for training services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0400, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0405 Can I receive training services from a private school, an out-of-state training agency or an out-of-state college? If you choose training services from a private school, an out-of-state training agency or an out-of-state college when an in-state or public program is available and adequate to meet your needs, the following conditions apply:

- (1) The private school, out-of-state training agency or out-of-state college must meet DVR standards; and
- (2) You are responsible for any costs related to the training in excess of what DVR would pay for the training service from a public school or in-state training agency.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0405, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0410 What are transition services? (1) Transition services are work-related activities you begin while you are in high school that are coordinated with VR services to help you prepare for and go to work in the community after you leave high school.

(2) Transition services may include any of the VR services listed under WAC 388-890-0145.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0410, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0415 Under what conditions does DVR provide transition services? DVR provides transition services under the conditions listed in WAC 388-890-0110, and if you:

- (1) Are a high school student with a disability; and
- (2) Will complete high school during the next twelve months.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0415, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0420 How does DVR coordinate with public high schools to provide transition services? VR counselors work with teachers and other staff in public high schools to coordinate and provide transition services as outlined under an interagency agreement between DVR and the office of superintendent of public instruction.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0420, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0425 How does DVR help me plan transition services? DVR offers counseling and guidance to help you to make informed choices about what VR services and activities you need to:

- (1) Assess your rehabilitation needs, including your need to move to a more independent living arrangement;
- (2) Decide on an employment goal; and
- (3) Decide what VR services are needed to reach your employment goal.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0425, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0430 Who decides what transition services I get from DVR? With support from a VR counselor, you use informed choice to make decisions about which activities and VR services to use based on your individual needs, preferences, interests, and employment goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0430, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0435 What activities does DVR support after I leave high school? DVR supports activities that help you select and reach your employment goal, including but not limited to:

- (1) Employment, including supported employment;
- (2) Training at a vocational school, technical school, on-the-job training, or other training agency;
- (3) Continuing education at a college, community college, or other post-secondary school;
- (4) Referral to other community services or organizations that offer services to adults to live more independently and to get or keep a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0435, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0440 What are transportation services? Transportation services help you get around in the community to participate in VR services or to get or keep a job. Transportation services include, but are not limited to:

- (1) Public transportation fares or passes;
- (2) Estimated cost of gasoline;
- (3) Vehicle repair and maintenance;
- (4) Attendant fees and travel costs while in travel status;
- (5) Purchase of vehicles.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0440, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0445 Under what conditions does DVR provide transportation services? DVR provides transportation services to you under conditions specified in WAC 388-890-0110 and if provided in connection with another VR service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0445, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0450 Under what conditions does DVR provide and issue a vehicle? (1) DVR provides a vehicle under the conditions outlined under WAC 388-890-0110 and 388-890-0125, and:

- (a) Your disability is stable or slowly progressive, and is not likely to impair your ability to drive in the future.
- (b) You and a VR counselor agree it is a necessary service under your individualized plan for employment (IPE) because:
 - (i) No other transportation options are available and it is not feasible for you to relocate to live closer to employment or other transportation options; or

(ii) A vehicle is required as a condition of employment before you can get or keep a job.

(c) The vehicle is provided in support of another VR service.

(d) You do not have a vehicle or your vehicle cannot be modified or repaired to the extent that you can drive it.

(e) You agree to:

(i) Be the registered owner of the vehicle; and

(ii) Pay for and have a current driver's license, vehicle license, and vehicle registration.

(f) Pay for and have driver insurance and vehicle insurance adequate to cover the cost of replacement for loss or damage at the time the vehicle is issued to you.

(2) DVR issues a vehicle as outlined under WAC 388-890-0455 through 388-890-0480.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0450, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0455 Under what conditions does DVR issue a device, tool, piece of equipment or other item I need to participate in VR services or to get a job? If you need a device, tool, piece of equipment or other item to participate in VR services or to go to work, DVR provides the item under the conditions listed in WAC 388-890-0110 and if the item meets applicable local, state and national engineering safety, and, health standards.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0455, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0460 What conditions apply to the use of a device, tool, piece of equipment or other item that is issued to me? If DVR determines an item may be re-used by another person if it is returned, you must sign a statement agreeing to the following before DVR issues the item to you:

(1) DVR has ownership of the item issued to you, and you understand permission for use may be taken away by DVR at any time;

(2) You agree to immediately return the item if DVR requests you to do so and you understand you are responsible to pay for the item if you do not immediately return it to DVR;

(3) You agree to maintain the item according to manufacturer's guidelines, if applicable, and keep it secure from damage, loss or theft; and

(4) You agree to engrave an identification number on all or part of the item, if requested to do so by DVR.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0460, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0465 What types of devices, tools, pieces of equipment or other items can DVR issue to me? DVR issues devices, tools, equipment, or other items that you need to participate in VR services or to get a job, including but not limited to:

(1) Assistive technology devices as outlined under WAC 388-890-0175;

(2) Equipment, supplies or other items needed for self-employment as outlined under WAC 388-890-0345;

(3) Tools, equipment, initial stocks or supplies as outlined under WAC 388-890-0370;

(4) A vehicle as outlined under WAC 388-890-0440;

(5) Tools and other training supplies as outlined under WAC 388-890-0380.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0465, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0470 Does DVR issue new or used devices, tools, pieces of equipment, or other items? (1) If an item is readily available from DVR's inventory that is appropriate and adequate to meet your specific needs, DVR issues the item to you.

(2) If the item is not available from DVR's inventory, DVR locates the item for issue to you from another source.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0470, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0475 What happens if I fail to return a device, tool, piece of equipment or other item if requested by DVR? If DVR directs you to return any item issued to you but owned by DVR and you do not immediately return it, DVR reports the loss to the DSHS office of financial recovery (OFR). The OFR attempts to recover the item or payment for the item from you. If the OFR cannot recover the item(s) or payment for the item(s) from you, the OFR report may the loss to the local county prosecutor for legal action.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0475, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0480 What happens to a device, tool, piece of equipment or other item if I need it when my DVR case service record is closed? DVR transfers ownership of the device, tool, piece of equipment or other item to you at the time DVR closes your case if you:

(1) Are working in a job that requires the item;

(2) Do not need additional VR services; and

(3) A VR counselor determines you have achieved an employment outcome.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0480, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0485 What is an individualized plan for employment (IPE)? (1) An individualized plan for employment (IPE) is a written document prepared on forms provided by DVR.

(2) An IPE is an agreement that records the decisions and commitments you and a VR counselor make about VR services and activities.

(3) The IPE documents the VR services you will use to prepare for, get or keep a job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0485, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0490 How do I develop an IPE? (1) You have the following options for developing an IPE. You may use each option separately or in combination with the other options to develop all or part of the IPE:

(a) Develop the IPE with assistance and support from a VR counselor;

(b) Develop the IPE on your own; and

(c) Develop the IPE with a representative, family member, advocate, or other individual of your choice.

