WSR 26-15-066
PERMANENT RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Home and Community Living Administration)
[Filed July 15, 2026, 8:21 a.m., effective August 15, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The amendments and new sections will incorporate the requirements of E2SSB 5337 (chapter 187, Laws of 2025), Memory care certification, creating a certification process for assisted living facilities (ALF) providing memory care services in a memory care facility or memory care unit. There are also minor changes and clarifications to other sections of chapter 388-78A WAC, Assisted living facility rules. Proposed changes to the ALF chapter for operators of memory care facilities or memory care units adds new sections for certification requirements, implementation of certification for licensed ALFs, certified memory care disclosure, the evaluation of certification, and the addition of the Consumer Protection Act for memory care.

Proposed changes to existing rules include definitions for dementia, memory care facility or memory care unit, and memory care services. The proposed rules allow dementia services to be provided in a nonrestricted egress ALF; semi-annual ongoing assessments for residents receiving memory care services; daily activity requirements; and health support services to include memory care services, physical environment requirements, caregiver availability 24 hours per day, including caregivers physically present 24 hours a day in cottages or buildings, caregivers completing six hours of continuing education related to dementia, and policies and procedures to address residents with behavioral challenges.

Proposed changes to existing rules include ALF developing an emergency plan addressing residents with dementia, extreme heat and cold in the emergency and disaster preparedness plan, a licensee's responsibility to post the certification certificate, how an ALF will apply for certification, what the department of social and health services (department) can review during a certification application, the annual renewal process for certification, and how an ALF with a certification completes a change of ownership. The proposed rules also provide enforcement remedies for ALFs providing memory care services without being certified; continued use of terminology, such as memory care or specialized dementia care without certification; and the ability to suspend or revoke a certification.

The proposed rules make minor changes to existing rules, [including] updating reporting of abuse and neglect, and reporting fires and incidents. Edits were also made to reflect the organizational name change, include the option to report online, correct a rule reference in sewage and liquid waste disposal, change an "or" to "and" in resident units, update toilet rooms and bathrooms to the current building code regulations for roll-in showers, and update laundry to allow for hot water temperatures or chemical sanitizer.

Citation of Rules Affected by this Order: New WAC 388-78A-2383, 388-78A-2384, 388-78A-2385, 388-78A-2387, and 388-78A-2389; and amending WAC 388-78A-2020, 388-78A-2050, 388-78A-2100, 388-78A-2180, 388-78A-2200, 388-78A-2381, 388-78A-2450, 388-78A-2600, 388-78A-2630, 388-78A-2650, 388-78A-2700, 388-78A-2730, 388-78A-2750, 388-78A-2760, 388-78A-2775, 388-78A-2790, 388-78A-2960, 388-78A-3010, 388-78A-3030,

388-78A-3040, 388-78A-3160, 388-78A-3170, 388-78A-3181, and 388-78A-3230.

Statutory Authority for Adoption: RCW 18.20.090 and 18.20.550.

Adopted under notice filed as WSR 26-09-129 on April 21, 2026.

Changes Other than Editing from Proposed to Adopted Version: Clarifying language changes were made to WAC 388-78A-2381 General design requirements for memory care: The language in subsection (2)(g)(i)(B) was changed from "provide" to "maintain." Additionally, a reference to an already established subsection in this WAC was added to subsection (2)(g)(i)(B) clarifying a facility must have policy and procedures to ensure residents can access an outdoor space when the facility provides an alternative viewing area. Finally, the department inadvertently missed an amended reference in WAC 388-78A-2020 that had been adopted in WSR 26-05-046 but had not been codified on the legislative website. That amended rule is reflected in this permanent adoption filing.

A final cost-benefit analysis is available by contacting Tamara Tredo, P.O. Box 45600, Olympia, WA 98504-5600, phone 360-999-0237, TTY 711 relay service, email RCSPolicy@dshs.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 5, Amended 18, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 5, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 5, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 24, Repealed 0.

Date Adopted: July 14, 2026.

Lisa N.H. Yanagida
Chief of Staff

SHS-5135.6

AMENDATORY SECTION (Amending WSR 25-16-099, filed 8/6/25, effective 9/6/25)

WAC 388-78A-2020 Definitions. "Abandonment" means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means ((~~the~~)) intentional, willful, or reckless action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and

improper use of restraint against a vulnerable adult, which have the following meanings:

(1) **"Sexual abuse"** means any form of nonconsensual sexual conduct, including, but not limited to, unwanted or inappropriate touching, rape, ((~~sodomy~~)) molestation, indecent liberties, sexual coercion, sexually explicit photographing or recording, voyeurism, indecent exposure, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person, who is not also a resident or a client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.

(2) **"Physical abuse"** means the intentional, willful, or reckless action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding.

(3) **"Mental abuse"** means ((~~a~~)) an intentional, willful, or reckless verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing.

(4) **"Personal exploitation"** means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

(5) **"Improper use of restraint"** means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a manner that:

(a) Is inconsistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW;

(b) Is not medically authorized; or

(c) Otherwise constitutes abuse under the section.

"Activities of daily living" means the following tasks related to basic personal care: Bathing; toileting; dressing; personal hygiene; mobility; transferring; and eating.

"Administrator" means an assisted living facility administrator who must be in active administrative charge of the assisted living facility as required in this chapter. Unless exempt under RCW 18.88B.041, the administrator must complete long-term care training and home care aide certification.

"Adult day services" means care and services provided to a nonresident individual by the assisted living facility on the assisted living facility premises, for a period of time not to exceed 10 continuous hours, and does not involve an overnight stay.

"Ambulatory" means capable of walking or traversing a normal path to safety without the physical assistance of another individual:

(1) **"Nonambulatory"** means unable to walk or traverse a normal path to safety without the physical assistance of another individual;

(2) **"Semiambulatory"** means physically and mentally capable of traversing a normal path to safety with the use of mobility aids, but unable to ascend or descend stairs without the physical assistance of another individual.

"Applicant" means a person, as defined in this section, that has submitted, or is in the process of submitting, an application for an assisted living facility license.

"**Assisted living facility**" means any home or other institution, however named, that is advertised, announced, or maintained for the express or implied purpose of providing housing, basic services, and assuming general responsibility for the safety and well-being of the residents, and may also provide domiciliary care, consistent with this chapter to seven or more residents after July 1, 2000. However, an assisted living facility that is licensed for three to six residents prior to or on July 1, 2000, may maintain its assisted living facility license as long as it is continually licensed as an assisted living facility. "Assisted living facility" may also include persons associated with the assisted living facility to carry out its duties under this chapter. "Assisted living facility" does not include facilities certified as group training homes under RCW 71A.22.040, nor any home, institution, or section that is otherwise licensed and regulated under state law that provides specifically for the licensing and regulation of that home, institution, or section. "Assisted living facility" also does not include independent senior housing, independent living units in continuing care retirement communities, or other similar living situations including those subsidized by the U.S. Department of Housing and Urban Development.

"**Basic services**" means housekeeping services, meals, nutritious snacks, laundry, and activities.

"**Bathing fixture**" means a bathtub, shower, or sit-down shower.

"**Bathroom**" means a room containing at least one bathing fixture.

"**Building code**" means the building codes and standards adopted by the Washington state building code council.

"**Caregiver**" means anyone providing direct personal care to another person including, but not limited to, cuing, reminding, or supervision of residents, on behalf of an assisted living facility, except volunteers who are directly supervised.

"**Construction review services**" means the office of construction review services within the Washington state department of health.

"**Continuing care contract**" means, as stated in RCW 70.38.025, a contract providing a person, for the duration of that person's life or for a term in excess of one year, shelter along with nursing, medical, health-related, or personal care services, which is conditioned upon the transfer of property, the payment of an entrance fee to the provider of such services, or the payment of periodic charges for the care and services involved. A continuing care contract is not excluded from this definition because the contract is mutually terminable or because shelter and services are not provided at the same location.

"**Continuing care retirement community**" means, as stated in RCW 70.38.025, an entity which provides shelter and services under continuing care contracts with its members and which sponsors or includes a health care facility or a health service.

"**Contractor**" means an agency or person who contracts with a licensee to provide resident care, services, or equipment.

"**Crimes relating to financial exploitation**" means the same as "crimes relating to financial exploitation" as defined in RCW 43.43.830 or 43.43.842.

"**Dementia**" means the irreversible loss of cognitive or intellectual function such as thinking, remembering, and reasoning so severe that it interferes with an individual's daily functioning and everyday life. "Dementia" is not a specific diagnosis, but rather a group of symptoms that accompany certain diseases or conditions including, but not limited to: Alzheimer's disease, vascular dementia, frontotemporal dementia, Lewy body dementia, alcohol-related dementia, and major neu-

rocognitive disorder. "Dementia" does not include temporary or reversible destabilization due to delirium or behavioral or mental health disorders.

"Department" means the Washington state department of social and health services.

"Dietitian" means an individual certified under chapter 18.138 RCW.

"Direct supervision" means oversight by a person on behalf of the assisted living facility who has met training requirements, demonstrated competency in core areas, or has been fully exempted from the training requirements, is on the premises, and is quickly and easily available to the caregiver.

"Document" means to record, with signature, title, date, and time:

(1) Information about medication administration, medication assistance or disposal, a nursing care procedure, accident, occurrence, or change in resident condition that may affect the care or needs of a resident; and

(2) Processes, events, or activities that are required by law, rule, or policy.

"Domiciliary care" means:

(1) Assistance with activities of daily living provided by the assisted living facility either directly or indirectly;

(2) Health support services, if provided directly or indirectly by the assisted living facility; or

(3) Intermittent nursing services, if provided directly or indirectly by the assisted living facility.

"Enforcement remedy" means one or more of the department's responses to an assisted living facility's noncompliance with chapter 18.20 RCW and this chapter, as authorized by RCW 18.20.190.

"Essential Support Person" means an individual who is: at least 18 years of age; designated by the resident, or by the resident's representative, if the resident is determined to be incapacitated or otherwise legally incapacitated; and necessary for the resident's emotional, mental, or physical well-being during situations that include, but are not limited to, circumstances involving compassionate care of end-of-life care, circumstances where visitation from a familiar person will assist with important continuity of care or the reduction of confusion and anxiety for residents with cognitive impairments, or other circumstances where the presence of an essential support person will prevent or reduce significant emotional distress to the resident.

"Financial exploitation" means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage. Some examples of financial exploitation are given in RCW 74.34.020.

"Food service worker" means according to chapter 246-217 WAC, an individual who works (or intends to work) with or without pay in a food service establishment and handles unwrapped or unpackaged food or who may contribute to the transmission of infectious diseases through the nature of the individual's contact with food products or equipment and facilities. This does not include persons who simply assist residents with meals.

"General responsibility for the safety and well-being of the resident" means the provision of any one or more of the following:

(1) Prescribed general low sodium diets;

(2) Prescribed general diabetic diets;
(3) Prescribed mechanical soft foods;
(4) Emergency assistance;
(5) Monitoring of the resident;
(6) Arranging health care appointments with outside health care providers and reminding residents of such appointments as necessary;
(7) Coordinating health care services with outside health care providers consistent with WAC 388-78A-2350;
(8) Assisting the resident to obtain and maintain glasses, hearing aids, dentures, canes, crutches, walkers, wheelchairs, and assistive communication devices;
(9) Observation of the resident for changes in overall functioning;
(10) Blood pressure checks as scheduled;
(11) Responding appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning;
(12) Medication assistance as permitted under RCW 69.41.085 and as described in RCW 69.41.010 and chapter 246-945 WAC.

"Harm" means a physical or mental or emotional injury or damage to a resident including those resulting from neglect or violations of a resident's rights.

"Health support services" means any of the following optional services:
(1) Blood glucose testing;
(2) Puree diets;
(3) Calorie controlled diabetic diets;
(4) Dementia care;
(5) Memory care provided only in an assisted living facility certified as a memory care facility or memory care unit;
(6) Mental health care; and
((~~(6)~~)) (7) Developmental disabilities care.

"Independent living unit" means:
(1) Independent senior housing;
(2) Independent living unit in a continuing care retirement community or other similar living environments;
(3) Assisted living facility unit where domiciliary services are not provided; or
(4) Assisted living facility unit where one or more items listed under "general responsibilities" are not provided.

"Independent senior housing" means an independent living unit occupied by an individual or individuals 60 or more years of age.

"Infectious" means capable of causing infection or disease by entrance of organisms into the body, which grow and multiply there, including, but not limited to, bacteria, viruses, protozoans, and fungi.

"Licensee" means a person, as defined in this section, to whom the department issues an assisted living facility license.

"Licensed resident bed capacity" means the resident occupancy level requested by a licensee and approved by the department. All residents receiving domiciliary care or the items or services listed under general responsibility for the safety and well-being of the resident as defined in this section count towards the licensed resident bed capacity. Adult day services clients do not count towards the licensed resident bed capacity.

"Long-term care worker" or **"caregiver"** means the same as "long-term care workers" is defined in RCW 74.39A.009.

"Majority owner" means any person that owns:

(1) More than 50 percent interest;

(2) If no one person owns more than 50 percent interest, the largest interest portion; or

(3) If more than one person owns equal largest interest portions, then all persons owning those equal largest interest portions.

"Manager" means a person, as defined in this section, that provides management services on behalf of a licensee.

"Management agreement" means a written, executed agreement between a licensee and manager regarding the provision of certain services on behalf of the licensee.

"Mandated reporter:"

(1) Is an employee of the department, law enforcement officer, social worker, professional school personnel, individual provider, employee of a facility, operator of a facility, employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency, county coroner or medical examiner, Christian Science practitioner, or health care provider subject to chapter 18.130 RCW; and

(2) For the purpose of the definition of mandated reporter, "facility" means a residence licensed or required to be licensed under chapter 18.20 RCW (assisted living facility), chapter 18.51 RCW (nursing homes), chapter 70.128 RCW (adult family homes), chapter 72.36 RCW (soldiers' homes), chapter 71A.20 RCW (residential habilitation centers), or any other facility licensed by the department.

"Maximum facility capacity" means the maximum number of individuals that the assisted living facility may serve at any one time, as determined by the department.

(1) The maximum facility capacity includes all residents, respite care residents, and adult day services clients.