(2) If you choose to develop the IPE with someone other than a VR counselor, DVR helps you identify sources external to DVR that may help you develop your IPE. DVR does not pay for any related costs or fees charged by other parties to develop the IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0490, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0495 What information does DVR give me to develop my IPE? DVR gives you the following information in writing about how to develop an IPE:

(1) A description of the information that must be included on an IPE;

(2) Financial conditions or restrictions that relate to the IPE;

(3) Other information you request;

(4) Where to get help to fill out forms required by DVR;

(5) Your rights if you disagree with DVR about a decision relating to the IPE;

(6) Information about the client assistance program (CAP) and how to contact the program.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0495, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0500 Who makes decisions about what to include on my IPE? You use informed choice to make decisions about what to include on your IPE. You have the right to make decisions that are consistent with your strengths, abilities, capabilities, and interests, including but not limited to:

(1) The type of job you want;

(2) What VR services you need to help you reach your employment goal;

(3) What service provider to use.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0500, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0505 Can I include any VR services I want on my IPE? DVR provides only those VR services that you and a VR counselor agree are:

(1) Consistent with your strengths, abilities, capabilities, and interests; and

(2) Needed to achieve the employment goal listed on your IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0505, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0510 What if the employment goal I choose is religious in nature? DVR is prohibited from supporting an employment goal that is religious in nature under the Washington State Constitution, Article 1, subsection 11.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0510, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0515 What must be included on my IPE? An IPE must include all of the following items, at a minimum:

- (1) Your employment goal;
- (2) The VR services you plan to use;
- (3) The date VR services included on the plan begin;
- (4) When you expect to begin working;
- (5) The name of the person or organization providing each service included on the IPE;
- (6) What criteria you will use to evaluate whether you are making progress toward your employment goal;
- (7) Terms and conditions, including:
 - (a) A description of what DVR has agreed to do to support your IPE; and
 - (b) A description of what you have agreed to do to reach your employment goal, including:
 - (i) Steps you will take to achieve your employment goal;
 - (ii) What services you agree to help pay for, and how much you will pay; and
 - (iii) What services you agree to apply for as comparable services and benefits.
- (8) What services will be provided by another organization as a comparable service or benefit;
- (9) The expected need for post-employment services;
- (10) The process used to provide or procure services;
- (11) The basis on which DVR determines you have achieved an employment outcome as outlined in WAC 388-890-0535;
- (12) Your rights under the IPE and your options to appeal a decision your DVR counselor makes that you do not agree with as outlined in WAC 388-890-1180;
- (13) Your rights and procedures to file a complaint to report and resolve any dissatisfaction; and
- (14) The availability of the client assistance program as outlined in WAC 388-890-1185.
- (15) An IPE that includes a supported employment outcome must also document:
 - (a) The extended services or natural supports you need;
 - (b) The name of the person or organization paying for the extended services, if extended services are used;
 - (c) If it is not known who will pay for extended services or natural supports when the IPE is developed, the IPE includes a statement explaining the expected source of extended service or a plan to identify a source of extended services;
 - (d) A goal for the number of hours per week you are going to work based on your strengths, abilities, capabilities, interest and informed choice;
 - (e) A description of how the services on your IPE are coordinated with other federal or state services you get under another individualized plan; and

(f) The basis on which DVR determines you have achieved a supported employment outcome as outlined in WAC 388-890-0535 (1) through (4), 388-890-0650 and 388-890-0660.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0515, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0520 Who signs the IPE? You and a VR counselor must agree to and sign your IPE. DVR gives you a copy of the signed IPE, in writing or in another method of communication, if needed.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0520, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0525 Is the IPE reviewed and updated? You and a VR counselor review the IPE at least once a year, or more often if needed.

(1) You and a VR counselor amend the IPE if there are major changes in the employment goal, the VR services to be used, or the service provider to be used.

(2) Changes to an IPE take effect when you and a VR counselor sign the updated IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0525, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0530 Why does DVR close a case service record? A VR counselor closes your case service record for any of the following reasons:

- (1) You are working and no longer need VR services;
- (2) You decline VR services;
- (3) Anytime DVR determines that you are not eligible or no longer eligible;
- (4) You are no longer available to participate in services;
- (5) You cannot be located;
- (6) You ask DVR to close your case service record; or
- (7) You refuse to cooperate in required or agreed upon services

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0530, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0535 Under what conditions does DVR determine that I am working and no longer need VR services? DVR determines that you have achieved an employment outcome and no longer need VR services if:

- (1) You received services under an IPE that helped you get a job;
- (2) Your job matches your strengths, needs, abilities, interests and choices;
- (3) You have been working for at least ninety days; and
- (4) You and a VR counselor agree the job is satisfactory and that you are performing the job well; and
- (5) You are working in an integrated setting or in a non-integrated setting of your choice.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0535, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0540 Am I involved in the decision to close my case? (1) Before closing your case service record, a VR counselor gives you an opportunity to discuss the decision.

(2) DVR notifies you in writing, or another method of communication, if needed, about the reason your case service record is being closed and your rights if you disagree with the decision as outlined under WAC 388-890-1180.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0540, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0545 What is competitive employment? Competitive employment is work in the competitive labor market that you perform on a full-time or part-time basis in an integrated setting for which you earn a wage at or above the minimum wage, but not less than the usual wage and level of benefits your employer pays to nondisabled employees who do the same or similar work as you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0545, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0550 What is extended employment? Extended employment is:

(1) Work in a nonintegrated setting for a public or non-profit agency or organization which provides support services to you to continue to train or prepare for competitive employment unless you choose to remain in extended employment; and

(2) Work for which you earn a wage according to special certificate provisions of 14(c) of the U.S. Department of Labor Fair Labor Standards Act (29 U.S.C. 214 (c)).

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0550, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0555 If the job I get is in extended employment, what follow-up does DVR provide? (1) If you go to work in extended employment, DVR reviews your status annually to:

(a) Determine your interest and need to move to competitive employment;

(b) Determine your interest and need to receive training for competitive employment; and

(c) Evaluate whether there are VR services or other services that would assist you to move to competitive employment.

(2) DVR provides an opportunity for you to give input during the annual review.

(3) DVR reviews your status annually for two years following the date you go to work.

(4) After two years, you may request that DVR continue to review your status annually.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0555, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0560 Under what conditions does DVR follow up with me if I am determined ineligible for

VR services? (1) If DVR determines you are ineligible because you are too significantly disabled to benefit from VR services in terms of employment under any of the following conditions, DVR contacts you within twelve months of the date determined ineligible to review whether anything has changed to affect your eligibility:

(a) You are too significantly disabled to participate in a trial work experience;

(b) You decline a trial work experience and you and your VR counselor agree that you are too significantly disabled to benefit from VR services in terms of employment;

(c) You participate in a trial work experience as outlined under WAC 388-890-0670 through 388-890-0705 and are determined too significantly disabled to benefit from services in terms of employment; or

(d) You and your VR counselor cannot find a source for extended services and/or cannot establish natural supports during the initial eighteen months of your individualized plan for supported employment.

(2) After DVR completes the initial twelve month review, you or your representative may request additional annual reviews.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0560, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0570 What is supported employment?

(1) Supported employment is:

(a) Competitive work; or

(b) Work in an integrated setting while you work toward competitive work consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice; or

(c) Transitional employment for an individual with a most significant disability due to chronic mental illness.

(2) Supported employment is for an individual with a most significant disability who:

(a) Has not traditionally worked in competitive employment; or

(b) Has worked in competitive employment, but the disability has caused the individual to stop working, or work off and on; and

(c) Needs intensive supported employment services and extended services to work because of the nature and significance of the disability.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0570, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0575 Who is eligible for supported employment? You are eligible for supported employment services if:

(1) You are eligible for vocational rehabilitation services under WAC 388-890-0035;

(2) You are an individual with a most significant disability under WAC 388-890-0755 category one; and

(3) Supported employment is appropriate for you based on a comprehensive assessment of your needs, including an evaluation of your rehabilitation, career and job needs.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0575, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0580 Who decides if I am eligible for supported employment? DVR decides if you are eligible for supported employment services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0580, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0585 What is competitive work in supported employment? Competitive work, as used in supported employment, is:

(1) Work in the competitive labor market that you perform on a full-time or part-time basis in an integrated setting; and

(2) Work for which you are paid at or above the minimum wage, but not less than the usual wage your employer pays to nondisabled employees who do the same or similar work as you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0585, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0590 What is an integrated setting in supported employment? An integrated setting in supported employment is a work setting commonly found in the community in which you interact with nondisabled people to the same extent that a nondisabled person in the same type of job interacts with other persons.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0590, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0595 Is my work setting integrated if my interactions at the work site are with nondisabled supported employment service providers? Interactions at your work site between you and a nondisabled supported employment service provider do not meet the requirement for an integrated setting.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0595, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0600 What is transitional employment? Transitional employment is a work model using a series of consecutive jobs in competitive employment for individuals with the most significant disabilities due to mental illness.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0600, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0605 What are supported employment services? Supported employment services are:

(1) Ongoing support services as described in WAC 388-890-0610; and

(2) Vocational rehabilitation services listed in WAC 388-890-0145.

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[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0605, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0610 What are ongoing support services? Ongoing support is a type of supported employment service to help you get and keep a job. Ongoing support services include:

(1) An assessment of your employment situation at least twice a month, or under special circumstances and especially at your request, an assessment regarding your employment situation that takes place away from your worksite at least twice a month to:

(a) Determine what is needed to maintain job stability; and

(b) Coordinate services or provide specific intensive services that are needed at or away from your worksite to help you maintain job stability.

(2) Intensive job skill training for you at your job site by skilled job trainers.

(3) Job development, job placement and job retention services.

(4) Social skills training.

(5) Regular observation or supervision.

(6) Follow-up services such as regular contact with your employer, you, your representatives, and other appropriate individuals to help strengthen and stabilize the job placement.

(7) Facilitation of natural supports at the worksite.

(8) Other services similar to services described in subsections (1) through (7) above.

(9) Any other vocational rehabilitation service described in WAC 388-890-0145 through 388-890-0450.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0610, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0615 Under what conditions does DVR provide supported employment services? DVR provides supported employment services under the conditions in WAC 388-890-0110 and if you are an individual with a most significant disability as described in category one, WAC 388-890-0755.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0615, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0620 What is included on my individualized plan for supported employment? Your individualized plan for supported employment includes the information specified in WAC 388-890-0515.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0620, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0625 What are extended services? Extended services help you keep your job after DVR stops providing supported employment services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0625, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0630 Does DVR provide extended services? DVR does not provide extended services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0630, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0635 Who provides the extended services I need? Extended services are provided by nonprofit private organizations such as community rehabilitation programs, state and local public agencies, employers, or any other appropriate resources.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0635, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0640 What is natural support? Natural support is a method used to help you keep your job after DVR stops providing supported employment services. Natural support uses the people who you ordinarily come into contact with at work and/or at home to help you with work routines and social interactions at the work site.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0640, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0645 Are supported employment services time-limited? DVR provides supported employment services as part of your individualized plan for employment for a period not to exceed eighteen months, unless under special circumstances you and your VR counselor jointly agree to extend the time in order to achieve the employment goals in your individualized plan for employment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0645, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0650 What is required for me to change from supported employment services to extended services? Prior to helping you change from supported employment services to extended services, a VR counselor must ensure the following:

- (1) You have made substantial progress toward meeting the number of work hours per week you want to work as documented on your individualized plan for employment;
- (2) You are stabilized in the job; and
- (3) Extended services are readily available and can be provided to you without an interruption in services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0650, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0655 What happens if my VR counselor and I do not find a source for extended services and/or we cannot establish natural supports during the initial eighteen months of my individualized plan for employment? If you and your VR counselor do not find a source for extended services and/or cannot establish natural supports during the initial eighteen months of your individualized plan for employment, DVR must determine that you are no longer eligible for VR services under WAC 388-890-0065.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0655, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0660 Under what conditions does DVR close my case service record for supported employment? A VR counselor closes your case service record for supported employment under WAC 388-890-0530 through 388-890-0540, except if you have achieved a supported employment outcome, DVR must wait at least ninety days after helping you change from supported employment services to extended services before closing your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0660, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0665 Under what conditions does DVR provide supported employment services as post-employment services? DVR provides supported employment services to you as post-employment services following the change from supported employment services to extended services if:

- (1) Your extended service provider cannot provide the services; and
- (2) You need such services as job station redesign, repair and maintenance of assistive technology devices and replacement of prosthetic and orthotic devices to keep your job.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0665, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0670 What is a trial work experience? A trial work experience is a method of assessment used by DVR to determine eligibility for VR services:

- (1) Only if a VR counselor cannot presume that VR services will enable you to work because of the significance of your disability; and
- (2) After you have applied for VR services and before an individualized plan for employment is developed.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0670, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0675 What happens during a trial work experience? (1) During a trial work experience, you are placed in a sufficient variety of realistic integrated employment settings and provided with VR services to assess how you perform.

(2) The trial work experience continues long enough to provide sufficient information for a VR counselor to determine whether:

- (a) VR services will enable you to work and that you are eligible for VR services; or
- (b) VR services will not enable you to work, because of the significance of your disability; and/or
- (c) Service providers are able to meet your VR service needs.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0675, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0680 Who decides if a trial work experience is needed to determine if I am eligible for DVR services? DVR determines whether a trial work experience is needed to determine your eligibility for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0680, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0685 What services does DVR provide during a trial work experience? DVR may use the individual VR services listed under WAC 388-890-0145 through 388-890-0450 during a trial work experience.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0685, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0690 What if I am too significantly disabled to participate in a trial work experience? If DVR is unable to identify VR services or service providers that would enable you to perform a trial work experience because of the significance of your disability, DVR follows the procedures outlined under WAC 388-890-0065 to determine that you are not eligible for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0690, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0695 What choices can I make about the trial work experience? If a trial work experience is needed to decide if you are eligible for VR services, DVR provides information and support to help you make informed choices that include, but are not limited to:

- (1) What type of work setting to use;
- (2) What service providers to use.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0695, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0700 Am I evaluated during the trial work experience? DVR evaluates your progress in a trial work experience as often as needed, but at least every ninety days.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0700, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0705 When does DVR make an eligibility decision when I am in a trial work experience? There is no time limit for a trial work experience. As soon as DVR has enough information to decide whether VR services will enable you to get or keep a job, DVR must:

- (1) Make an eligibility decision;
- (2) Document the basis for eligibility or ineligibility; and
- (3) Discontinue trial work experience.

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[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0705, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0710 Are there any vocational rehabilitation services that can be provided to a group of individuals with disabilities? The following vocational rehabilitation services may be provided to a group of individuals with disabilities:

(1) Services to establish, develop, or improve a community rehabilitation program may be provided to a group of individuals with disabilities who are currently not being served or whose service needs are not being met by DVR.

(2) Services may be provided to an identified group of individuals with disabilities if the VR services:

(a) Are likely to contribute to the rehabilitation of those in the group; and

(b) Cannot be purchased on an individual basis.

(3) Consulting and/or technical assistance services may be provided to support planning the development of school programs to meet the long-term employment needs of a group of students with disabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0710, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0715 Under what conditions does DVR provide services to a group of individuals with disabilities to establish, develop or improve a community rehabilitation program? (1) DVR may provide services to a group of individuals with disabilities to establish, develop, or improve a community rehabilitation program if:

(a) DVR has identified a group of individuals with disabilities who are not being served or whose service needs are not being met by DVR because of limited staff resources.

(b) Services of a community rehabilitation are needed in a geographic area.

(c) DVR has evaluated the community rehabilitation program services and determined that VR services to groups are needed and are likely to meet the service needs of the group.

(2) DVR does not pay for the cost of construction related to establishing or developing a community rehabilitation program.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0715, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0720 Under what conditions does DVR provide services to a group of individuals with disabilities that cannot be purchased under an individual IPE? (1) DVR may provide services to a group of individuals with disabilities if the services are likely to contribute to the rehabilitation of those in the group, but cannot be purchased under an individualized plan for employment of any one person within the group because:

(a) The services are needed by the individuals in the group to apply for DVR services when a barrier exists that hinders access to VR services for a group of individuals with disabilities.

(b) The services needed by the group are not designated by a unit or per person cost and/or cannot be prorated equitably to the IPE's of those in the group.

(2) DVR does not purchase equipment in excess of five thousand dollars as a service to groups of individuals with disabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0720, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0725 Under what conditions does DVR provide consulting and/or technical assistance to plan for the transition of students with disabilities? (1) DVR may purchase consulting and/or technical assistance for schools to plan for the transition of students with disabilities if:

(a) DVR has determined that the school needs consulting or technical assistance services to plan for the transition of students with disabilities;

(b) The school has expressed a commitment to provide the resources needed to implement a plan for the transition of students with disabilities;

(c) DVR has determined the services are likely to result in increased capacity within the school system to assist students with disabilities to transition from school to work; and

(d) DVR does not have adequate staff resources to provide the needed consulting or technical assistance.