(2) The maximum facility capacity is equal to the lesser of:

(a) The sum of the number of approved bed spaces for all resident rooms (total number of approved bed spaces), except as specified in subsection (3) of this section;

(b) Twice the seating capacity of the dining area(s) consistent with WAC 388-78A-2300;

(c) The number of residents permitted by calculating the ratios of toilets, sinks, and bathing fixtures to residents consistent with WAC 388-78A-3030;

(d) For assisted living facilities licensed on or before December 31, 1988, the total day room area in square feet divided by 10 square feet, consistent with WAC 388-78A-3050; or

(e) For assisted living facilities licensed after December 31, 1988, the total day room area in square feet divided by 20 square feet, consistent with WAC 388-78A-3050.

(3) For the purposes of providing adult day services consistent with WAC 388-78A-2360, one additional adult day services client may be served, beyond the total number of approved bed spaces, for each additional 60 square feet of day room area greater than the area produced by multiplying the total number of approved bed spaces by 20 square feet, provided that:

(a) There is at least one toilet and one hand washing sink accessible to adult day services clients for every eight adult day services clients or fraction thereof;

(b) The total number of residents and adult day services clients does not exceed twice the seating capacity of the dining area(s) consistent with WAC 388-78A-2300; and

(c) The adult day services program area(s) and building do not exceed the occupancy load as determined by the local building official or state fire marshal.

"Medication administration" means the direct application of a prescribed medication whether by injection, inhalation, ingestion, or other means, to the resident's body by an individual legally authorized to do so.

"Medication assistance" means assistance with self-administration of medication rendered by a nonpractitioner to a resident of an assisted living facility in accordance with chapter 246-945 WAC.

"Medication organizer" means a container with separate compartments for storing oral medications organized in daily doses.

"Medication service" means any service provided either directly or indirectly by an assisted living facility related to medication administration, medication administration provided through nurse delegation, medication assistance, or resident self-administration of medication.

"Memory care facility" or **"memory care unit"** means any assisted living facility which markets, or otherwise represents itself as providing memory care or specialized dementia care services, whether as a facility dedicated solely to serving residents with dementia or within a dedicated unit or wing within a larger facility. An assisted living facility does not need to specifically use the terms "memory care facility," "specialized dementia care," or similar terms in its name to be considered a memory care facility. If any part of an assisted living facility has restricted egress that prevents residents with cognitive impairment from leaving the facility without accompaniment by staff or another individual, it is sufficient to be considered as a memory care facility or memory care unit requiring certification.

"Memory care services" and **"specialized dementia care services"** means services offered and provided in addition to the domiciliary care services provided by the assisted living facility that are responsive to the typical needs of an individual with dementia.

"Neglect" means:

(1) A pattern of conduct or inaction by a person or entity with a duty of care that fails ((~~resulting in the failure~~)) to provide the goods and services that maintain physical or mental health of a ((~~resident~~)) vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a resident; or

(2) An act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the ((~~resident's~~)) vulnerable adult's health, welfare, or safety, including but not limited to, conduct prohibited under RCW 9A.42.100.

"Nonresident individual" means an individual who resides in independent senior housing, independent living units in continuing care retirement communities, other similar living environment, or an unlicensed room located within an assisted living facility. A nonresident individual must not receive from the assisted living facility:

(1) Domiciliary care directly or indirectly; or

(2) Items or services listed in the definition of "general responsibility for the safety and well-being of the resident," except as allowed under WAC 388-78A-2032 or when the person is receiving adult day services.

"Nonpractitioner" means any individual who is not a practitioner as defined in WAC 388-78A-2020 and chapter 69.41 RCW.

"Nurse" means an individual currently licensed under chapter 18.79 RCW as either a:

(1) **Licensed practical nurse** (LPN); or

(2) **Registered nurse** (RN).

"Over-the-counter (OTC) medication" means any medication that may be legally purchased without a prescriptive order, including, but not limited to, aspirin, antacids, vitamins, minerals, or herbal preparations.

"Person" means any individual, firm, partnership, corporation, company, association, joint stock association, or any other legal or commercial entity.

"Physician" means an individual licensed under chapter 18.57 or 18.71 RCW.

"Practitioner" means a licensed physician, osteopathic physician, podiatric physician, pharmacist, licensed practical nurse, registered nurse, advanced registered nurse practitioner, dentist, and physician assistant. Refer to chapter 69.41 RCW for a complete listing of practitioners.

"Prescribed medication" means any medication (legend drug, controlled substance, and over-the-counter) that is prescribed by an authorized practitioner.

"Prescriber" means a health care practitioner authorized by Washington state law to prescribe drugs.

"Problem" means a violation of any WAC or RCW applicable to the operation of an assisted living facility:

(1) **"Recurring problem"** means, for all purposes other than those described in RCW 18.20.400, that the department has cited the assisted living facility for a violation of WAC or RCW and the circumstances of either (a) or (b) of this subsection are present. If the previous violation in (a) or (b) of this subsection was pursuant to WAC or RCW that has changed at the time of the new violation, citation to the equivalent current WAC or RCW section is sufficient. When there is a change in licensees between the first and the second or third citations, the new licensee must accept, and the department will consider, the prior licensee's compliance and enforcement record as part of the new licensee's compliance record at that assisted living facility if any person affiliated with the new licensee was affiliated with the prior licensee at the same assisted living facility. A person is considered affiliated with the licensee if the person is an applicant for the assisted living facility license, or is listed on the license application as a partner, officer, director, or majority owner of the applicant.

(a) The department previously imposed an enforcement remedy for a violation of the same section of WAC or RCW for substantially the same problem following any type of inspection within the preceding 36 months.

(b) The department previously cited a violation under the same section of WAC or RCW for substantially the same problem following any type of inspection on two occasions within the preceding 36 months.

(2) **"Serious problem"** means that there has been a violation of a WAC or RCW and:

(a) The resident was significantly harmed; or

(b) It is likely that the resident will be significantly harmed or die.

(3) **"Uncorrected problem"** means the department has cited a violation of WAC or RCW following any type of inspection and the violation remains uncorrected at the time the department makes a subsequent in-

spection for the specific purpose of verifying whether such violation has been corrected. When there is a change in licensee, the new licensee is responsible for correcting any remaining violations that may exist, including complying with any plan of correction in effect immediately prior to the change in licensee.

"Prospective resident" means an individual who seeks admission to a licensed assisted living facility and has completed and signed an application for admission, or the individual's legal representative or designated representative, if any, completed and signed the application on their behalf.

"Reasonable accommodation" or **"reasonably accommodate"** have the meaning given in federal and state antidiscrimination laws and regulations which include, but are not limited to, the following:

(1) Reasonable accommodation means that the assisted living facility must:

(a) Not impose admission criteria that excludes individuals unless the criteria is necessary for the provision of assisted living facility services;

(b) Make reasonable modification to its policies, practices, or procedures if the modifications are necessary to accommodate the needs of the resident;

(c) Provide additional aids and services to the resident.

(2) Reasonable accommodations are not required if:

(a) The resident or individual applying for admission presents a significant risk to the health or safety of others that cannot be eliminated by the reasonable accommodation;

(b) The reasonable accommodations would fundamentally alter the nature of the services provided by the assisted living facility; or

(c) The reasonable accommodations would cause an undue burden, meaning a significant financial or administrative burden.

"RCW" means Revised Code of Washington.

"Records" means:

(1) **"Active records"** means the current, relevant documentation regarding residents necessary to provide care and services to residents; or

(2) **"Inactive records"** means historical documentation regarding the provision of care and services to residents that is no longer relevant to the current delivery of services and has been thinned from the active record.

"Resident" means an individual who:

(1) Chooses to reside in an assisted living facility, including an individual receiving respite care;

(2) Is not related by blood or marriage to the operator of the assisted living facility;

(3) Receives basic services; and

(4) Receives one or more of the services listed in the definition of "general responsibility for the safety and well-being of the resident," and may receive domiciliary care or respite care provided directly, or indirectly, by the assisted living facility. Whereas, a nonresident individual may receive services that are permitted under WAC 388-78A-2032.

"Resident's representative" means one of the following:

(1) The legal representative who is the person or persons identified in RCW 7.70.065 and who may act on behalf of the resident pursuant to the scope of their legal authority. The legal representative must not be affiliated with the licensee, assisted living facility, or

management company, unless the affiliated person is a family member of the resident.

(2) If there is no legal representative, a person designated voluntarily by a competent resident in writing, to act in the resident's behalf concerning the care and services provided by the assisted living facility, and to receive information from the assisted living facility if there is no legal representative. The resident's representative must not be affiliated with the licensee, assisted living facility, or management company, unless the affiliated person is a family member of the resident. The resident's representative under this subsection must not have authority to act on behalf of the resident once the resident is no longer competent. The resident's competence must be determined using the criteria in chapter 11.130 RCW.

"Respite care" means short-term care for any period in excess of 24 continuous hours for a resident to temporarily relieve the family or other caregiver of providing that care.

"Restraint" means any method or device used to prevent or limit free body movement, including, but not limited to:

(1) **"Confinement"** unless agreed to as provided in WAC 388-78A-2370;

(2) **"Chemical restraint"** means the administration of any drug to manage a vulnerable adult's behavior in a way that reduces the safety risk to the vulnerable adult or others, has the temporary effect of restricting the vulnerable adult's freedom of movement, and is not standard treatment for the vulnerable adult's medical or psychiatric condition.

(3) **"Mechanical restraint"** means any device attached or adjacent to the vulnerable adult's body that they cannot easily remove and restricts freedom of movement or normal access to the vulnerable adult's body. "Mechanical restraint" does not include the use of devices, materials, or equipment that are:

(a) Medically authorized, as required, and;

(b) Used in a manner that is consistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW.

(4) **"Physical restraint"** means the application of physical force without the use of any device, for the purpose of restraining the free movement of a vulnerable adult's body. "Physical restraint" does not include:

(a) Briefly holding without undue force a vulnerable adult in order to calm or comfort the vulnerable adult; or

(b) Holding a vulnerable adult's hand to safely escort the vulnerable adult from one area to another.

"Room" means a space set apart by floor to ceiling partitions on all sides with all openings provided with doors or windows.

(1) **"Sleeping room"** means a room where a resident is customarily expected to sleep and contains a resident's bed.

(2) **"Resident living room"** means the common space in a resident unit that is not a sleeping room, bathroom, or closet.

"Significant change" means a change in the resident's physical, mental, or psychosocial status that causes either life-threatening conditions or clinical complications.

"Special needs" means a developmental disability, mental illness, or dementia.

"Staff person" means any assisted living facility employee, temporary employee, or contractor, whether employed or retained by the licensee or any management company or volunteer.

"State fire marshal" means the director of fire protection under the direction of the chief of the Washington state patrol.

"Toilet" means a disposal apparatus used for urination and defecation fitted with a seat and flushing device.

"Volunteer" means an individual who interacts with residents without reimbursement.

"Vulnerable adult" means a person:

(1) Sixty years of age or older who has the functional, mental, or physical inability to care for themselves;

(2) Found incapacitated under RCW 74.34.020;

(3) Who has a developmental disability as defined under RCW 71A.10.020;

(4) Admitted to any facility, including any assisted living facility;

(5) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW;

(6) Receiving services from an individual provider; or

(7) For the purposes of requesting and receiving background checks pursuant to RCW 43.43.832, includes a person who is an adult of any age who lacks the functional, mental, or physical ability to care for themselves.

"WAC" means Washington Administrative Code.

"Wellness program" means an educational program provided by the assisted living facility. It is a proactive and preventative approach to assist residents and nonresident individuals in achieving optimal levels of health, social, and emotional functioning. A wellness program does not include medical care or interventions.

"Willful" means the deliberate, or nonaccidental action or inaction by an alleged perpetrator that the alleged perpetrator knows, or reasonably should have known, could cause a negative outcome, including harm, injury, pain, or anguish.

"WISHA" means the Washington Industrial Safety and Health Act, chapter 49.17 RCW administered by the Washington state department of labor and industries.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2050 Resident characteristics. (1) The assisted living facility may admit and retain an individual as a resident in an assisted living facility only if:

((~~(1)~~)) (a) The assisted living facility can safely and appropriately serve the individual with appropriate available staff providing:

((~~(a)~~)) (i) The scope of care and services described in the assisted living facility's disclosure information, except if the assisted living facility chooses to provide additional services consistent with RCW 18.20.300(4); and

((~~(b)~~)) (ii) The reasonable accommodations required by state or federal law, including providing any specialized training to caregivers that may be required according to WAC 388-78A-2490 through 388-78A-2510;

((~~(2)~~)) (b) The individual does not require the frequent presence and frequent evaluation of a registered nurse, excluding those individuals who are receiving hospice care or individuals who have a short-term illness that is expected to be resolved within fourteen

days as long as the assisted living facility has the capacity to meet the individual's identified needs; and

((~~(3)~~)) (c) The individual is ambulatory, unless the assisted living facility is approved by the Washington state director of fire protection to care for semiambulatory or nonambulatory residents.

(2) The assisted living facility may admit and provide care for residents with dementia in a building without restricted egress when the facility does not represent themselves to the public, prospective residents, residents, and resident representatives as providing memory care services, as a memory care facility, or memory care unit without obtaining a certification.

AMENDATORY SECTION (Amending WSR 23-14-029, filed 6/26/23, effective 7/27/23)

WAC 388-78A-2100 Ongoing assessments. (1) The department amended portions of this rule from January 18, 2022, through June 8, 2023, in response to the state of emergency related to the COVID-19 pandemic. For requirements in place during that time, see WAC 388-78A-2101.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(b) For residents with dementia living in an assisted living facility certified as a memory care facility or memory care unit, complete a full assessment addressing the elements set forth in 388-78A-2090 for each resident at least semi-annually.

(c) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

((~~(c)~~)) (d) Ensure the staff person performing the ongoing assessments is qualified to perform them.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2180 Activities. The assisted living facility must:

(1) Provide space and staff support necessary for:

(a) Each resident to engage in independent or self-directed activities that are appropriate to the setting, consistent with the resident's assessed interests, functional abilities, preferences, and negotiated service agreement; and

(b) Group activities at least three times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.

(2) Make available routine supplies and equipment necessary for activities described in subsection (1) of this section.