(2) DVR does not pay for:

(a) The cost to implement a plan; or

(b) Individual VR services to students with disabilities as a service to groups.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0725, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0730 What if DVR does not have funding to serve all eligible individuals? (1) When funds or other resources are not available to serve all eligible individuals, DVR establishes an order to select eligible individuals to develop and carry out an individualized plan for employment (IPE).

(2) When the selection order is in effect and you are eligible for services, DVR assigns your name to one of three selection categories.

(3) You can develop and carry out an IPE based on:

(a) The priority of the selection category you are in; and

(b) The order in which you applied for DVR services as indicated by the date on your application. If you are a public safety officer with a disability that was acquired while acting in the line of duty you are placed first within a category, regardless of the date on your application.

(4) If the category you are in is one that DVR does not have funds or other resources for you to develop and carry out an IPE, DVR provides you with vocational rehabilitation information, guidance, and referral services to access other federal and state programs suited to address specific employment needs of individuals with disabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0730, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0745 If DVR has to decide in what category to place me, who decides what assessment services I need and where to get the assessment services? If DVR has to decide in what category to place you because funds or other resources are not available to all eligible individuals:

(1) DVR decides what assessment services are needed; and

(2) You choose the service providers for the assessment services you need based on informed choice.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0745, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0750 What categories are used by DVR to determine the priority by which eligible individuals are served and in what order are the categories prioritized? (1) DVR uses the following categories to determine the priority by which to serve you if you are eligible for VR services:

(a) Category one—First priority, individuals with the most significant disabilities;

(b) Category two—Second priority, individuals with significant disabilities; and

(c) Category three—Third priority, individuals with disabilities.

(2) The categories are prioritized for eligible individuals to develop and carry out an IPE in the following order:

(a) Individuals with the most significant disabilities first;

(b) Individuals with significant disabilities second; and

(c) Individuals with disabilities third.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0750, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0755 What information does DVR use to determine whether I am in category one? DVR determines you are in category one—first priority, eligible individuals with the most significant disabilities if you are an individual with a significant disability as outlined in WAC 388-890-760 except:

(1) You have one or more physical, mental, or sensory impairments that constitute or result in a substantial impediment to employment for you and cause you to experience serious limitations in **four** or more of the following areas in terms of an employment outcome:

(a) Mobility;

(b) Communication;

(c) Self-care;

(d) Self-direction;

(e) Interpersonal skills;

(f) Work tolerance;

(g) Work skills in terms of an employment outcome; and

(2) You require extended services in order to work.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0755, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0760 What information does DVR use to determine whether I am in category two? DVR determines you are in category two—second priority, eligible individuals with significant disabilities if you meet all of the following criteria:

(1) You are receiving disability benefits under Title II or Title XVI of the Social Security Act; or you have one or more physical, mental, or sensory impairments including:

- (a) Amputation;
- (b) Arthritis;
- (c) Autism;
- (d) Blindness;
- (e) Burn injury;
- (f) Cancer;
- (g) Cerebral palsy;
- (h) Cystic fibrosis;
- (i) Deafness;
- (j) Head injury;
- (k) Heart disease;
- (l) Hemiplegia;
- (m) Hemophilia;
- (n) Respiratory or pulmonary dysfunction;
- (o) Mental retardation;
- (p) Mental illness;
- (q) Multiple sclerosis;
- (r) Muscular dystrophy;
- (s) Musculo-skeletal disorders;
- (t) Neurological disorders (including stroke and epilepsy);
- (u) Paraplegia;
- (v) Quadriplegia;
- (w) Other spinal cord conditions;
- (x) Sickle cell anemia;
- (y) Specific learning disability;
- (z) End stage renal disease; or
- (aa) Other disability or combination of disabilities to cause comparable substantial functional limitation as identified by an assessment for determining eligibility and vocational rehabilitation needs.

(2) You have one or more physical, mental, or sensory impairments that constitute or result in a substantial impediment to employment for you and cause you to experience serious limitations in **one** or more of the following areas in terms of an employment outcome:

- (a) Mobility,
- (b) Communication,
- (c) Self-care,
- (d) Self-direction,
- (e) Interpersonal skills,
- (f) Work tolerance,
- (g) Work skills in terms of an employment outcome.

(3) Your vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0760, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0765 What information does DVR use to determine whether I am in category three? DVR deter-

mines you are in category three—third priority, eligible individuals with disabilities if you are eligible for VR services and you do not meet the criteria to qualify as an individual with a **most** significant disability as outlined in WAC 388-890-755, or an individual with a significant disability as outlined in WAC 388-890-760.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0765, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0780 What is the independent living (IL) program? (1) The independent living (IL) program is authorized by the department of social and health services, division of vocational rehabilitation under Title VII of the Rehabilitation Act, as amended.

(2) Independent living (IL) is a program of services that assists adults and emancipated minors with significant disabilities to live more independently in their families and communities. IL program services are not offered in all DVR offices. Individuals interested in IL program services must be able to receive services in a region where IL program services are offered.

(3) In addition to the rules in sections WAC 388-890-0780 through 388-890-1095 covering independent living program services, the following vocational rehabilitation rules apply:

- (a) Payment for VR and IL program services, WAC 388-890-1100 through 388-890-1175;
- (b) Confidentiality of personal information, WAC 388-890-1265 through 388-890-1295; and
- (c) How to contact DVR if you don't speak English, WAC 388-890-1300 through 388-890-1310.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0780, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0785 What types of services does the IL program offer? If you are eligible, the IL program can help you get the following types of services, as needed, to reach your IL goals:

- (1) Advocacy services;
- (2) Rehabilitation technology services;
- (3) Communications services;
- (4) IL counseling services;
- (5) Housing services;
- (6) IL skills training;
- (7) Information and referral services;
- (8) Mobility training;
- (9) Peer counseling services;
- (10) Personal assistance services;
- (11) Physical rehabilitation services;
- (12) Preventative services;
- (13) Recreational services;
- (14) Services to family members;
- (15) Therapeutic treatment services;
- (16) Transportation services; and
- (17) Other IL program services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0785, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0790 Who is eligible for Title VII IL program services? (1) You are eligible for IL program services under Title VII if you are an adult or emancipated minor and you:

(a) Have a significant disability, as defined under WAC 388-890-0795;

(b) Are not currently eligible for VR services; and

(c) Can receive IL program services in a region that offers the services.

(2) Eligibility is not based on your age, color, creed, gender, sexual orientation, national origin, race, religion, or type of disability.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0790, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0795 What is a significant disability? In the Title VII IL program, you have a significant disability if:

(1) You have a physical, mental, cognitive or sensory impairment that greatly limits your level of independence in your family or community; and

(2) IL program services are likely to improve or maintain your level of independence in any of these areas.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0795, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0800 Who provides IL program services? (1) An IL counselor provides IL program services; or
(2) The IL counselor may refer you to a service provider who meets standards established by the IL program.

(3) When a service provider is used, the service provider must provide IL program services that you, the IL counselor, and the service provider have agreed to in advance of starting the service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0800, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0805 What are my responsibilities in the IL program? To receive independent living services, you must:

(1) Complete tasks that you have agreed to complete to reach your IL goals;

(2) Be willing to learn new skills and try new things; and

(3) Accept responsibility for your decisions and actions related to your IL goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0805, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0810 How do I apply for IL program services? To apply for IL program services you:

(1) Fill out and sign an IL program services application form; or

(2) Submit the following information:

(a) Your name, address and the county where you live;

(b) Your birthdate and gender;

(c) Your Social Security Number (optional);

(d) A short description of the type of disability; and

(e) The date of your application.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0810, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0815 What happens after I submit my application for IL program services? After you apply for IL program services, you meet with an IL counselor to:

(1) Fill out other forms and releases needed by the IL program to collect the information needed to decide if you are eligible for services;

(2) Complete an assessment to:

(a) Verify whether you have a significant disability that greatly limits your level of independence in your family or community;

(b) Identify your IL needs; and

(c) Decide if IL program services can help you to improve or maintain your level of independence in your family or community.

(3) The assessment may include, but is not limited to, the following areas:

(a) Your home and living environment, including housing, ability to get around, and safety;

(b) Financial issues, such as budgeting, paying bills, and managing money;

(c) Your basic skills in cooking, cleaning, shopping and general home and family care;

(d) How you relate to your family or others socially, and how you spend your free time;

(e) How you manage your own personal care;

(f) School or work interests.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0815, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0820 Who decides if I am eligible for IL program services? (1) An IL counselor determines whether you meet the eligibility requirements as outlined under WAC 388-890-0790; or

(2) If an individual or organization has a contract with the IL program to offer IL program services, the individual or organization may determine whether you meet the eligibility requirements under WAC 388-890-0790.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0820, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0825 Where does the IL program get the information needed to decide if I am eligible? The IL program uses information that you, your family, your doctor, or other organizations submit to decide if you are eligible.

(1) If the information does not verify whether you are eligible for IL program services, you may need to get additional assessments, exams, or tests to get the information.

(2) The IL program pays for services needed to verify whether you are eligible.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0825, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0830 How do I find out if I am eligible for IL program services? (1) If the IL program verifies you are eligible, the IL program notifies you of the decision.

(2) If the IL program determines you are not eligible, the IL program must:

- (a) Talk with you about the decision;
- (b) Send you, or your representative, a notice of the decision in writing, including information about the services offered by the client assistance program and how to ask for services; and
- (c) When possible, refer you to other agencies or programs that offer services to meet your needs.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0830, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0835 What if I disagree with a decision about my eligibility for IL or a decision about IL program services? If an IL counselor makes a decision about your IL program services that you don't agree with, you have the following options:

- (1) Try to resolve the disagreement by talking to the IL counselor, his or her supervisor, or regional administrator;
- (2) Contact the client assistance program as outlined under WAC 388-890-1185; and/or
- (3) Request mediation as outlined under WAC 388-890-1190 through 388-890-1215.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0835, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0840 Under what conditions can I get IL program services? (1) The IL program offers services as needed to:

- (a) Establish your eligibility;
- (b) Assess your IL needs;
- (c) Develop an IL plan; and
- (d) Reach your IL goals.

(2) The IL program provides services only if you are not eligible to receive a comparable service from another organization or program.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0840, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0845 How are my IL program services planned? (1) If you are eligible for IL program services, you work with an IL counselor to develop a written IL plan or a verbal IL plan.

(a) You can get the same IL program services under a written IL plan and a verbal IL plan.

(b) If you choose a verbal IL plan, you must sign a waiver declining a written IL plan.

(2) Before the IL program purchases services under a written IL plan or verbal IL plan, you must complete a financial statement as outlined under WAC 388-890-1145, unless you receive public assistance or support from another program as outlined under WAC 388-890-1150.

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[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0845, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0850 What is included on a written or verbal IL plan? The written or verbal IL plan includes:

- (1) Your goals for addressing the barriers that limit your level of independence in your family or community;
- (2) The IL program services you are using to achieve each goal; and
- (3) How long you expect to use each service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0850, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0855 Who signs and keeps a written IL plan? (1) You and an IL counselor sign the written IL plan.

(2) The IL counselor gives you a copy of the written IL plan in a format that you can understand and use.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0855, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0860 How often is my IL plan reviewed? (1) You and an IL counselor review your IL plan at least once a year, and more often if needed to decide whether:

- (a) IL program services should continue, change or stop;
 - (b) You can and want to be referred to DVR to apply for vocational rehabilitation services as outlined under WAC 388-890-105; and
 - (c) You should be referred to another program or service.
- (2) You may develop a new plan, if changes are needed.
- (3) When you develop a new plan, the new plan is developed as outlined in WAC 388-890-0845 through 388-890-0855.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0860, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0870 What are IL advocacy services? IL advocacy services support and assist you to express your interests or concerns to others to:

- (1) Reach your IL goals; or
- (2) Get other benefits and services you need.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0870, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0875 What are IL rehabilitation technology services? IL rehabilitation technology services assist you to use devices, equipment, or technology services that enable you to reach your IL goals. IL rehabilitation technology services assist you to:

- (1) Assess your technology needs;
- (2) Try out different types of devices, equipment, and services;
- (3) Obtain devices; and/or
- (4) Receive training on the use of devices or equipment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0875, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0880 What are IL communication services? IL communication services assist you to learn skills or use services that enable you to understand and share information. Examples of communication services include, but are not limited to:

- (1) How to get and use interpreter services, including tactile interpreter services;
- (2) Training in the use of equipment that helps you communicate;
- (3) Braille training;
- (4) How to get and use reader services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0880, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0885 What are IL counseling services? (1) IL counseling services include support and advice from an IL counselor to help you reach your IL goals by finding out about issues that get in the way of your independence. (2) IL counseling services also includes therapeutic counseling services purchased from a qualified therapist on a short-term basis to help you:

- (a) Adjust to your disabling condition; and
- (b) Deal with issues about being more independent.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0885, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0890 What are IL housing services? IL housing services assist you to find or keep a suitable living arrangement and take steps needed to move, if needed. Housing services include, but are not limited to, assisting you to:

- (1) Find out about low-income housing resources and different types of housing;
- (2) Find housing that accommodates your disability;
- (3) Assess what is needed in your current housing to accommodate your disability;
- (4) Find out about ways to make your home accessible.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0890, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0895 Are IL program payments for home modifications limited? (1) The IL program pays for home modifications if:

- (a) The modifications are related to a disability and will improve or maintain independence or safety.
 - (b) You and/or a family member with whom you live:
 - (i) Own the place where you live; and
 - (ii) Complete a financial statement based on the family income to determine whether you must pay, in whole or in part, for home modifications.
 - (c) The housing construction complies with appropriate building codes and permit requirements.
- (2) The IL program does not pay for the cost of labor to construct home modifications.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0895, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1000 What is IL skills training? IL skills training teaches you skills to manage and balance your life in areas including, but not limited to:

- (1) Budgeting;
- (2) Meal planning and/or preparation;
- (3) Consumer skills;
- (4) Personal care;
- (5) Social interaction.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1000, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1005 What are IL information and referral services? IL information and referral services help you to find out about and get help from other community programs and services. IL information and referral services include, but are not limited to:

- (1) Information about a variety of disability issues;
- (2) Information about health insurance and where it is available;
- (3) Help with contacting other programs and services in the community.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1005, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1010 What is IL peer counseling? IL peer counseling is support, advice, teaching, and information sharing with people with disabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1010, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1015 What is IL mobility training? IL mobility training improves your ability to get around in your home or your community, including but not limited to:

- (1) How to use a wheelchair;
- (2) How to make transfers;
- (3) Training on the use of public transportation.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1015, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1020 What is IL personal assistance training? IL personal assistance training helps you develop the skills to get or keep the services of an attendant or assistant to meet your personal assistance needs. Personal assistance training includes, but is not limited to:

- (1) How to find an attendant or assistant;
- (2) How to manage services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1020, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1025 Does the IL program pay for attendant services as part of personal assistance training?

The IL program does not pay for attendant services as part of personal assistance training.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1025, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1030 What are IL physical rehabilitation services? IL physical rehabilitation services include medical assessments or short-term services to assist you to identify or reach your IL goals. Physical rehabilitation services include, but are not limited to:

- (1) Occupational therapy;
- (2) Speech therapy;
- (3) Physical therapy.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1030, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1035 What are IL preventative services? IL preventative services enable you to prevent or limit conditions that result from your disability. IL preventative services enable you to reduce the risk that conditions or limitations worsen. IL preventative services may include, but are not limited to, the purchase of items used to prevent decubitus ulcers.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1035, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1040 What are IL recreational services? IL recreational services assist you to find ways to enjoy activities or hobbies of personal interest to you. IL recreational services may include but are not limited to:

- (1) Assisting you to find information and contact local programs or organizations that offer activities you are interested in;
- (2) Getting short-term instruction in an area of interest to you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1040, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1045 What are IL program services to family members? (1) IL program services to family members assist you and your family members with issues related to your disability or independence. Services to family members may include, but are not limited to:

- (a) Giving your family training to understand disability issues;
- (b) Assisting you to get child care needed to allow you to use IL program services.
- (2) Family member means:
 - (a) Your legal guardian;
 - (b) Someone related to you; or
 - (c) Someone you live with who has a strong interest in your well being and who needs IL program services for you to achieve your IL goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1045, filed 8/27/99, effective 11/1/99.]