(3) The assisted living facility certified as a memory care facility or memory care unit must provide daily activities consistent

with functional abilities, interests, habits, and preferences of the individual residents. On a daily basis, except during the activation of the disaster preparedness plan, the facility or unit must provide residents access to:

(a) Opportunities for independent, self-directed activities;

(b) Individual activities, in which a staff person or volunteer engages the resident in a planned or spontaneous activity of interest. Activities may include personal care activities and provide opportunities for purposeful and positive interactions;

(c) Group activities; and

(d) Offer opportunities for activities that accommodate variations in a resident's mood, energy, and preferences. The facility or unit must make appropriate activities available based upon each resident's individual schedule and interests. For example, a resident up at night must have access to staff support, food, and appropriate activities.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2200 Health support services. Health support services are an optional service that the assisted living facility may provide. The assisted living facility may choose to provide any of the following health support services; however, an assisted living facility may or may not need to provide additional health support services to comply with the reasonable accommodation requirements in federal and state law. The assisted living facility may provide:

(1) Blood glucose testing;

(2) Puree diets;

(3) Calorie controlled diabetic diets;

(4) Dementia care;

(5) Memory care only in an assisted living facility certified as a memory care facility or memory care unit;

(6) Mental health care; and

((~~(6)~~)) (7) Developmental disabilities care.

AMENDATORY SECTION (Amending WSR 20-02-104, filed 12/31/19, effective 1/31/20)

WAC 388-78A-2381 General design requirements for memory care. (1) When planning for new construction, renovations or change of service to include certified memory care services, the facility must document design considerations appropriate to residents with dementia, mental health issues, or cognitive and developmental disabilities within its functional program consistent with WAC 388-78A-2380.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, by using various sized furniture groupings that stimulate activity with environmental cues such as a garden area, resident kitchen, workshop, or ((~~contain~~)) contains areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(i) Giving residents opportunities for privacy, socialization, and common spaces that account for wandering behaviors;

(ii) Ensuring any public address system in the area of specialized dementia care services is used only for emergencies;

(iii) Encouraging residents' individualized spaces to be furnished and decorated with personal items based on resident needs and preferences; and

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

(b) Unless an alternative viewing area is provided as described in (c) of this subsection and written policies and procedures are created as described in ((~~(c)~~)) (d) of this subsection, the facility must provide an outdoor area for residents that:

(i) Is located on the floor on which the resident resides;

(ii) Is designed with a minimum of ((~~twenty-five~~)) 25 square feet of space per resident served;

(iii) Has areas protected from direct sunshine and rain throughout the day;

(iv) Has walking surfaces that are firm, slip-resistant and free from abrupt changes, and suitable for individuals using wheelchairs and walkers;

(v) Has outdoor furniture;

(vi) Has plants that are not poisonous or toxic to humans; ((~~and~~))

(vii) Has areas appropriate for outdoor activities of interest to residents, such as walking paths, raised garden, flowerbeds, or bird feeders((~~.~~)); and

(viii) Is surrounded by a wall or fence at least six feet high.

(c) If a facility does not provide an outdoor area located on the floor on which the resident resides in compliance with subsection (b)(i) of this subsection, then a facility must provide an alternative viewing area that:

(i) Is not obstructed by indoor furniture, storage areas, cleaning equipment, trash receptacles, snack food((~~/~~)) or drink tables, and other such encumbrances that would minimize access to the viewing area;

(ii) Must not serve as a hallway, or an additionally required community space such as a dining area, activity room, mobile healthcare services (such as home health, podiatrist, and dental services), or other purposes;

(iii) Must be a community space, not within the residents' room; and

(iv) Has windows that have an unobstructed and viewable height accessible by wheelchair.

(d) If a facility does not provide an outdoor area located on the floor on which the resident resides in compliance with subsection (b)(i) of this section, a facility must put in place and maintain a written policy and procedure that documents how the facility provides residents with access to an outdoor area on a floor other than the floor on which the resident resides. Upon request the facility shall present that plan to the department for review. Such a plan must include:

(i) The location of the outdoor space;

(ii) A description of any assistance necessary for the resident to reach the outdoor space at any time, and documented in the negotiated service agreement plan per WAC 388-78A-2140(2);

(iii) The facility's plan for providing any necessary staff assistance described in subsection (d)(ii) of this section; and

(iv) A plan to maintain safety and security to prevent wandering or exit seeking while the resident is using the outdoor space.

(e) The required outdoor area must be accessible to residents ((~~with minimal staff assistance in a manner consistent with the residents' individual negotiated service agreement,~~)) without staff assistance except where pursuant to a facility policy, and consistent with WAC 388-78A-2600, the facility administrator or other appropriate staff will monitor or temporarily restrict access if staff reasonably believe that the health ((~~or~~)), safety, or well-being of a resident or residents may be at risk, including, but not limited to, instances of:

(i) Inclement weather;

(ii) Dangerous construction or maintenance activities; or

(iii) Other temporary environmental factors that create an unsafe environment.

((~~(e) If a facility does not provide an outdoor area located on the floor on which the resident resides in compliance with subsection (b)(i) of this subsection, a facility must put in place and maintain a written policy and procedure that documents how the facility provides residents with access to an outdoor area on a floor other than the floor on which the resident resides. Upon request the facility shall present that plan to the department for review. Such a plan must include:~~

~~(i) The location of the outdoor space;~~

~~(ii) A description of any assistance necessary for the resident to reach the outdoor space at any time, and documented in the negotiated service agreement plan per WAC 388-78A-2140(2);~~

~~(iii) The facility's plan for providing any necessary staff assistance described in (e)(ii) of this subsection;~~

~~(iv) A plan to maintain safety and security to prevent wandering or exit seeking while the resident is using the outdoor space; and~~))

(f) Facilities licensed prior to date of implementation of this rule that have an outdoor area on each floor, may not eliminate the required outdoor space.

(g) The department may grant an exemption to an assisted living facility applying for certification of memory care when:

(i) The facility was licensed between February 1, 2020, and July 1, 2025:

(A) To the requirement of an outdoor area located on the floor on which the resident resides in compliance with subsection (b)(i) of this section; and

(B) If the exemption is granted the facility must maintain an alternative viewing area meeting subsection (c)(i) through (iv) of this section and must comply with subsection (d)(i) through (iv) of this section.

(ii) The facility was licensed prior to January 31, 2020:

(A) The requirement of an outdoor area located on the same floor which the resident resides in compliance with subsection (b)(i) and an alternative viewing area in compliance with subsection (c)(i) through (iv); and

(B) If the exemption is granted the facility must comply with subsection (d)(i) through (iv) of this section.

NEW SECTION

WAC 388-78A-2383 Certified memory care. (1) After July 1, 2026, an assisted living facility may not operate as a memory care facility or maintain a memory care unit without becoming certified.

(2) To be certified by the department the assisted living facility must:

(a) Have a valid, current, license to operate an assisted living facility as required under RCW 18.20.030;

(b) Apply for certification and submit the initial certification fee as required by WAC 388-78A-2750;

(c) Not have a pattern of uncorrected or recurring significant enforcement remedies prior to the date of application. Evidence of significant enforcement may include:

(i) Citations issued in areas of resident harm or serious risk of harm, or actions or inactions resulting in serious disregard for resident health, safety, or deterioration of quality of care; or

(ii) Civil fines based on the department's determination of moderate to severe violations as defined in WAC 388-78A-3183;

(d) Not have a stop placement or conditions on a license related to resident care, or license revocation actions prior to the date of application for certification;

(e) Have permanent infrastructure considering the specialized needs of residents with dementia in WAC 388-78A-2381 including elements to restrict egress and meet daily activity requirements in WAC 388-78A-2180;

(f) Have a staffing plan that maintains 24-hour awake caregivers at a level adequate to respond to each resident's accessed needs, including waking and sleeping patterns and routine assistance with eating;

(g) Have a staffing plan, if applicable, when residents live in separate buildings or cottages that maintains at least 1 awake caregiver physically present in each building or cottage 24-hours per day; and

(h) Have policies and procedures outlining how staff respond to and manage residents who wander, actions to take when a resident is missing, and how and when consultive services will be obtained and utilized for residents experiencing behavioral challenges.

(3) The department at its sole discretion, on a case-by-case basis, after taking into consideration information on the certification application of the assisted living facility licensed before July 1, 2026, may grant conditional exemptions to prevent disruption of services or displacement of residents.

NEW SECTION

WAC 388-78A-2384 Certification memory care—Implementation. (1) For the purpose of certification implementation for an assisted living facility with a current license issued on or before July 1, 2026, and operating a memory care facility or memory care unit as defined in WAC 388-78A-2020 the department may:

(a) Grant certification, deeming the licensee compliant from the application submission date to the effective date of certification,

while the department processes the application, when the application is submitted to the department by July 1, 2026: and

(b) Work with the licensee during the application process up to 120 calendar days to:

(i) Obtain information for an incomplete certification application from the licensee;

(ii) Complete the conditional exemption process, if applicable.

(2) If the department determines during the review process the licensee does not meet the certification requirements, the licensee may request a conditional exemption by submitting a written request to the department that includes:

(a) A description of the requested conditional exemption;

(b) The specific rule for which the exemption is sought;

(c) A description of what the assisted living facility has in place to meet the certification requirements at the time of application; and

(d) A detailed plan and timeline to meet the certification requirements, when applicable, to the exemption request.

(3) If the assisted living facility is granted a conditional exemption for certification a copy of the exemption must be retained in the facility.

(4) If the department determines a licensee will not be certified, or denies a request for conditional exemption, the assisted living facility may not appeal the department's denial.

(5) During the time of application review for certification and the department's decision to grant or deny a certification, the assisted living facility will not be subject to citations related to certified memory care requirements, provided the application was submitted by July 1, 2026.

(6) If during the application review the assisted living facility licensee withdraws from the certification process, or the department denies a certification, the assisted living facility must:

(a) Within 30 calendar days provide to residents, and their representatives, if applicable, notice of the withdrawal or denial of the certification application; and

(b) Assist all residents requiring memory care services to transition to a certified memory care facility or memory care unit within 180 calendar days of the date the facility withdrew their application or the department denied the certification.

(7) The assisted living facility will not be subject to citation related to memory care certification requirements for the period of application through resident transition after a withdrawal or denial of certification if the application was submitted by July 1, 2026.

(8) The department may consider an application for certification void when the applicant:

(a) Does not return information to the department within 60 days of the first request for additional information for an incomplete certification application; or

(b) Has not obtained certification within 120 days of the first submission of an application for certification to the department.

(9) When an assisted living facility with a current license, not meeting the definition of a memory care facility or memory care unit in WAC 388-78A-2020 on July 1, 2026, decides to transition to a certified memory care facility or add a memory care unit the facility must:

(a) Meet construction review requirements consistent with WAC 388-78A-2821, when applicable;

(b) Meet construction review requirements consistent with WAC 388-78A-2850, when applicable;

(c) Submit an application for certification;

(d) Request a capacity increase consistent with WAC 388-78A-2800; and

(e) Meet criteria for increased licensed capacity consistent with WAC 388-78A-2810.

NEW SECTION

WAC 388-78A-2385 Certified memory care—Disclosure. (1) An assisted living facility certified as a memory care facility or memory care unit must post in a prominent location in the facility or unit and make available upon request a memory care disclosure to residents, resident representatives, if any, and interested consumers in substantially the following format:

Memory care disclosure required by RCW 18.20.300 (2)(a):

(a) Facility information, including:

(i) Facility name;

(ii) Facility address;

(iii) Facility phone number;

(b) Number of licensed beds in the memory care facility or memory care unit;

(c) Number of awake overnight caregivers and direct care staff available per resident occupied bed;

(i) Caregivers;

(ii) Other direct care staff;

(d) Number of regular direct care staff and caregivers per resident occupied bed during the day and evening hours;

(i) Caregivers;

(ii) Other direct care staff;

(2) The assisted living facility certified as a memory care facility or memory care unit must provide written notice informing the resident and their representative, if any, as defined in RCW 70.129.010, of a significant change in staffing within 30 days of the change and make the notification available for department review.

(3) For the purpose of this section "significant change in staffing" is defined as a reduction in the caregiver or direct care staff workforce in the memory care facility or memory care unit lasting more than five days where the facility or unit only meets basic essential needs such as eating, drinking, toileting, and medications for residents based on staffing. A significant change in staffing does not apply when an adjustment to the memory care facility or memory care unit staffing is based on a fluctuation in resident census.

NEW SECTION

WAC 388-78A-2387 Certified memory care—Evaluation. The department will conduct an on-site certification evaluation during regular licensing activities for an assisted living facility certified as a memory care facility or memory care unit.

NEW SECTION

WAC 388-78A-2389 Certified memory care—Application of consumer protection act. Operation of an assisted living facility memory care facility or memory care unit without a certification are matters vitally affecting the public interest for the purpose of applying the consumer protection act, chapter 19.86 RCW. A violation of this chapter is not reasonable in relation to the development and preservation of business and is unfair or deceptive acts in trade or commerce and an unfair method of competition for the purpose of applying the consumer protection act, chapter 19.86 RCW.

AMENDATORY SECTION (Amending WSR 25-16-099, filed 8/6/25, effective 9/6/25)

WAC 388-78A-2450 Staff. (1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with their negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(c) Implement fire and disaster plans.

(2) The assisted living facility must:

(a) Develop and maintain written job descriptions for the administrator and each staff position and provide each staff person with a copy of their job description before or upon the start of employment;

(b) Verify staff persons' work references prior to hiring;

(c) Verify prior to hiring that staff persons have the required licenses, certification, registrations, or other credentials for the position, and that such licenses, certifications, registrations, and credentials are current and in good standing;

(d) Document and retain for 12 weeks, weekly staffing schedules, as planned and worked;

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience, and other qualifications necessary to provide the care and services;

(f) Ensure at least one caregiver, who is 18 years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times:

(i) When one or more residents are present on the assisted living facility premises; and

(ii) During assisted living facility activities off of the assisted living facility premises.

(g) Ensure caregiver provides on-site supervision of any resident voluntarily providing services for the assisted living facility;

(h) Provide staff orientation and appropriate training for expected duties when staff begin work in the facility, including, but not limited to:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working;

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW; ((~~and~~))

(viii) The facility's comprehensive disaster plan and related on-duty staff procedures; and

(ix) The assisted living facility certified as a memory care facility or memory care unit must train staff on the comprehensive disaster preparedness plan and related on-duty staff procedures, considering the needs of residents with dementia as required in WAC 388-78A-2700.