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WAC 388-890-1050 What are IL therapeutic services? IL therapeutic services include evaluations to assist you to get specific information from a medical professional, such as a psychologist or neuropsychologist, to help you:

- (1) Identify your IL goals; and/or
- (2) Decide best methods for you to receive services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1050, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1055 What are IL transportation services? (1) IL transportation services help you participate in other IL program services and include, but are not limited to:

- (a) Public transportation fares or passes,
- (b) Estimated cost of gasoline,
- (c) Parking fees.

(2) IL transportation services do not include the purchase of vehicles.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1055, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1060 What other services does the IL program offer? The IL program may offer other services needed to help you to understand IL program services and options or achieve your IL goals. Other IL program services may include, but are not limited to support to attend a class, and support to find volunteer work.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1060, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1065 How long can I receive independent living services? There is no limit on how long IL program services may be provided.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1065, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1070 Why does the IL program stop providing or paying for IL program services? (1) The IL program stops providing or paying for IL program services if you:

- (a) Agree with an IL counselor that you have completed the goals and objectives in your IL plan.
- (b) Are no longer available to receive services at a DVR office where IL program services are offered.
- (c) Choose to quit using IL program services.
- (d) Are eligible and plan to use vocational rehabilitation services.

(2) The IL program stops providing or paying for IL program services if an IL counselor:

- (a) Determines you no longer need IL program services.
- (b) Determines you are not progressing in your IL plan.
- (c) Determines that you are no longer eligible for IL program services.
- (d) Refers you to another service or program that offers services that are more likely to meet your needs.
- (e) Cannot locate you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1070, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1075 Am I involved in the decision to stop receiving IL program services? Before the IL program decides to stop providing or paying for your IL program services, an IL counselor must give you an opportunity to discuss the reasons for the decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1075, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1080 How does the IL program notify me that my services are stopping? (1) If an IL counselor decides that you are no longer eligible for IL program services, the IL counselor must follow the procedures in WAC 388-890-0065 to notify you about the decision.

(2) If you and an IL counselor have decided to stop IL program services for another reason, the IL program must send you a written notice. The written notice must explain:

- (a) The reason the IL program has decided to stop providing or paying for IL program services; and
- (b) The services offered by the client assistance program as outlined under WAC 388-890-1185 and how to ask for those services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1080, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1085 If the IL program decides I am not eligible for IL program services, is the decision reviewed? (1) If the IL program decides that you are not eligible for IL program services, an IL counselor must contact you to review the decision within twelve months.

(2) If you have a change in your life that affects your eligibility for IL program services, you may ask the IL program to review the decision.

(3) The IL program is not required to review your eligibility if you:

- (a) Refuse or decline a review;
- (b) Are no longer available to receive services at a DVR office that provides IL program services; or
- (c) Cannot be located.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1085, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1090 Does the IL program keep a record of my IL program services? The IL program keeps a record of your services, either electronically or in writing for three years after you stop receiving IL program services. The record includes, but is not limited to:

- (1) Records that verify your eligibility or ineligibility;
- (2) IL goals and objectives that are:
 - (a) Established with your input, whether on a written IL plan or not; and
 - (b) Achieved by you.
- (3) Services you requested and received;

(4) A written IL plan or a written form signed by you declining a plan.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1090, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1095 Does the IL program keep personal information confidential? (1) The IL program protects your personal information as outlined in WAC 388-890-1255 through 388-890-1295.

(2) When a service provider is used, the service provider must have and follow policies and procedures that are consistent with WAC 388-890-1255 through 388-890-1295.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1095, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1100 How are costs for VR and IL program services paid? DVR may only pay for VR and IL program services after you and a counselor have looked for other resources available to pay for the services, including:

- (1) Comparable services and benefits; and
- (2) Your own financial resources.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1100, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1110 What are comparable services and benefits? Comparable services and benefits are services or benefits that are similar to services DVR would provide that are available to you from another public program, under a health insurance program, or as an employee benefit. For example, if you need a mental health service and it is available to you at no cost from a local mental health center, DVR will not pay another organization or service provider for that service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1110, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1115 What VR or IL program services are provided without a determination of comparable services or benefits? (1) The following VR services are provided without a determination of comparable services and benefits:

- (a) Assessment services, as outlined under WAC 388-890-0150;
- (b) Assistive technology services, as outlined under WAC 388-890-0190;
- (c) Assistive technology devices, as outlined under WAC 388-890-0175;
- (d) Counseling and guidance services, as outlined under WAC 388-890-0200;
- (e) Independent living services, including assessments, when provided directly by a VR or IL counselor, as outlined under WAC 388-890-0220;
- (f) Referral services, as outlined under WAC 388-890-0325;
- (g) Job placement and job retention services, as outlined under WAC 388-890-0240;

(h) Training services, as outlined under WAC 388-890-380 except training at an institution of higher education as outlined under 388-890-0395;

(i) Rehabilitation engineering services, as outlined under WAC 388-890-0335; and

(j) Post-employment services as outlined under WAC 388-890-0305 that include any of the services listed in subsections (a) through (i) above.

(2) The IL program does not pay for IL program services as outlined under WAC 388-890-870 through 388-890-1060 that you can get at no cost from another public program or as an employee or insurance benefit.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1115, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1120 What if determining the availability of comparable services and benefits would result in a delay or interrupt my progress? (1) A determination of comparable services and benefits is not required before you begin receiving VR services if you and a VR or IL counselor agree the determination would delay or interrupt:

(a) A service you need when you are at extreme medical risk;

(b) An immediate job placement; or

(c) Your progress toward achieving the employment outcome identified on your individual plan for employment or toward achieving your IL goals.

(2) A VR or IL counselor may complete the determination of comparable services and benefits while you receive VR or IL program services if it is expected that services and benefits exist and could be used at a later time without resulting in a delay.

(3) If comparable services and benefits are available, you must apply for and use comparable services and benefits.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1120, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1125 What is extreme medical risk? Extreme medical risk means a likelihood of death or a functional impairment will substantially worsen if medical services, including mental health services, are not provided quickly.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1125, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1130 Does DVR pay for a service if comparable services and benefits are available, but I don't want to use them? DVR does not pay for a service that is available to you as a comparable service or benefit. If you choose not to apply for or use comparable services or benefits that a VR or IL counselor determines are adequate to meet your needs, you are responsible to pay for the services or benefits.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1130, filed 8/27/99, effective 11/1/99.]

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WAC 388-890-1135 Are awards and scholarships based on merit considered comparable services and benefits? Awards and scholarships you earn based on merit are not considered comparable services and benefits.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1135, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1140 How do I get comparable services and benefits? (1) You apply for comparable services and benefits from the organization or agency from which the service or benefit is available.

(2) If you need assistance to apply for comparable services and benefits, a VR or IL counselor helps you apply for the services or benefits.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1140, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1145 How does DVR determine whether I pay for all or part of my VR or IL services using my own financial resources? To determine whether you must pay for all or part of your VR or IL program services using your own financial resources:

(1) You must complete a DVR financial statement to document your financial status before DVR purchases services under an IPE or IL Plan, except the services outlined in WAC 388-890-1175.

(2) You must provide copies of financial records requested by DVR to establish your financial status.

(3) Depending on your income tax filing status for the previous year, you must provide financial information based on your own individual resources or based on your family resources.

(a) If your income tax status was reported as married filing jointly, married filing separately, or as a dependent of another person, complete the financial statement based on family resources.

(b) If your income tax status was reported as single, complete the financial statement based on your own financial resources.