(i) Develop and implement a process to ensure caregivers:

(i) Acquire the necessary information from the preadmission assessment, on-going assessment, and negotiated service agreement relevant to providing services to each resident with whom the caregiver works;

(ii) Are informed of changes in the negotiated service agreement of each resident with whom the caregiver works; and

(iii) Are given an opportunity to provide information to responsible staff regarding the resident when assessments and negotiated service agreements are updated for each resident with whom the caregiver works.

(j) Ensure all caregivers have access to resident records relevant to effectively providing care and services to the resident.

(3) The assisted living facility certified as a memory care facility or memory care unit must:

(a) Maintain awake caregiving staff 24 hours per day at a level that is adequate to respond to residents' assessed needs, including waking and sleeping patterns;

(b) Maintain, if applicable, in each separate memory care building or memory care cottage at least 1 awake and physically present caregiving staff 24 hours per day;

(c) Maintain a staffing level to routinely provide:

(i) Cueing for eating and drinking;

(ii) Physical assistance with eating and drinking such as cutting up food, preparing food and beverages, and bringing food and fluids to the resident; and

(iii) Occasional feeding assistance such as cutting up food and assisting the residents to get food and fluids into their mouth.

(4) Nothing in (3)(c)(iii) is intended to require a memory care facility or memory care unit to provide a resident with total feeding assistance for an extended or indefinite amount of time.

(5) The assisted living facility must:

(a) Protect all residents by ensuring any staff person suspected or accused of abuse, neglect, financial exploitation, or abandonment does not have access to any resident until the assisted living facility investigates and takes action to ensure resident safety;

(b) Not interfere with the investigation of a complaint, coerce a resident or staff person regarding cooperating with a complaint investigation, or conceal or destroy evidence of alleged improprieties occurring within the assisted living facility;

(c) Prohibit staff persons from being directly employed by a resident or a resident's family during the hours the staff person is working for the assisted living facility;

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112A WAC;

(B) The assisted living facility certified as a memory care facility or memory care unit must ensure long-term care workers who work directly with memory care residents have at least six hours per year of continuing education related to dementia. The six hours of continuing education related to dementia may be part of the continuing education requirements under chapter 388-112A WAC;

(C) Home care aide certification as required by this chapter and chapter 246-980 WAC;

((~~(C)~~)) (D) Cardiopulmonary resuscitation; and

((~~(D)~~)) (E) First aid; ((~~and~~

~~(E) HIV/AIDS training.~~))

(ii) Disclosure statements and background checks as required in WAC 388-78A-2461 through 388-78A-2471; and

(iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (2) of this section.

((~~(4)~~)) (6) The assisted living facility is not required to keep on the assisted living facility premises, staff records that are unrelated to staff performance of duties. Such records include, but are not limited to, pay records, and health and insurance benefits for staff.

Reviser's note: The typographical errors in the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 25-16-099, filed 8/6/25, effective 9/6/25)

WAC 388-78A-2600 Policies and procedures. (1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(c) Safely operate the assisted living facility; and

(d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70, 69.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

(2) The assisted living facility must develop, implement, and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(b) When there is reason to believe a resident is not capable of making necessary decisions and no substitute decision maker is available;

(c) When a substitute decision maker is no longer appropriate;

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

(e) When a resident does not have a personal physician or health care provider;

(f) In response to medical emergencies;

(g) When there are urgent situations in the assisted living facility requiring additional staff support;

(h) In the event of an internal or external disaster, consistent with WAC 388-78A-2700;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

(j) To appropriately respond to aggressive or assaultive residents, including, but not limited to:

(i) Actions to take if a resident becomes violent;

(ii) Actions to take to protect other residents; and

(iii) When and how to seek outside intervention.

(k) To prevent and limit the spread of infections consistent with WAC 388-78A-2610;

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290; sending medications with a resident when the resident leaves the premises;

(m) When services related to medications and treatments are provided under the delegation of a registered nurse consistent with chapter 246-840 WAC;

(n) Related to food services consistent with chapter 246-215 WAC and WAC 388-78A-2300;

(o) Regarding the safe operation of any assisted living facility vehicles used to transport residents, and the qualifications of the drivers;

(p) To coordinate services and share resident information with outside resources, consistent with WAC 388-78A-2350;

(q) To coordinate with state and local agencies and ombuds;

(r) Regarding the management of pets in the assisted living facility, if permitted, consistent with WAC 388-78A-2620;

(s) When receiving and responding to resident grievances consistent with RCW 70.129.060; and

(t) Related to providing respite care services consistent with RCW 18.20.350, if respite care is offered.

(3) For an assisted living facility certified as a memory care facility or memory care unit, the facility must develop, implement, and train staff persons on policies and procedures to address what a staff person must do:

(a) To respond to and manage residents who wander;

(b) When a resident is missing; and

(c) To utilize consultative services, when needed, for residents with behavioral challenges. This policy will identify at a minimum:

(i) A relevant professional, including but not limited to, a clinical psychologist, psychiatrist, psychiatric nurse practitioner, or a specialist with demonstrated experience working with individuals with cognitive disorders;

(ii) When the consultation will be utilized; and

(iii) How the consultation will be utilized.

(4) The assisted living facility must make the policies and procedures specified in subsection (2) and (3) of this section available to staff persons at all times and must inform residents and residents'

representatives of their availability and make them available upon request.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2630 Reporting abuse and neglect. (1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's ((~~Aging and Disability Services Administration Complaint Resolution Unit~~)) complaint resolution unit hotline or complete an online report consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

(2) The assisted living facility must prominently post so it is readily visible to staff, residents and visitors, the department's toll-free telephone number for reporting resident abuse and neglect.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's ((~~aging and disability services administration~~)) complaint resolution unit hotline or complete an online report for:

(1) Any accidental or unintended fire, or any deliberately set but improper fire, such as arson, in the assisted living facility;

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

AMENDATORY SECTION (Amending WSR 26-02-045, filed 1/2/26, effective 2/2/26)

WAC 388-78A-2700 Emergency and disaster preparedness. (1) The assisted living facility must:

(a) Maintain the premises free of hazards;

(b) Maintain any vehicles used for transporting residents in a safe condition;

(c) Provide, and tell staff persons of a means of emergency access to resident-occupied bedrooms, toilet rooms, bathing rooms, and other rooms;

(d) Provide emergency lighting or flashlights in all areas accessible to residents of the assisted living facility;

(e) Make sure first-aid supplies are:

(i) Readily available and not locked;
(ii) Clearly marked;
(iii) Able to be moved to the location where needed; and
(iv) Stored in containers that protect them from damage, deterioration, or contamination.
(f) Make sure first-aid supplies are appropriate for:
(i) The size of the assisted living facility;
(ii) The services provided;
(iii) The residents served; and
(iv) The response time of emergency medical services.
(2) The assisted living facility must develop and maintain a written emergency preparedness plan that describes measures to take in the event of emergencies or disasters, including, but not limited to:
(a) Fires;
(b) Earthquakes;
(c) Extreme cold;
(d) Extreme heat;
(e) Floods;
((~~(d)~~)) (f) Infectious disease outbreaks;
((~~(e)~~)) (g) Loss of power or water; and
((~~(f)~~)) (h) Other events that may require sheltering in place, evacuations, or other emergency measures to protect the health and safety of residents.
(3) The assisted living facility's emergency preparedness plan must include procedures for:
(a) Staff roles and responsibilities;
(b) Identifying and locating residents;
(c) Summoning emergency assistance and coordinating with first responders;
(d) Communicating emergency information to staff and residents as well as external partners, including emergency contacts for residents, state and local agencies, developmental disability ombuds, and long-term care ombuds;
(e) How resident care and treatment needs will be maintained;
(f) Provision of essential resident needs and supplies, including water, food, medications, and personal care items; ((~~and~~))
(g) Alternative resident accommodations; and
(h) An assisted living facility certified as a memory care facility or memory care unit must address the special needs of residents with dementia.
(4) The assisted living facility must incorporate infection prevention and control capability into its emergency preparedness plan. At minimum, the plan must:
(a) Include procedures for the procurement, inventory, tracking, safe storage, and rotation of personal protective equipment to ensure supplies remain within manufacturer recommended shelf life and are available for use; and
(b) Describe how the facility will ensure adequate staffing and implement isolation or cohorting procedures during an infectious disease emergency.
(5) In addition to the plan requirements, the assisted living facility must:
(a) Maintain an adequate supply of personal protective equipment appropriate to the facility size and resident population, including, but not limited to: gloves, gowns, surgical masks, eye protection, and NIOSH-approved respirators;

(b) Train all employees in the comprehensive emergency preparedness plan and staff procedures upon hire and reviewed annually thereafter;

(c) Review the comprehensive emergency preparedness plan and procedures and update at least annually;

(d) Communicate the location of the emergency preparedness plan to residents and staff to ensure access as needed during emergencies; and

(e) Comply with WAC 388-78A-3140.

AMENDATORY SECTION (Amending WSR 25-16-099, filed 8/6/25, effective 9/6/25)

WAC 388-78A-2730 Licensee's responsibilities. (1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(c) The care and services provided to the assisted living facility residents.

(2) The licensee must:

(a) Maintain the occupancy level at or below the licensed resident bed capacity of the assisted living facility;

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(i) A current assisted living facility license, including any related conditions on the license;

(ii) A current memory care certification as required in RCW 18.20.540;

(iii) The name, address, and telephone number of:

(A) The department;

(B) Appropriate resident advocacy groups; and

(C) The state and local long-term care ombuds with a brief description of ombuds services.

((~~(iii)~~)) (iv) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department; and

((~~(iv)~~)) (v) Post stop placement and limited stop placement orders as required in RCW 18.20.520.

(c) Ensure any party responsible for holding or managing residents' personal funds is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident funds; and provides proof of bond or insurance to the department.

(3) The licensee must not delegate to any person responsibilities that are so extensive that the licensee is relieved of responsibility for the daily operations and provisions of services in the assisted living facility.

(4) The licensee must act in accord with any department-approved management agreement, if the licensee has entered into a management agreement.

(5) The licensee must appoint the assisted living facility administrator consistent with WAC 388-78A-2520.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2750 Application process. (1) To apply for an assisted living facility license, a person must:

((~~(1)~~)) (a) Submit to the department a complete license application on forms designated by the department at least ((~~ninety~~)) 90 days prior to the proposed effective date of the license;

((~~(2)~~)) (b) Submit all relevant attachments specified in the application;

((~~(3)~~)) (c) Submit department background authorization forms;

((~~(4)~~)) (d) Sign the application;

((~~(5)~~)) (e) Submit the license fee as specified in WAC 388-78A-3230;

((~~(6)~~)) (f) Submit verification that construction plans have been approved by construction review services;

((~~(7)~~)) (g) Submit a revised application before the license is issued if any information has changed since the initial license application was submitted; and

((~~(8)~~)) (h) Submit a revised application containing current information about the proposed licensee or any other persons named in the application, if a license application is pending for more than one year((~~; and~~)).

((~~(9)~~)) (2) If the licensee's agent prepares an application on the licensee's behalf, the licensee must review, sign, and attest to the accuracy of the information contained in the application.

(3) The department may consider an application void when the applicant or licensee's agent does not return information to the department within 60 days of the first request for additional information for an incomplete application.

((~~(10)~~)) (4) A license must be issued only to the person who applied for the license.

((~~(11)~~)) (5) A license may not exceed ((~~twelve~~)) 12 months in duration and expires on a date set by the department.

(6) To apply for a memory care certification, a person must:

(a) Submit to the department a complete application for certification on the form designated by the department at least 90 days prior to the proposed date of certification;

(b) Sign the application for memory care certification; and

(c) Submit the initial certification fee as specified in WAC 388-78A-3220.

(7) If the licensee's agent prepares the memory care certification application on behalf of the licensee, the licensee must review, sign, and attest to the accuracy of the information contained in the certification application.

(8) A memory care certification must only be issued to the entity who applied for the certification.

(9) A certification may not exceed 12 months in duration and expires on the date set by the department.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2760 Necessary information. (1) In making a determination whether to issue an assisted living facility license, in ad-

dition to the information for each person named in the application, the department may review other documents and information the department deems relevant, including inspection and complaint investigation findings for each facility with which the applicant or any partner, officer, director, managerial employee, or owner of five percent or more of the applicant has been affiliated.

(2) In making a determination whether to issue a certification for memory care, the department may review other documents and information the department deems relevant, including enforcement remedies, inspections, and complaint investigation findings for each facility applying for certification.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2775 Change in licensee/change of ownership—Application. (1) The prospective licensee must complete, sign, and submit to the department a change of ownership application prior to the proposed date of change in licensee.

(2) The annual assisted living facility license fee, if a license fee is due, must accompany the change in ownership application.

(3) The prospective licensee must submit the following information that must be submitted along with the change of ownership application:

(a) Evidence of control of the real estate on which the assisted living facility is located, such as a purchase and sales agreement, lease contract, or other appropriate document; and

(b) Any other information requested by the department.

(4) The prospective licensee must submit the completed application to the department within the applicable time frames of WAC 388-78A-2785 or 388-78A-2787.

(5) A prospective licensee completing a change of ownership for an assisted living facility with a memory care certification must:

(a) Apply for a memory care certification at the same time an application for change of ownership is submitted to the department; and

(b) Submit the initial certification fee with the certification application.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2790 Annual renewal. To renew an assisted living facility license, the assisted living facility must:

(1) Submit a completed license renewal application on forms designated by the department, at least ((~~thirty~~)) 30 days prior to the license expiration date;

(2) Sign the application;

(3) Submit the annual license fee as specified in WAC 388-78A-3230; and

(4) If the licensee's agent prepares a renewal application on the licensee's behalf, the licensee must review, sign, and attest to the accuracy of the information contained on the renewal application.

(5) To renew a memory care certification, the assisted living facility must:

(a) Have a valid, current, assisted living facility license; and

(b) Submit the annual certification fee with the department designated form at least 30 days prior to the certification expiration date.

(6) The assisted living facility certified as a memory care facility or memory care unit must ensure the department receives the annual certification fee when it is due.

(7) If the assisted living facility does not pay the annual certification fee the department will impose remedies.

AMENDATORY SECTION (Amending WSR 20-02-104, filed 12/31/19, effective 1/31/20)

WAC 388-78A-2960 Sewage and liquid waste disposal. The assisted living facility must:

(1) Ensure that all sewage and waste water drain into a municipal sewage disposal system according to chapter ((~~246-272A~~)) 173-240 WAC, if available; or

(2) Provide on-site sewage disposal systems designed, constructed, and maintained as required by chapters ((~~246-272B~~)) 246-272A and ((~~173-240~~)) 246-272B WAC, and local ordinances.

AMENDATORY SECTION (Amending WSR 20-02-104, filed 12/31/19, effective 1/31/20)

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(1) **General characteristics:**

(a) Units must have lever door hardware and option for lockable entry doors;

(i) Locking entry doors must unlock with single lever handle motion;

(b) Residents may not enter their rooms through another resident unit or resident bedroom;

(c) The functional program shall identify the number of units or number of licensed beds designed for staff assisted movement, bathing and toileting;

(2) **Number of residents:** Each resident unit shall be limited to not more than two residents.

(3) **Unit configuration types:**

(a) A studio unit or single room;

(b) A companion unit sized appropriately to provide two separate sleeping rooms or spaces of a common entry vestibule;

(c) A one bedroom unit with separate living and sleeping rooms; or

(d) A two bedroom unit with separate living and sleeping rooms;

(4) **Bathrooms:** Access to bathing/toileting facilities within the resident unit must not be through a resident sleeping room or otherwise compromise resident dignity or privacy.

(5) **Sleeping rooms size:**

(a) One person rooms shall have not less than ((~~eighty~~)) 80 square feet of usable floor space;

(b) Two person rooms shall not have less than ((~~seventy~~)) 70 square feet of usable floor space per individual;

(c) When a resident sleeping room is located within a private apartment:

(i) The private apartment includes a resident sleeping room, a resident living room, and a private bathroom;

(ii) The total square footage in the private apartment equals or exceeds ((~~two hundred-twenty~~)) 220 square feet excluding the bathroom;

(iii) There are no more than two residents living in the apartment; ((~~or~~)) and

(iv) Both residents mutually agree to share the resident sleeping room; and

(v) If all other requirements of this section are met, then the two residents may share a sleeping room with less than ((~~one hundred forty~~)) 140 square feet; and

(d) All sleeping rooms must be of sufficient size to allow three feet between the bed and the adjacent walls or furnishings and five feet between other beds.

(6) **Calculating floor space:**

(a) Usable floor space in a resident's sleeping room is calculated by measuring from interior wall to interior wall surface;

((~~(i)~~)) (b) Including areas of door swings and entryways into the sleeping room((~~.~~)); and

((~~(ii)~~)) (c) Excluding areas under ceilings less than seven feet high, closet space and built-in storage, areas under counters, sinks, or appliances, bathroom, and toilet rooms.

(7) **Room arrangement:**

(a) Each sleeping room must have unrestricted direct access to a hallway, living room, outside, or other common-use area;

(b) A resident sleeping room may not be used as a passageway, hall, intervening room, or corridor.

(8) Miscellaneous: Each sleeping room must have:

(a) One or more outside windows with:

(i) Window sills at or above grade, with grade extending horizontally ((~~ten~~)) 10 or more feet from the building; and

(ii) Adjustable curtains, shades, blinds, or equivalent for visual privacy.

(b) Electrical receptacles consistent with the requirements of the electrical code;

(c) A light control switch located by the entrance for a light fixture in the room;

(d) An individual towel and washcloth rack or equivalent, except when there is a private bathroom attached to the resident sleeping or living room, the individual towel and washcloth rack may be located in the attached private bathroom;

(e) A lockable drawer, cupboard, or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

(f) Separate storage facilities for each resident in or immediately adjacent to that residents sleeping room to adequately store a reasonable quantity of clothing and personal possessions; and

(g) Separate storage containers for materials used in the administration of intermittent nursing services appropriate to the needs of the resident and documented in the functional program.

AMENDATORY SECTION (Amending WSR 20-02-104, filed 12/31/19, effective 1/31/20)

WAC 388-78A-3030 Toilet rooms and bathrooms. (1) The assisted living facility must provide private or common-use toilet rooms and bathrooms to meet the needs of each resident.

(2) The assisted living facility must provide each toilet room and bathroom with:

(a) Water resistant, smooth, low gloss, nonslip, and easily cleanable materials;

(b) Washable walls to the height of splash or spray;

(c) Grab bars installed and located to minimize accidental falls including one or more grab bars at each:

(i) Bathing fixture; and

(ii) Toilet.

(d) Plumbing fixtures designed for easy use and cleaning and kept in good repair; and

(e) Provide mechanical ventilation to the outside; and

(f) Separation from other rooms or areas by four walls and a door.

(3) The assisted living facility must provide each toilet room with a:

(a) Toilet with a clean, nonabsorbent seat free of cracks;

(b) Handwashing sink in or adjacent to the toilet room; and

(c) A mirror with adequate lighting for general illumination.

(4) The assisted living facility must provide a toilet and handwashing sink in, or adjoining, each bathroom.

(5) When providing common-use toilet rooms and bathrooms, for residents who do not have access to a private toilet room in their apartment, the assisted living facility must provide toilets and handwashing sinks for residents in the ratios of one toilet and one handwashing sink for every eight residents. For example: One toilet and one handwashing sink for one to eight residents, two for nine to ((~~sixteen~~)) 16 residents, three for ((~~seventeen~~)) 17 to ((~~twenty-four~~)) 24 residents, and so on.

(6) When providing common-use toilet rooms and bathrooms for residents who do not have access to a private bathroom in their apartment, the assisted living facility must provide bathing fixtures for residents in the ratio of one bathing fixture for every ((~~twelve~~)) 12 residents. For example: One bathing fixture for one to ((~~twelve~~)) 12 residents, two for ((~~twelve~~)) 13 to ((~~twenty-four~~)) 24 residents, three for ((~~twenty-five~~)) 25 to ((~~thirty-six~~)) 36 residents, and so on.

(7) When providing common-use toilet rooms and bathrooms, the assisted living facility must:

(a) Designate toilet rooms containing more than one toilet for use by men or women;

(b) Designate bathrooms containing more than one bathing fixture for use by men or women, unless the bathroom is identified as a single resident use only;

(c) Equip each toilet room and bathroom designed for use by, or used by, more than one person at a time, in a manner to ensure visual privacy for each person using the room. The assisted living facility is not required to provide additional privacy features in private bathrooms with a single toilet and a single bathing fixture located within a private apartment;

(d) Provide a handwashing sink with soap and single use or disposable towels, blower, or equivalent hand-drying device in each toilet room;

(e) Provide reasonable access to bathrooms and toilet rooms for each resident by:

(i) Locating a toilet room on the same floor or level as the sleeping room of the resident served;

(ii) Locating a bathroom on the same floor or level, or adjacent floor or level, as the sleeping room of the resident served;

(iii) Providing access without passage through any kitchen, pantry, food preparation, food storage, or dishwashing area, or from one bedroom through another bedroom; and

(f) Provide and ensure toilet paper is available at each common-use toilet.

(8) The assisted living facility must ensure ((~~twenty-five percent~~)) 25% of all resident use, and at least one common use bathing fixtures are roll-in type showers that have:

(a) One-half inch or less threshold that may be a collapsible rubber water barrier; and

(b) A minimum size of ((~~thirty-six~~)) 30 inches by ((~~forty-eight~~)) 60 inches.

AMENDATORY SECTION (Amending WSR 20-02-104, filed 12/31/19, effective 1/31/20)

WAC 388-78A-3040 Laundry. (1) The assisted living facility must provide laundry and linen services on the premises, or by commercial laundry.

(2) The assisted living facility must handle, clean, and store linen according to acceptable methods of infection control. The assisted living facility must:

(a) Provide separate areas for handling clean laundry and soiled laundry;

(b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;

(c) Ensure areas where clean laundry is stored are not exposed to contamination from other sources;

(d) Ensure all staff persons wear gloves and use other appropriate infection control practices when handling soiled laundry; and

(e) Have a utility sink and a table or counter for folding clean laundry.

(3) The assisted living facility must use washing machines that have a continuous supply of hot water with a temperature of 140°F measured at the washing machine intake, or that automatically dispenses a chemical sanitizer as specified by the manufacturer, or that employs alternate sanitization methods recommended by the manufacturer.

(4) The assisted living facility or a resident washing an individual resident's personal laundry, separate from other laundry, may wash the laundry at temperatures below 140°F and without the use of a chemical sanitizer.

(5) The assisted living facility must ventilate laundry rooms and areas to the outside of the assisted living facility, including areas or rooms where soiled laundry is held for processing by off site commercial laundry services.

(6) The assisted living facility must locate laundry equipment in rooms other than those used for open food storage, food preparation, or food service.

(7) The assisted living facility must provide a laundry area or develop and implement policy and procedure to ensure residents have access to an area where residents' may do their personal laundry that is:

(a) Equipped with:

(i) A utility sink;

(ii) A table or counter for folding clean laundry;

(iii) At least one washing machine and one clothes dryer; and

(iv) Mechanical ventilation to the outside of the assisted living facility.

(b) Arranged to reduce the chances of soiled laundry contaminating clean laundry.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-3160 Authorized enforcement remedies. (1) Whenever the circumstances in WAC 388-78A-3170(1) are present, the department may impose any one or more of the following enforcement remedies authorized by RCW 18.20.050((~~(4)~~)), 18.20.185((~~(7)~~)), and 18.20.190 on an assisted living facility, including:

(a) Denying an assisted living facility license;

(b) Suspending an assisted living facility license or memory care certification;

(c) Revoking an assisted living facility license or memory care certification;

(d) Refusing to renew an assisted living facility license or memory care certification;

(e) Suspending admissions to an assisted living facility, memory care facility, or memory care unit;

(f) Suspending admissions to an assisted living facility of a specific category or categories of residents as related to cited problems;

(g) Imposing conditions on the assisted living facility license; ((~~and/or~~))

(h) Imposing civil penalties of not more than ((~~one hundred dollars~~)) $3,000 per day per violation.

(2) Notwithstanding subsection (1) of this section, the department may impose a civil penalty on an assisted living facility of up to ((~~three thousand dollars~~)) $3,000 per day per violation for interference, coercion, discrimination ((~~and/~~)), or reprisal by an assisted living facility as set forth in RCW 18.20.185((~~(7)~~)).

AMENDATORY SECTION (Amending WSR 14-14-031, filed 6/24/14, effective 7/25/14)

WAC 388-78A-3170 Circumstances that may result in enforcement remedies. (1) The department is authorized to impose enforcement remedies described in WAC 388-78A-3160 if any person described in subsection (2) of this section is found by the department to have:

(a) A history of significant noncompliance with federal or state laws or regulations in providing care or services to frail elders, vulnerable adults, or children, whether as a licensee, contractor, managerial employee, or otherwise. Evidence of significant noncompliance may include, without limitation:

(i) Citations for violation of laws or regulations imposed by regulating entities;

(ii) Sanctions for violation of laws or regulations imposed by regulating entities;

(iii) Involuntary termination, cancellation, suspension, or nonrenewal of a medicaid contract or medicare provider agreement, or any other agreement with a public agency for the care or treatment of children, frail elders, or vulnerable adults;

(iv) Been denied a license or contract relating to the care of frail elders, vulnerable adults, or children; or

(v) Relinquished or failed to renew a license or contract relating to care of frail elders, vulnerable adults, or children following written notification of the licensing agency's initiation of denial, suspension, cancellation, or revocation of a license.

(b) Failed to provide appropriate care to frail elders, vulnerable adults, or children under a contract, or having such contract terminated, or not renewed by the contracting agency due to such failure;

(c) Failed or refused to comply with the requirements of chapter 18.20 RCW, applicable provisions of chapter 70.129 RCW, or this chapter;

(d) Retaliated against a staff person, resident, or other individual for:

(i) Reporting suspected abuse, neglect, financial exploitation, or other alleged improprieties;

(ii) Providing information to the department during the course of an inspection of the assisted living facility; or

(iii) Providing information to the department during the course of a complaint investigation in the assisted living facility.

(e) Operated a facility for the care of children or vulnerable adults without a current, valid license or under a defunct or revoked license;

(f) Attempted to obtain a contract or license from the department by fraudulent means or by misrepresentation;

(g) A conviction or pending charge for a crime that is not automatically disqualifying under chapter 388-113 WAC, but that:

(i) Was committed on an assisted living facility premises; or knowingly permitted, aided, or abetted an illegal act on an assisted living facility premises;

(ii) Involved the illegal use of drugs or the excessive use of alcohol; or

(iii) Is reasonably related to the competency of the person to operate an assisted living facility.

(h) Abused, neglected, or exploited a vulnerable adult;

(i) Had a sanction or corrective or remedial action taken by federal, state, county, or municipal officials, or safety officials related to the care or treatment of children or vulnerable adults;

(j) Failed to report alleged abuse, neglect, or exploitation of a vulnerable adult in violation of chapter 74.34 RCW;

(k) Failed to exercise fiscal accountability and responsibility involving a resident, the department, public agencies, or the business community; or to have insufficient financial resources or unencumbered income to sustain the operation of the assisted living facility;

(l) Knowingly or with reason to know, made false statements of material fact in the application for the license or the renewal of the license or any data attached thereto, or in any matter under investigation by the department;

(m) Willfully prevented or interfered with or attempted to impede in any way any inspection or investigation by the department, or the work of any authorized representative of the department, or the lawful enforcement of any provision of this chapter;

(n) Refused to allow department representatives or agents to examine any part of the licensed premises including the books, records, and files required under this chapter;

(o) Continue to use terminology such as memory care facility, or dementia care facility, without having been issued a certification under RCW 18.20.540;

(p) Continue to operate a facility or unit within a facility, that has restricted egress, without having been issued a certification under RCW 18.20.540;

(q) Moved all residents out of the assisted living facility without the department's approval and appears to be no longer operating as an assisted living facility; or

((~~(p)~~)) (r) Demonstrated any other factors that give evidence the applicant lacks the appropriate character, suitability, and competence to provide care or services to vulnerable adults.

(2) This section applies to any assisted living facility:

(a) Applicant;

(b) Partner, officer, or director;

(c) Manager or managerial employee; or

(d) Majority owner of the applicant or licensee:

(i) Who is involved in the management or operation of the assisted living facility;

(ii) Who may have direct access to assisted living facility residents;

(iii) Who controls or supervises the provision of care or services to assisted living facility residents; or

(iv) Who exercises control over daily operations of the assisted living facility.