(4) If you fail to report your financial status accurately or provide the required information, DVR may deny or suspend services at any time in the rehabilitation process, except the services listed under WAC 388-890-1175.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1145, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1150 Do I have to report my financial status if I receive public assistance or income support from another public program? You meet DVR's financial need criteria if you qualify for one of the programs listed below, regardless of whether you are married, are a dependent, or receive financial support from another family member. If you give DVR proof that you receive benefits from one of these programs, you do not need to give DVR any other information about your financial status:

(1) DSHS income assistance,

(2) Medicaid, or

(3) Supplemental Security Income.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1150, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1155 What financial information does DVR use to decide if I need to help pay for VR services?

The following information is used to determine whether you must pay any part of the cost of VR or IL program services:

- (1) Your income from all sources;
- (2) Your assets and property, including but not limited to bank accounts, vehicles, personal property, stocks, bonds and trusts; and
- (3) Your living expenses, including household expenses, credit payments, disability-related expenses and other financial obligations.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1155, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1160 Are any of my resources not counted in the decision about whether I have to help pay for services? DVR does not count the following resources when deciding whether you need to help pay for VR or IL program services:

- (1) The value of your primary home and furnishings;
- (2) The value of items that you keep because of personal attachment or hobby interest, rather than because of monetary value;
- (3) The value of one vehicle per household member if the vehicle is needed for work, school, or to participate in VR or IL program services;
- (4) Retirement, insurance, or trust accounts that do not pay a current benefit to you or your family;
- (5) If a retirement, insurance or trust account pays a current benefit, only the monthly benefit is counted as income. The balance of the account is excluded;
- (6) Up to five thousand dollars of your total assets are excluded as exempt;
- (7) Equipment or machinery used to produce income;
- (8) Livestock used to produce income; and
- (9) Disability-related items.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1160, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1165 How does DVR decide whether I have resources to help pay for VR services? (1) You must complete a financial statement that compares your total income and assets to your total living expenses and obligations, unless you meet the conditions listed under WAC 388-890-1150.

- (2) DVR allows you to deduct five thousand dollars from your total assets as an exemption.
- (3) DVR pays for your VR or IL program services if the results of the financial statement show that you do not have resources available to help pay for your VR or IL program services.
- (4) You must help pay for VR or IL program services if the results of the financial statement show that you have

resources available to help pay for your VR or IL program services.

(5) DVR does not pay for VR or IL program services under an IPE or IL plan when the financial statement shows that you have resources available and choose not to use them to pay for VR or IL program services, except for the services listed under WAC 388-890-1150.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1165, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1170 How is the amount I pay for VR or IL program services determined? (1) After completing the financial statement, you and a VR or IL counselor must agree how to use the resources identified on the financial statement to help pay for VR or IL program services.

- (2) The costs you agree to pay are documented on the IPE or IL plan.
- (3) If your financial status changes, report the change to a VR or IL counselor.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1170, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1175 What VR or IL program services am I not required to help pay for? You are not required to help pay for the following VR or IL program services, regardless of your financial status:

- (1) Assessment services needed to determine eligibility or rehabilitation needs, including independent living assessment services;
- (2) Counseling, guidance, and referral services provided by DVR staff;
- (3) Job placement and job retention services;
- (4) Independent living services provided directly by DVR staff or for which there is no cost; and
- (5) Post-employment services that include any of the services listed in subsections (1) through (4) of this section.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1175, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1180 What if a VR counselor makes a decision about my VR services that I don't agree with? (1) If a VR counselor makes a decision relating to your VR services that you don't agree with, you have the following options:

- (a) Try to resolve the disagreement by talking to the VR counselor, a VR supervisor, or regional administrator;
- (b) Contact the Client Assistance Program as outlined under WAC 388-890-1185;
- (c) Request mediation; and/or
- (d) Request a formal hearing.
- (2) You have the right to use one or more of these options at any time.
- (3) Your efforts to reach an agreement with the VR counselor, VR supervisor, or regional administrator are not used to deny or delay your right to mediation or a formal hearing.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1180, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1185 What is the client assistance program (CAP)? (1) The client assistance program (CAP) is a program that offers advice and information at no cost to you about your rights as a DVR participant and to help you understand and receive services available.

(2) You may ask for help or information from CAP at any time during the rehabilitation process by:

(a) Asking a DVR staff person for information about how to contact CAP; or

(b) Calling CAP at the toll-free number 1-800-544-2121 voice/TTY.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1185, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1190 What is mediation? (1) Mediation is a method used when you and a VR counselor cannot resolve a disagreement about your VR services.

(2) A trained mediator who knows the laws and rules about VR services conducts a meeting with you and a representative from DVR.

(3) The mediator does not work for DVR.

(4) The mediator does not make decisions about the disagreement between you and a VR counselor.

(5) During a mediation meeting, the mediator:

(a) Allows each party to present information or evidence;

(b) Helps each party listen to and understand the other party's position;

(c) Reviews and explains any laws that apply; and

(d) Facilitates an agreement, if possible, between the parties.

(6) You may be represented by another person of your choice at the mediation meeting.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1190, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1195 When can I ask for mediation?

(1) Mediation is an option any time you disagree with a decision DVR makes about your VR services.

(2) All parties involved in the issue, including DVR, must agree to mediation.

(3) Mediation is not used to deny or delay your right to a formal hearing. You may request both mediation and a formal hearing at the same time. If an agreement is:

(a) Reached during mediation, the formal hearing is canceled.

(b) Not reached during mediation, the formal hearing is held as scheduled.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1195, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1200 Who arranges and pays for mediation? (1) DSHS schedules and holds mediation ses-

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sions in a timely manner at a location that is convenient to all parties.

(2) DSHS pays for costs related to mediation, except costs related to a representative or attorney you ask to attend.

(3) DVR may pay for VR services you require to participate in mediation, such as transportation or child care.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1200, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1205 Is information discussed during mediation confidential? Information discussed during mediation is kept confidential and may not be used in a later hearing or civil proceeding, if one is held. Before beginning a mediation session, all parties must sign a statement of confidentiality.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1205, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1210 How do I request mediation? For more information or to request mediation, ask a VR counselor, supervisor or regional administrator or call DVR's state-wide toll free number 1-800-637-5627.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1210, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1215 After the mediation session, do I receive a written statement of the results? (1) When you and the DVR representative reach an agreement during the mediation meeting, DSHS provides you with a written statement of the agreement.

(2) Agreements you and DVR make through mediation are not legally binding.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1215, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1220 What is a formal hearing? (1) A formal hearing is a proceeding conducted as outlined under the Administrative Procedure Act, chapter 388-08 WAC.

(2) A formal hearing is similar to a trial and is held by an administrative law judge who does not work for DSHS.

(3) During the formal hearing, both you and DVR may present information, witnesses, and/or documents to support your position.

(4) You may be represented by an attorney, a friend, a relative, or someone else if you choose.

(5) The administrative law judge makes a decision after:

(a) Hearing all of the information presented;

(b) Reviewing any documents submitted; and

(c) Reviewing relevant federal and state laws and regulations.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1220, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1225 When is a formal hearing available? (1) You have the right to a formal hearing when you

disagree with a decision made by DVR about your eligibility for VR services or a decision about VR services.

(2) You must ask for a formal hearing in writing within twenty days of the decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1225, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1230 How do I request a formal hearing? (1) To ask for a formal hearing, you must send a written request to the Office of Administrative Hearings, P.O. Box 2465, Olympia, Washington 98507-2465.

(2) You must include the following information in your written request:

- (a) Your name, address, and telephone number;
- (b) A written statement about the decision and the reasons you disagree; and
- (c) Any other information that supports your position.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1230, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1235 After I submit a request for a formal hearing, when is it held? The office of administrative hearings must hold a formal hearing within forty-five days of receipt of your written request for a hearing, unless:

- (1) You or DVR ask for a delay; and
- (2) There is a reasonable cause for the delay.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1235, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1240 Do I receive a written formal hearing decision? The office of administrative hearings sends you a written report of the findings and decisions within thirty days of the formal hearing.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1240, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1245 Is the decision after a formal hearing final? (1) The office of administrative hearings decision is final and DVR must implement the decision.