(3) For other circumstances resulting in discretionary enforcement remedies, see WAC 388-78A-3200.

AMENDATORY SECTION (Amending WSR 20-09-108, filed 4/16/20, effective 5/17/20)

WAC 388-78A-3181 Remedies—Specific—Civil penalties. (1) The department may impose civil penalties of at least ((~~one hundred dollars~~)) $100 per day per violation.

(2) Fines up to ((~~one thousand dollars~~)) $1,000 per day per violation may be issued under RCW 18.20.190 through June 30, 2019, and thereafter as follows:

(a) Beginning July 1, 2019, through June 30, 2020, the civil penalties may not exceed ((~~two thousand dollars~~)) $2,000 per day per violation; and

(b) Beginning July 1, 2020, the civil penalties may not exceed ((~~three thousand dollars~~)) $3,000 per day per violation.

(3) Fines up to ((~~three thousand dollars~~)) $3,000 may be issued under RCW 18.20.185 for willful interference with a representative of the long-term care ombuds.

(4) Fines up to ((~~three thousand dollars~~)) $3,000 may be issued under RCW 74.39A.060 for retaliation against a resident, employee, or any other person making a complaint, providing information to, or cooperating with, the ombuds, the department, the attorney general's office, or a law enforcement agency.

(5) Fines up to ((~~ten thousand dollars~~)) $10,000 may be issued under RCW 18.20.190 for a current or former licensed provider who is operating an unlicensed ((~~home~~)) assisted living facility, uncertified memory care facility, or uncertified memory care unit.

(6) When the assisted living facility fails to pay a fine under this chapter when due, the department may, in addition to other remedies, withhold an amount equal to the fine plus interest, if any, from any contract payment due to the provider from the department.

(7) Civil monetary penalties are due ((~~twenty-eight~~)) 28 days after the assisted living facility or the owner or operator of an unlicensed assisted living facility is served with notice of the penalty unless the assisted living facility requests a hearing in compliance with chapter 34.05 RCW, RCW 43.20A.215, and this chapter. If the hearing is requested, the penalty becomes due ((~~ten~~)) 10 days after a final decision affirming the assessed civil penalty. Thirty days after the department serves the assisted living facility with notice of the penalty, interest begins to accrue at a rate of one percent per month as authorized under RCW 43.20B.695.

(8) All receipts from civil penalties imposed under this chapter must be deposited in the assisted living facility temporary management account ((~~created in~~)) per RCW 18.20.430.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-3230 Fees. (1) The assisted living facility must:

((~~(1)~~)) (a) Submit an annual per bed license fee based on the licensed bed capacity and as established in the state's biennial omnibus appropriation act and any amendment or addition made to that act;

((~~(2)~~)) (b) Submit an additional late fee in the amount of ((~~ten dollars~~)) $10 per day from the license renewal date until the date of mailing the fee, as evidenced by the postmark; and

((~~(3)~~)) (c) Submit to construction review services a fee for the review of the construction documents per the review fee schedule that is based on the project cost.

(2) The assisted living facility must submit an initial certification fee as established by the department when applying for memory care certification.

(3) The assisted living facility must submit an annual certification fee as established by the department when renewing a memory care certification.

WSR 26-17-004
PERMANENT RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Home and Community Living Administration)
[Filed August 5, 2026, 2:51 p.m., effective September 20, 2026]

Effective Date of Rule: September 20, 2026.

Purpose: The department of social and health services (department) received a petition requesting the department update [chapter 388-76 WAC] to align with federal requirements for long-term care ombuds access to resident records. The department received a petition requesting a change in the requirement for adult family providers to conduct emergency evacuation drills from every "sixty days" to every "two months." The change will reduce the burden on adult family home providers who must count 60 calendar days from each drill to ensure they comply with the time frame. The requirement that the department not issue a license to certain department employees and their household members will be repealed (ethics laws and department rules require employees to report any conflict of interest and outside employment to their employer). Other updates clarify when an adult family home license must, or may, be denied to a multiple home provider, remove the requirement that the resident record contain the resident's Social Security number, add a requirement to keep the notice of rights and services in the resident record (as required in other sections of the chapter), add a minimum interior door width requirement, require residential care services approval of modifications or new construction of resident bedrooms occurring after licensure, and clarify requirements for provider plan of correction. Amendments to WAC 388-76-10037 were originally included in the proposed rules, but are not being adopted.

Citation of Rules Affected by this Order: Repealing WAC 388-76-10045; and amending WAC 388-76-10120, 388-76-10125, 388-76-10315, 388-76-10320, 388-76-10685, 388-76-10715, 388-76-10895, and 388-76-10930.

Statutory Authority for Adoption: RCW 70.128.040, 70.128.065; and 45 C.F.R. § 1324.11 (e)(2).

Adopted under notice filed as WSR 26-09-013 on April 2, 2026.

Changes Other than Editing from Proposed to Adopted Version: WAC 388-76-10037 is excluded from adoption at this time. Minor edits were made to WAC 388-76-10120(4), removing the reference to WAC 388-76-10037. An effective date was added to WAC 388-76-10715(6).

A final cost-benefit analysis is available by contacting Colleen Jensen, P.O. Box 45600, Olympia, WA 98504, phone 360-725-2300, TTY 711 relay service, email rcspolicy@dshs.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 2, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 6, Repealed 1.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 8, Repealed 1; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 5, 2026.

Lisa N.H. Yanagida
Chief of Staff

SHS-5131.4

AMENDATORY SECTION (Amending WSR 20-05-016, filed 2/6/20, effective 3/8/20)

WAC 388-76-10120 License—Must be denied. The adult family home license will not be granted if:

(1) The applicant has not successfully completed a department-approved adult family home administration and business planning class except as provided in WAC 388-76-10064;

(2) It has been less than ((~~twenty~~)) 20 years since the applicant surrendered or relinquished an adult family home license after receiving notice of the department's initiation of a denial, suspension, nonrenewal, or revocation of the license; or

(3) The applicant, the spouse, or domestic partner of an applicant who is a sole proprietor, the spouse or domestic partner of an entity representative with an ownership interest in the business, or any partner, officer, director, managerial employee, or majority owner of the applying entity:

(a) Has a history of significant noncompliance with federal or state laws or regulations in the provision of care or services to children or vulnerable adults;

(b) Has prior violations of federal or state laws or regulations relating to residential care facilities resulting in revocation, suspension, or nonrenewal of a license or contract with the department within the past ((~~ten~~)) 10 years;

(c) Has a conviction or pending criminal charge for a crime that is automatically disqualifying under chapter 388-113 WAC; or

(d) Has one or more of the following disqualifying negative actions:

(i) A court has issued a permanent restraining order or order of protection, either active or expired, against the person that was based upon abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult;

(ii) The person is a registered sex offender;

(iii) The person is on a registry based upon a final finding of abuse, neglect, or financial exploitation of a vulnerable adult, unless the finding was made by adult protective services prior to October 2003;

(iv) A founded finding of abuse or neglect of a child was made against the person, unless the finding was made by child protective services prior to October 1, 1998;

(v) The individual was found in any dependency action to have sexually assaulted or exploited any child or to have physically abused any child;

(vi) The individual was found by a court in a domestic relations proceeding under Title 26 RCW, or under any comparable state or federal law, to have sexually abused or exploited any child or to have physically abused any child;

(vii) The individual has had a contract or license denied, terminated, revoked, or suspended due to abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult; or

(viii) The individual has relinquished a license or terminated a contract because an agency was taking an action against the individual related to alleged abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult.

(4) The applicant is the operator of one or more currently licensed adult family homes and does not meet the requirements of being a multiple home provider under RCW 70.128.065.

AMENDATORY SECTION (Amending WSR 20-05-016, filed 2/6/20, effective 3/8/20)

WAC 388-76-10125 License—May be denied. The adult family home license may be denied if the applicant or the applicant's spouse, domestic partner, or any partner, officer, director, managerial employee, or majority owner of the applying entity:

(1) Has any conviction or pending criminal charge for crime that is not automatically disqualifying under chapter 388-113 WAC, but that the department determines is reasonably related to the competency of the person to be involved in the ownership or operation of an adult family home;

(2) Has abused, neglected, or financially exploited a vulnerable adult, unless denial is required under WAC 388-76-10120;

(3) Has engaged in the illegal use, sale, or distribution of drugs or excessive use of alcohol or drugs without the evidence of rehabilitation;

(4) Has been found in any final decision of a federal or state agency to have abandoned, neglected, abused, or financially exploited a vulnerable adult, unless such decision requires a license denial under WAC 388-76-10120;

(5) Has had a license for the care of children or vulnerable adults denied, suspended, revoked, or not renewed in connection with the operation of any facility for the care of children or vulnerable adults, relinquished or returned a license, or did not seek license renewal following written notification that the licensing agency intended to deny, suspend, or revoke the license, unless such action requires a license denial under WAC 388-76-10120;

(6) Has a history of prior violations of chapter 70.128 RCW or any law regulating residential care facilities that resulted in revocation, suspension, or nonrenewal of a license;

(7) Has been enjoined from operating a facility for the care and services of children or adults;

(8) Has had a medicaid or medicare provider agreement or any other contract for the care and treatment of children or vulnerable adults, terminated, cancelled, suspended, or not renewed by any public agency, including a state medicaid agency;

(9) Has been the subject of a sanction, ((~~or~~)) corrective, or remedial action taken by federal, state, county, or municipal officials

or safety officials related to the care or treatment of children or vulnerable adults;

(10) Has obtained or attempted to obtain a license from the department by fraudulent means or misrepresentation;

(11) Knowingly, or with reason to know, made a false statement of material fact on ((~~his or her~~)) their application for a license or any data attached to the application, or in any matter involving the department;

(12) Permitted, aided, or abetted the commission of any illegal act on the adult family home premises;

(13) Willfully prevented or interfered with or failed to cooperate with any inspection, investigation, or monitoring visit made by the department, including refusal to permit authorized department representatives to interview residents or have access to their records;

(14) Failed or refused to comply with:

(a) A condition imposed on a license or a stop placement order; or

(b) The requirements of chapters 70.128, 70.129, 74.34 RCW, this chapter, or other applicable laws and regulations;

(15) Misappropriated property of a resident, unless such action requires a license denial under WAC 388-76-10120;

(16) Exceeded licensed capacity in the operation of an adult family home;

(17) Operated a facility for the care of children or adults without a license or with a revoked license;

(18) When providing care to children or vulnerable adults, has had resident trust funds or assets seized by the Internal Revenue Service or a state entity for failure to pay income or payroll taxes;

(19) Failed to meet financial obligations as the obligations fell due in the normal course of owning or operating a business involved in the provision of care and services to children or vulnerable adults;

(20) Has failed to meet personal financial obligations, or if the applicant is an entity, has failed to meet the entity's financial obligation, or both;

(21) Interfered with a long-term care ombuds or department staff in the performance of ((~~his or her~~)) their duties;

(22) Has not demonstrated financial solvency or management experience in its currently licensed homes, or has not demonstrated the ability to meet other relevant safety, health, and operating standards pertaining to the operation of multiple homes, including ways to mitigate the potential impact of vehicular traffic related to the operation of the homes;

(23) The home is currently licensed:

(a) As an assisted living facility; or

(b) To provide care for children in the same home, unless:

(i) It is necessary in order to allow a resident's child(ren) to live in the same home as the resident or to allow a resident who turns ((~~eighteen~~)) 18 to remain in the home;

(ii) The applicant provides satisfactory evidence to the department of the home's capacity to meet the needs of children and adults residing in the home; and

(iii) The total number of residents receiving care and services in the home does not exceed the number permitted by the licensed capacity of the home;

(24) Failed to give the department access to all parts of the home as authorized under RCW 70.128.090; or

(25) ((~~Has an ownership interest in one or more currently licensed adult family homes or additional applications and does not meet the requirements of being a multiple home provider; or~~

~~(26)~~)) Has demonstrated any other factors that give evidence the individual lacks the appropriate character, competence, and suitability to provide care or services to vulnerable adults.

AMENDATORY SECTION (Amending WSR 15-03-037, filed 1/12/15, effective 2/12/15)

WAC 388-76-10315 Resident record—Required. The adult family home must:

(1) Create, maintain, and keep records for residents in the home where the resident lives and ensure that the records:

(a) Contain enough information so the home can provide the needed care and services to each resident;

(b) Be in a format useful to the home;

(c) Be kept confidential so that only authorized persons see their contents;

(d) Are only released to the following persons:

(i) A health care institution;

(ii) When requested by the law;

(iii) To department representatives; and

(iv) To the resident;

(e) Be protected to prevent loss, alteration, or destruction, and unauthorized use;

(f) Be kept for three years after the resident leaves the home or death of the resident;

(g) Be available so that department staff may review them when requested; and

(h) Provide access to the resident to review their record and obtain copies of their record at a reasonable cost.

(2) Ensure staff has access to the parts of residents' records needed by staff to provide care and services; and

(3) Allow representatives of the long-term care ombuds access to a ((~~resident record if approved by the resident~~)) resident's records in accordance with RCW 70.129.090.

AMENDATORY SECTION (Amending WSR 26-05-046, filed 2/12/26, effective 3/15/26)

WAC 388-76-10320 Resident record—Content. The adult family home must ensure that each resident record contains, at a minimum, the following information:

(1) Identifying information about the resident, including, but not limited to:

(a) Name;

(b) Bedroom they reside in;

(c) Telephone number, if available; and

(d) Email address, if available.

(2) The name, address, and telephone number of the resident's:

(a) Representative and the representative's;

(i) Relationship to the resident; and
(ii) Email address, if available.
(b) Health care providers;
(c) Significant family members identified by the resident; and
(d) Other individuals the resident wants involved or notified.
(3) Current medical history;
(4) The resident assessment information;
(5) The preliminary service plan;
(6) The negotiated care plan;
(7) List of resident medications;
(8) ((~~The resident's Social Security number;~~)) A copy of:
(a) The notice of rights and services required by this chapter; and
(b) The acknowledgement required by this chapter that the resident received a copy of the notice, signed and dated by:
(i) The resident; and
(ii) The home;
(9) When the resident was:
(a) Admitted to the home;
(b) Absent from the home; and
(c) Discharged from the home.
(10) A current inventory of the resident's personal belongings dated and signed by:
(a) The resident; and
(b) The adult family home.
(11) Financial records.
(12) The residency agreement for residents with medicaid as a payor.