(2) If you do not agree with the office of administrative hearings decision, you may pursue civil action through superior court to review that decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1245, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1250 Can DVR suspend, reduce or terminate my services while waiting for a formal hearing decision? DVR must not suspend, reduce, or terminate services while a decision is waiting for a formal hearing decision, unless you:

- (1) Provide false information to obtain VR services; or
- (2) Commit fraud or other criminal action to obtain VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1250, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1255 How do I know what personal information I must give DVR and how it is used? When you apply for services, DVR must explain:

- (1) What types of personal information you must share;
- (2) What information DVR must get and what information is optional;
- (3) How DVR uses personal information;
- (4) What laws allow DVR to use personal information; and
- (5) Your options if you decline to give DVR required information.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1255, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1260 Does DVR keep a record of my VR services on file? DVR keeps a record of VR services for three years after your case is closed. The VR case service record includes, but is not limited to:

- (1) The application form or request for VR services.
- (2) Records that verify the type and severity of your disability.
- (3) A summary of how your disability limits your ability to get or keep a job.
- (4) Records that explain and support:
 - (a) The eligibility or ineligibility decision; and
 - (b) Your rehabilitation needs.
- (5) Records that support the need for a trial work experience, if needed, and summaries of trial work progress reviews.
- (6) Financial statement or proof that you qualify for income assistance as outlined under WAC 388-890-1150.
- (7) Information collected to develop an individualized plan for employment (IPE), including:
 - (a) A summary of how your job goal matches your strengths, abilities, and interests;
 - (b) Each step needed to reach your job goal; and
 - (c) VR services to be used and how the services address the impediment to employment.
- (8) If VR services are provided in a setting that is not integrated, a written explanation of reasons for using a nonintegrated setting.
- (9) IPE, IPE amendments, and IPE progress reports.
- (10) Records that verify you are paid at or above the minimum wage, but not less than the usual wage your employer pays to nondisabled individuals doing the same or similar work, if you achieve a competitive employment outcome.
- (11) Summary of annual reviews, if done.
- (12) Written results of mediation sessions or formal hearings, if held.
- (13) Written summary of the need for post-employment services after getting a job, including a description of what services are needed.
- (14) Notification of case closure and appeal rights.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1260, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1265 Under what conditions does DVR share personal information in my record with another service provider or organization? DVR shares personal information with another service provider or organization only when:

- (1) You sign a written consent giving DVR permission to release the information; and
- (2) The information is needed to help you meet your rehabilitation goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1265, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1270 When DVR gets personal information about me from another agency or service provider, is it kept confidential? If DVR gets personal information about you from another agency or service provider, DVR only releases the information to others following rules established by the agency or service provider that provided the information and with your written consent.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1270, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1275 Does DVR change incorrect information in my record? (1) You may ask DVR to correct information in your record that you believe is incorrect.

(2) DVR corrects the information, unless there is a disagreement about whether the information is correct. If there is a disagreement about whether the information is correct, you may:

- (a) Write a summary describing why the information is not correct; or
 - (b) Ask DVR to write a summary describing your concerns about the information.
- (3) DVR puts the written summary in your record.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1275, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1280 How do I receive copies of information from my DVR record? (1) You may ask DVR for information contained in your record. A request for records must be in writing.

(2) DVR gives you copies of the records in a timely manner, unless DVR determines the information may be harmful to you.

(3) If DVR determines the records may be harmful to you, DVR releases the records to your representative, parent, legal guardian, another person you choose, or to a qualified medical professional.

(4) If a representative has been appointed by a court to represent you, the information must be released to the representative.

(5) If previously existing records are given to DVR by another organization or service provider, you must ask the organization or service provider for the records.

(6) If DVR requested or paid an organization or service provider to create records, such as an assessment to determine eligibility, DVR may release the records to you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1280, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1285 Can DVR release personal information without my written consent? DVR releases personal information without your written consent only under the following conditions:

- (1) When required by federal or state law;
- (2) When asked by a law enforcement agency to investigate criminal acts, unless prohibited by federal or state law;
- (3) When given an order signed by a judge, magistrate, or authorized court official;
- (4) When DVR decides you may be a danger to yourself or others;
- (5) When asked by the division of child support of the department of social and health services; or
- (6) To an organization, agency or person(s) for audit, evaluation or research.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1285, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1290 Under what conditions does DVR release personal information for audit, evaluation or research? DVR may release personal information for audit, evaluation or research when the results would improve the quality of life or DVR services for people with disabilities. Before any personal information is shared, the organization, agency, authority or individual must agree to the following conditions:

- (1) The information must only be used by people directly involved in the audit, evaluation or research;
- (2) The information must only be used for the reasons approved by DVR in advance;
- (3) The information must be kept secure and confidential;
- (4) The information must not be shared with any other parties, including you or your representative; and
- (5) The final product or report must not contain any personal information that would identify you without your written consent.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1290, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1295 How does DVR protect personal information about drug, alcohol, HIV/AIDS and sexually transmitted diseases? (1) DVR uses special protections when you share personal information about drug or alcohol abuse or about HIV/AIDS and sexually transmitted diseases.

(2) DVR asks for your specific permission to copy information of this nature before sharing it with a service provider or organization that is helping you reach your employment goals.

(3) Information about drug and alcohol abuse must be handled in accordance with RCW 70.96A.150 and applicable federal and state laws and regulations.

(4) Information about HIV/AIDS or other sexually transmitted diseases must be handled in accordance with RCW

70.24.105 and applicable federal and state laws and regulations.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1295, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1300 How do I contact DVR if I don't speak English? If you don't speak English, you may request another type of communication to meet with DVR. DVR arranges and pays for services you need to communicate with DVR to learn about or apply for DVR services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1300, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1305 What other methods of communication does DVR use? DVR uses equipment, devices or other services you need to understand and respond to information. Methods we can use to communicate with you include, but are not limited to, the use of:

- (1) Interpreters;
- (2) Readers;
- (3) Captioned videos;
- (4) Telecommunications devices and services;
- (5) Taped text;
- (6) Braille and large print materials;
- (7) Electronic formats;
- (8) Graphics;
- (9) Simple language materials.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1305, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1310 When does DVR communicate with me using methods other than English? DVR uses a method of communication that enables you to understand information and ask questions about the following, at a minimum:

- (1) How DVR keeps personal information confidential;
- (2) Your right to make informed choices throughout the rehabilitation process;
- (3) DVR's decision about whether you are eligible for VR or IL program services;
- (4) The options you have to develop an individualized plan for employment (IPE);
- (5) Other essential information relating to VR or IL program services and programs and answer your questions.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1310, filed 8/27/99, effective 11/1/99.]

Title 389 WAC

PUBLIC DEPOSIT PROTECTION COMMISSION

Chapters 389-12

Practice and procedure—Public depositaries.

Chapter 389-12 WAC

PRACTICE AND PROCEDURE—PUBLIC DEPOSITARIES

WAC

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WAC 389-12-020 Definitions. Unless the context requires otherwise:

(1) "Public depositary" means a financial institution which does not claim exemption from the payment of any sales or compensating use or ad valorem taxes under the laws of this state, which has segregated for the benefit of the commission eligible collateral having a value of not less than its maximum liability and whose charter has been approved by the commission to hold public deposits.

(2) "Financial institution" means any of the following which are located in this state and are lawfully engaged in business:

(a) Bank depositaries—Any branch of a bank engaged in the banking business in this state in accordance with RCW 30.04.300, and any state bank or trust company or national banking association.

(b) Thrift depositaries—Any state chartered mutual savings bank or stock savings bank, any state or federally chartered savings and loan association (including federally chartered savings bank).

(3) "Investment deposit" shall mean time deposits, savings deposits, and money market deposit accounts of public funds available for investment. Savings deposits shall mean an interest bearing deposit of public funds that is subject to withdrawal and that is not payable on a specified date or at the expiration of a specified time after the date of deposit. Time deposit shall mean a single maturity or multiple maturity interest bearing investment deposit of public funds, which is either evidenced by a certificate of deposit issued by a public depositary, or reflected in a book-entry system of