AMENDATORY SECTION (Amending WSR 21-11-074, filed 5/17/21, effective 8/1/21)

WAC 388-76-10685 Bedrooms. The adult family home must meet all of the following requirements:
(1) Ensure each resident's bedroom is an outside room that allows entrance of natural light.
(2) Ensure window and door screens:
(a) Do not hinder emergency escape; and
(b) Prevent entrance of flies and other insects.
(3) Ensure each resident, including those using mobility aids such as wheelchairs and walkers has direct, unrestricted, and free access from the bedroom through doors, hallways, and corridors to common use areas and other rooms used for care and services including bathrooms.
(4) When a bedroom will be shared by two residents, the home must:
(a) Document through the notice of rights and services that the resident's bedroom is a shared bedroom; and
(b) Allow residents to express their preference of roommate and allow residents who mutually consent to share a bedroom to live in a double occupancy bedroom together, unless this will pose a health or safety risk for any resident in the home;
(5) Provide each bedroom with a minimum usable floor space as required in WAC 388-76-10690.

(6) Give each resident the opportunity to have a lock on their bedroom door if they choose to unless having a locked door would be unsafe for the resident and this is documented according to WAC 388-76-10401.

(7) Ensure each bedroom has a closet or a wardrobe, armoire, or reasonable storage space for clothes accessible to residents. Neither the closet nor wardrobe/armoire floor space will be considered a part of the room's usable square footage. The home must not remove a closet in order to provide additional floor space.

(8) Ensure there are no more than two residents to a bedroom.

(9) Unless the resident chooses to provide their own furniture and bedding, the home must provide each resident a bed ((~~thirty-six~~)) 36 inches or wider with:

(a) A clean, comfortable mattress;

(b) A waterproof cover for use when needed or requested by the resident;

(c) Clean sheets and pillow cases;

(d) Adequate clean blankets to meet the needs of each resident; and

(e) Clean pillows.

(10) Do not use the upper bunk of double-deck beds for a resident's bed.

(11) Provide each resident a call bell, or an alternative way of alerting staff in an emergency, that the resident can use, unless the bedroom of an AFH staff member is within hearing distance of the resident's bedroom and a staff member will be within hearing distance at all times.

(12) Ensure that members of the household and staff do not share bedrooms with residents.

(13) Ensure a resident does not share a bedroom with a person under ((~~eighteen~~)) 18 years of age, unless the person is the resident's own child.

(14) The adult family home must notify the department and receive an approved inspection from the department before allowing a resident to sleep in a bedroom not previously inspected and approved by the department.

AMENDATORY SECTION (Amending WSR 21-11-074, filed 5/17/21, effective 8/1/21)

WAC 388-76-10715 Doors—Ability to open. The adult family home must ensure:

(1) Every bedroom and bathroom door opens from the inside and outside;

(2) Every closet door opens from the inside and outside;

(3) At least one door leading to the outside is designated as an emergency exit. In homes licensed after January 1, 2016, this door must have a lever door handle on both sides and hardware that allows residents to exit when the door is locked and immediately reenter without a key, tool, or special knowledge or effort by residents;

(4) Other doors leading to the outside that are not designated as an emergency exit must open without any special skills or knowledge, and they must remain accessible to residents unless doing so poses a risk to the health or safety of at least one resident; ((~~and~~))

(5) All internal and external doors comply with local jurisdictional requirements as well as the building code requirements in chapter 51-51 WAC((.)); and

(6) For homes licensed after September 20, 2026, all internal doors residents will pass through that are not designated as an emergency exit are at least 27 inches wide.

AMENDATORY SECTION (Amending WSR 21-11-074, filed 5/17/21, effective 8/1/21)

WAC 388-76-10895 Emergency evacuation drills—Frequency and participation. (1) There are two types of emergency evacuation drills:

(a) A full evacuation is evacuation from the home to the designated safe location; and

(b) A partial evacuation is evacuation to the designated emergency exit.

(2) The adult family home must conduct:

(a) Partial emergency evacuation drills which occur during random staffing shifts at least every ((~~sixty days~~)) two months, with each resident participating in at least one each calendar year;

(b) A full emergency evacuation drill at least once each calendar year, with all residents participating in the drill together and at the same time; and

(c) Emergency evacuation drills even if there are no residents living in the home for the purpose of staff practice.

(3) The home must respect the resident's right to refuse to participate in emergency evacuation drills. However, the home must still demonstrate the ability to safely evacuate all residents doing the following:

(a) Documenting the resident's wish to refuse to participate in the negotiated care plan;

(b) Providing an estimate of the amount of time it would take to evacuate the resident and how they calculated this estimate in the negotiated care plan;

(c) Adding the estimated time to the time recorded on the emergency evacuation drill log after each drill to ensure the length of time to evacuate does not exceed five minutes; and

(d) Continuing to offer the resident a chance to participate in every evacuation drill.

AMENDATORY SECTION (Amending WSR 09-03-029, filed 1/12/09, effective 2/12/09)

WAC 388-76-10930 Plan of correction (POC)—((~~Required~~)) When required. (1) ((~~The adult family home must comply with all applicable licensing laws and regulations at all times.~~

~~(2)~~)) When the department finds the adult family home out of compliance with any licensing law or regulation, the department will send the home an inspection report ((~~with an attestation of correction statement~~)) for each cited deficiency.

((~~(3)~~)) (2) The adult family home must complete an attestation of correction for ((~~any inspection report~~)) each cited deficiency as the department requires.

((~~(4)~~)) (3) For the purposes of this section an "attestation of correction statement" means a statement((~~, developed by the department and~~)) signed and dated by the home, that the home:

(a) Has or will correct each cited deficiency; and

(b) Will maintain correction of each cited deficiency.

((~~(5)~~)) (4) The home must be able to show to the department, upon request, that, for each deficiency cited, the home has:

(a) A plan of correction and maintaining correction;

(b) Corrected or is correcting each deficiency; and

(c) Maintained or is maintaining compliance.

((~~(6)~~)) (5) On each attestation of correction statement, the home must:

(a) Give a date, approved by the department, showing when the cited deficiency has been or will be corrected; and

(b) By signature and date show that the home has or will correct, and maintain correction, of each deficiency.

((~~(7)~~)) (6) The home must return the inspection report, with completed attestation of correction statements, to the department within ((~~ten~~)) 10 calendar days of receiving the report.

(7) This section does not apply where the department takes action to summarily suspend or revoke the adult family home license under its authority in RCW 70.128.100 or 70.128.160.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-76-10045	Licensing—Certain state employees and employee household members—Prohibited.

WSR 26-17-005
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 5, 2026, 4:07 p.m., effective September 5, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The health care authority (HCA) amended these rules to update when hospital safety net program assessment notices are sent from "on or about 30 calendar days prior" to "on or before 45 days" to align with RCW 74.60.030(1). The reference to RCW 74.60.030 (1)(a) was updated to RCW 74.60.030(1) in WAC 182-550-8100(1). HCA also added language for settlement guidelines to include timelines, appeals, and exclusions, and added a new section for assessment calculations, WAC 182-550-8200.

Citation of Rules Affected by this Order: New WAC 182-550-8200; and amending WAC 182-550-8100.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Adopted under notice filed as WSR 26-14-064 on June 26, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 1, Repealed 0.

Date Adopted: August 5, 2026.

Wendy Barcus
Rules Coordinator

RDS-7250.2

AMENDATORY SECTION (Amending WSR 23-20-048, filed 9/28/23, effective 10/29/23)

WAC 182-550-8100 Assessment notices—Process and timelines. (1) **Calculation of nonmedicare revenue for nonexempt hospitals.** The medicaid agency determines each nonexempt hospital's annual assessment using the process outlined in RCW 74.60.030. HCA uses the hospital's medicare cost report data as filed for the applicable year for these calculations. The agency uses the following time frames for determining what data set is used for the calculation of the hospital's assessment.

(a) For the purposes of this section, annualized means the total amount divided by actual months, multiplied by 12.

(b) The agency uses the second quarterly release of health care cost report information system (HCRIS) data from the Centers for Medi-

care and Medicaid Services (CMS). This release is typically available by July 31st of each year.

(c) If a second quarterly release is not available at the time of calculation, the agency will use the most recently available HCRIS data release from CMS.

(d) The agency uses the medicare cost report data for the hospital from three years prior. For example, for calculating calendar year 2027 assessments, the agency will use available medicare cost report data as filed for the hospitals' fiscal year ending in 2024. For subsequent years, the agency uses the cost report for the next succeeding fiscal year data.

(e) For any hospital without a medicare cost report for the relevant year, including any recently opened hospital, the agency uses the most recently available cost report at the time of calculation or an annualized partial report available by June 1st reflecting at least six months of information.

(2) **Notification.** ((~~The medicaid agency sends hospital safety net program (HSNP) assessment notices on or about 30 calendar days prior to the end of each quarter as required by RCW 74.60.030 (1)(a).~~

~~(2)~~)) (a) Before January 1st of each calendar year, the agency sends notices of annual assessment to each hospital informing the hospital of its calculated inpatient and outpatient nonmedicare net patient revenue and the assessed amount. The agency calculates quarterly assessment payments by dividing the hospital annual assessment by four.

(b) The agency sends quarterly hospital safety net (HSNP) assessment notices on or before 45 calendar days prior to the end of each quarter as required by RCW 74.60.030.

(c) A hospital may dispute the agency's assessment calculation by following the process outlined in WAC 182-502-0050.

(3) **Payment due date.** Each hospital must pay its assessment in full by the due date listed in the HSNP notice.

((~~(3)~~)) (4) **First past-due notification.**

(a) If a hospital does not pay its HSNP assessment in full by the due date, the agency sends the hospital ((~~a~~)) past-due notice.

(b) The past-due notice informs the hospital of the actions the agency may take if the hospital's assessment becomes 60 calendar days past due.

((~~(4)~~)) (5) **Final past-due notification.**

(a) If a hospital does not pay its assessment in full within 60 calendar days of ((~~its~~)) the due date stated in the HSNP notice, the agency sends the hospital a final past-due notice.

((~~(a)~~)) (b) The final past-due notice informs the hospital of the actions the agency takes, as required by RCW 74.60.050(2), to offset funds from the agency's scheduled payments to the hospital.

((~~(b)~~)) (c) The agency does not offset funds from managed care ((~~capitation~~)) payments, as described in RCW 74.60.130.

(d) The agency may charge interest on delinquent assessments at the rate specified in RCW 82.32.050.

((~~(5) **Appeal.**~~)) (6) **Dispute.** A hospital may ((~~appeal~~)) dispute the actions the agency takes to offset funds by following the process outlined in WAC 182-502-0050.

NEW SECTION

WAC 182-550-8200 Hospital safety net supplemental directed payments to hospitals. (1)(a) The medicaid agency performs an annual reconciliation of amounts paid to each hospital based on its annual claims data.

(b) The agency directs its agency-contracted managed care organizations (MCOs) to make adjusted payments, if necessary, in the subsequent quarter or quarters based on such reconciliation.

(c) Before the annual reconciliation, the agency sends the inpatient discharges and outpatient encounter data used for reconciliation to each hospital for review. The agency sends aggregated reconciliation data to the Washington state hospital association (WSHA) for review.

(2) **Annual reconciliation timelines.** The agency completes an annual reconciliation within one calendar year of the end of the payment year being reconciled, using accepted encounters available in the medicaid management information system (MMIS). For example, annual encounter data available from the MMIS in November 2025 would be used for the annual reconciliation of calendar year 2024.

(3) **Annual encounter data exclusions.** The following encounters are not included in supplemental payment calculations.

(a) Inpatient claims with the patient status "still patient;"

(b) Encounters reported as being paid under a subcapitated arrangement;

(c) Encounters reported as denied by an MCO;

(d) All state-only funded eligibility programs;

(e) Claims for clients with no medicaid eligibility on the date of service;

(f) Claims paid by agency noncontracted MCOs; and

(g) Encounters for patients classified as "normal newborn." Normal newborn is a patient assigned to the Solventum all patient refined diagnosis related group (APR-DRG). Normal newborns are excluded from the prospective payment system and critical access hospital supplemental payments to MCOs, as outlined in RCW 74.60.130.

(4) **Provider disputes of reconciliation calculations.**

(a) If a hospital wishes to dispute a determination by the agency during the reconciliation process that the hospital was overpaid, then the hospital must follow the process outlined in WAC 182-502-0230.

(b) If a hospital wishes to dispute a determination by the agency during the reconciliation process that the hospital was underpaid, then the hospital must follow the process outlined in WAC 182-502-0050.

WSR 26-17-008
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 5, 2026, 5:01 p.m., effective September 5, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The health care authority (agency) added speech-language pathology assistants (SLPAs), physical therapy assistants (PTAs), occupational therapy assistants (OTAs), and rural emergency hospitals (REHs) to the list of eligible providers in WAC 182-502-0002. OTAs and PTAs are already listed in WAC 182-545-200 but, for consistency, the agency added these providers to the general eligible provider list in WAC 182-502-0002. The agency added REHs to the eligible providers list to support the rule making filed under WSR 26-10-052. The agency also added SLPAs to the list of providers who may enroll with the agency under WAC 182-545-200.

Citation of Rules Affected by this Order: Amending WAC 182-545-200 and 182-502-0002.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Adopted under notice filed as WSR 26-14-055 on June 25, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: August 5, 2026.

Wendy Barcus
Rules Coordinator

RDS-7246.1

AMENDATORY SECTION (Amending WSR 25-22-061, filed 10/30/25, effective 1/1/26)

WAC 182-502-0002 Eligible provider types. The following health care professionals, health care entities, suppliers or contractors of service may request enrollment with the Washington state health care authority (medicaid agency) to provide covered health care services to eligible clients. For the purposes of this chapter, health care services include treatment, equipment, related supplies, and drugs.

(1) Professionals:

(a) Advanced registered nurse practitioners;

(b) Anesthesia providers, as provided in WAC 182-531-0300:

(i) Physician anesthesiologists;

(ii) Anesthesiology residents;

(iii) Certified anesthesiologist assistants; and
(iv) Certified registered nurse anesthetists;
(c) Applied behavior analysis (ABA) professionals, as provided in WAC 182-531A-0800:
(i) Licensed behavior analysts;
(ii) Licensed assistant behavior analysts; and
(iii) Certified behavior technicians;
(d) Audiologists;
(e) Birth doulas;
(f) Certified peer counselors;
(g) Certified behavioral health support specialists;
(h) Certified peer support specialists;
(i) Certified peer support specialist trainees;
(j) Chiropractors;
(k) Community health workers (CHWs);
(l) Dental health aide therapists, as provided in chapter 70.350 RCW;
(m) Dental hygienists;
(n) Dental therapists;
(o) Denturists;
(p) Dentists;
(q) Dietitians or nutritionists;
(r) Hearing aid fitters/dispensers;
(s) Home health aides credentialed with the department of health (DOH) as nursing assistants certified or nursing assistants registered;
(t) Licensed independent clinical social worker associates;
(u) Licensed independent clinical social workers;
(v) Licensed marriage and family therapists;
(w) Licensed marriage and family therapist associates;
(x) Licensed mental health counselors;
(y) Licensed mental health counselor associates;
(z) Licensed practical nurses;
(aa) Licensed social workers advanced;
(bb) Licensed social worker associates advanced;
(cc) Midwives;
(dd) Naturopathic physicians;
(ee) Nurse anesthetists;
(ff) Ocularists;
(gg) Occupational therapists;
(hh) Occupational therapy assistants;
(ii) Ophthalmologists;
((~~(ii)~~)) (jj) Opticians;
((~~(jj)~~)) (kk) Optometrists;
((~~(kk)~~)) (ll) Orthodontists;
((~~(ll)~~)) (mm) Orthotists;
((~~(mm)~~)) (nn) Osteopathic physicians;
((~~(nn)~~)) (oo) Osteopathic physician assistants;
((~~(oo)~~)) (pp) Podiatric physicians;
((~~(pp)~~)) (qq) Pharmacists;
((~~(qq)~~)) (rr) Physicians;
((~~(rr)~~)) (ss) Physician assistants;
((~~(ss)~~)) (tt) Physical therapists;
((~~(tt)~~)) (uu) Physical therapy assistants;
(vv) Prosthetists;
((~~(uu)~~)) (ww) Psychiatrists;
((~~(vv)~~)) (xx) Psychological associates;

((~~(ww)~~)) (yy) Psychologists;
((~~(xx)~~)) (zz) Radiologists;
((~~(yy)~~)) (aaa) Registered nurses;
((~~(zz)~~)) (bbb) Registered nurse delegators;
((~~(aaa)~~)) (ccc) Registered nurse first assistants;
((~~(bbb)~~)) (ddd) Respiratory therapists;
((~~(ccc) Speech/language~~)) (eee) Speech-language pathologists;
((~~and~~
~~(ddd)~~)) (fff) Speech-language pathology assistants; and
(ggg) Substance use disorder professionals.

(2) Agencies, centers, and facilities:

(a) Adult day health centers;

(b) Ambulance services (ground and air);

(c) Ambulatory surgery centers (medicare-certified);

(d) Birthing centers (licensed by DOH);

(e) Cardiac diagnostic centers;

(f) Case management agencies;

(g) Substance use disorder treatment facilities certified by DOH;

(h) Withdrawal management treatment facilities certified by DOH;

(i) Community acquired immune deficiency syndrome (AIDS) services alternative agencies;

(j) Community behavioral health support services provider facilities;

(k) Community mental health centers;

(l) Diagnostic centers;

(m) Family planning clinics;

(n) Federally qualified health centers (designated by the federal department of health and human services);

(o) Genetic counseling agencies;

(p) Health departments;

(q) Health maintenance organizations (HMOs)/managed care organizations (MCOs);

(r) Human immunodeficiency virus (HIV)/AIDS case management agencies;

(s) Home health agencies;

(t) Hospice agencies;

(u) Hospitals;

(v) Independent diagnostic testing facilities;

(w) Indian health service facilities/tribal 638 facilities;

(x) Inpatient psychiatric facilities;

(y) Intermediate care facilities for individuals with intellectual disabilities (ICF-IID);

(z) Kidney centers;

(aa) Laboratories (clinical laboratory improvement amendments (CLIA) certified);

(bb) Maternity support services agencies; maternity case managers; infant case management, first steps providers;

(cc) Neuromuscular and neurodevelopmental centers;

(dd) Nurse services/delegation;

(ee) Nursing facilities (approved by the department of social and health services home and community living administration);

(ff) Pathology laboratories;

(gg) Pharmacies;

(hh) Private duty nursing agencies;

(ii) Radiology - Stand-alone clinics;

(jj) Rural emergency hospitals;

(kk) Rural health clinics (medicare-certified);

((~~(kk)~~)) (ll) School districts and educational service districts;
((~~(ll)~~)) (mm) Sleep study centers; and
((~~(mm)~~)) (nn) Tribal or urban Indian clinics.
(3) Suppliers of:
(a) Blood, blood products, and related services;
(b) Complex rehabilitation technologies;
(c) Durable and nondurable medical equipment and supplies;
(d) Hearing aids;
(e) Infusion therapy equipment and supplies;
(f) Prosthetics/orthotics; and
(g) Respiratory care, equipment, and supplies.
(4) Contractors:
(a) Eyeglass and contact lens providers;
(b) Independent sign language interpreters;
(c) Spoken language interpreter services agencies; and
(d) Transportation brokers.

RDS-7247.1

AMENDATORY SECTION (Amending WSR 24-24-058, filed 11/27/24, effective 1/1/25)

WAC 182-545-200 Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy). (1) The following health professionals may enroll with the medicaid agency, as defined in WAC 182-500-0010, to provide outpatient rehabilitation (which includes occupational therapy, physical therapy, and speech therapy) within their scope of practice to eligible clients:
(a) A physiatrist;
(b) A licensed occupational therapist;
(c) A licensed occupational therapy assistant (OTA) supervised by a licensed occupational therapist;
(d) A licensed physical therapist;
(e) A physical therapist assistant supervised by a licensed physical therapist;
(f) A licensed speech-language pathologist; ((~~and~~))
(g) A speech-language pathology assistant (SLPA) supervised by a licensed speech-language pathologist; and
(h) A licensed optometrist to provide vision occupational therapy only.
(2) Clients covered by one of the Washington apple health programs listed in the table in WAC 182-501-0060 or receiving home health care services as described in chapter 182-551 WAC (subchapter II) are eligible to receive outpatient rehabilitation as described in this chapter.
(3) Clients enrolled in an agency-contracted managed care organization (MCO) must arrange for outpatient rehabilitation directly through their agency-contracted MCO.
(4) The agency pays for outpatient rehabilitation when the services are:
(a) Covered;
(b) Medically necessary;

(c) Within the scope of the eligible person's medical care program;

(d) Ordered by:

(i) A physician, physician assistant (PA), or an advanced registered nurse practitioner (ARNP); or

(ii) An optometrist, if the ordered services are for occupational therapy only.

(e) Within currently accepted standards of evidence-based medical practice;

(f) Authorized, as required within this chapter, under chapters 182-501 and 182-502 WAC and the agency's published billing instructions;

(g) Begun within 30 calendar days of the date ordered;

(h) Provided by one of the health professionals listed in subsection (1) of this section;

(i) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions; and

(j) Provided as part of an outpatient treatment program:

(i) In an office or outpatient hospital setting;

(ii) In the home, by a home health agency as described in chapter 182-551 WAC;

(iii) In a neurodevelopmental center, as described in WAC 182-545-900;

(iv) For children with disabilities, age six or younger, in natural environments including the home and community setting in which children without disabilities participate, to the maximum extent appropriate to the needs of the child; or

(v) When provided by licensed and certified behavioral health agencies as part of a mental health or substance use disorder treatment program.

(5) For eligible clients age 20 and younger, the agency covers unlimited outpatient rehabilitation.

(6) For clients age 21 and older, the agency covers a limited outpatient rehabilitation benefit.

(7) Outpatient rehabilitation services for clients age 21 and older must:

(a) Restore, improve, or maintain the person's level of function that has been lost due to a clinically documented condition; and

(b) Include an ongoing management plan for the client or the client's caregiver to support timely discharge and continued progress.

(8) For eligible clients age 21 and older, the agency limits coverage of outpatient rehabilitation as follows:

(a) Occupational therapy, per person, per year:

(i) Without authorization:

(A) For clients needing occupational therapy to treat physical conditions:

(I) One occupational therapy evaluation;

(II) One occupational therapy reevaluation at time of discharge; and

(III) Twenty-four units of occupational therapy, which is approximately six hours; and

(B) For clients needing occupational therapy to treat behavioral health conditions:

(I) One occupational therapy evaluation;

(II) One occupational therapy reevaluation at time of discharge; and

(III) Twenty-four units of occupational therapy, which is approximately six hours.

(ii) With expedited prior authorization, up to 24 additional units of occupational therapy to treat either the client's physical or behavioral health conditions may be available to continue treatment initiated under the original 24 units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The client's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Behavioral health conditions;

(III) Brain injury, which occurred within the past 24 months, with residual cognitive or functional deficits;

(IV) Burns - Second or third degree only;

(V) Cerebral vascular accident, which occurred within the past 24 months, with residual cognitive or functional deficits;

(VI) Lymphedema;

(VII) Major joint surgery - Partial or total replacement only;

(VIII) Muscular-skeletal disorders such as complex fractures that required surgical intervention, or surgery involving the spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(IX) Neuromuscular disorders that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(X) Reflex sympathetic dystrophy;

(XI) Swallowing deficits due to injury or surgery to the face, head, or neck;

(XII) Spinal cord injury that occurred within the past 24 months, resulting in paraplegia or quadriplegia; or

(XIII) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(b) Physical therapy, per person, per year:

(i) Without authorization:

(A) One physical therapy evaluation;

(B) One physical therapy reevaluation at time of discharge; and

(C) Twenty-four units of physical therapy, which is approximately six hours.

(ii) With expedited prior authorization, up to 24 additional units of physical therapy may be available to continue treatment initiated under the original 24 units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The person's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Brain injury, which occurred within the past 24 months, with residual functional deficits;

(III) Burns - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past 24 months, with residual functional deficits;

(V) Lymphedema;

(VI) Major joint surgery - Partial or total replacement only;

(VII) Muscular-skeletal disorders such as complex fractures that required surgical intervention, or surgery involving the spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(VIII) Neuromuscular disorders that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(IX) Reflex sympathetic dystrophy;

(X) Spinal cord injury, which occurred within the past 24 months, resulting in paraplegia or quadriplegia; or

(XI) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(c) Speech therapy, per person, per year:

(i) Without authorization:

(A) One speech language pathology evaluation;

(B) One speech language pathology reevaluation at the time of discharge; and

(C) Six units of speech therapy, which is approximately six hours.

(ii) With expedited prior authorization, up to six additional units of speech therapy may be available to continue treatment initiated under the original six units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The person's diagnosis is any of the following:

(I) Brain injury, which occurred within the past 24 months, with residual cognitive or functional deficits;

(II) Burns of internal organs such as nasal oral mucosa or upper airway;

(III) Burns of the face, head, and neck - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past 24 months, with residual functional deficits;

(V) Muscular-skeletal disorders such as complex fractures that require surgical intervention or surgery involving the vault, base of the skull, face, cervical column, larynx, or trachea;

(VI) Neuromuscular disorders that are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre));

(VII) Speech deficit due to injury or surgery to the face, head, or neck;

(VIII) Speech deficit that requires a speech generating device;

(IX) Swallowing deficit due to injury or surgery to the face, head, or neck; or

(X) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(d) Durable medical equipment (DME) needs assessments, two per person, per year.

(e) Orthotics management and training of upper or lower extremities, or both, two program units, per person, per day.

(f) Orthotic or prosthetic use, two program units, per person, per year.

(g) Muscle testing, one procedure, per person, per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical and occupational therapy procedures.

(h) Wheelchair needs assessment, one per person, per year.

(9) For the purposes of this chapter:

(a) Each 15 minutes of timed procedure code equals one unit; and

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(10) For expedited prior authorization (EPA):

(a) A provider must establish that:

(i) The person's condition meets the clinically appropriate EPA criteria outlined in this section; and

(ii) The services are expected to result in a reasonable improvement in the person's condition and achieve the person's therapeutic individual goal within 60 calendar days of initial treatment;

(b) The appropriate EPA number must be used when the provider bills the agency;

(c) Upon request, a provider must provide documentation to the agency showing how the person's condition met the criteria for EPA; and

(d) A provider may request expedited prior authorization once per year, per person, per each therapy type.

(11) If the client does not meet the EPA clinical criteria in this section, the agency uses the process in WAC 182-501-0165 to consider prior authorization requests and approves services that are medically necessary.

(12) The agency evaluates limitation extension (LE) requests regarding scope, amount, duration, and frequency of covered health care services under WAC 182-501-0169. Providers may submit LE requests for additional units when:

(a) The criteria for an expedited prior authorization does not apply;

(b) The number of available units under the EPA have been used and services are requested beyond the limits; or

(c) A new qualifying condition arises after the initial six visits are used.

(13) Duplicate services for outpatient rehabilitation are not allowed for the same person when both providers are performing the same or similar procedure(s).

(14) The agency does not pay separately for outpatient rehabilitation 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.

(15) The agency does not reimburse a health care professional for outpatient rehabilitation performed in an outpatient hospital setting when the health care professional is not employed by the hospital. The hospital must bill the agency for the services.

WSR 26-17-010
PERMANENT RULES
DEPARTMENT OF HEALTH
(Pharmacy Quality Assurance Commission)
[Filed August 6, 2026, 8:00 a.m., effective September 6, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Pharmacy registration for mobile opioid treatment program (OTP) units. The pharmacy quality assurance commission (commission) is adopting amendments for WAC 246-945-060 and 246-945-250 to exempt mobile OTP units from having to obtain separate registrations, as long as they are covered under the OTP site's controlled substance registration, and to incorporate comprehensive facility requirements for facilities that have an other controlled substance registration.

As the rules were previously written, an OTP was required to be licensed by the Washington department of health (department) as a behavioral health agency and register with the commission to obtain an "other controlled substance registration" in order to operate in Washington state and possess controlled substances. Then, if an OTP were to operate a mobile component, they were required to obtain a separate registration and licensure for each mobile component in order to possess controlled substances. In July 2021, the federal Drug Enforcement Agency lifted its moratorium on mobile units, eliminating a separate registration requirement for OTP mobile units by adding a "mobile component" to an OTP's existing registration. The department adopted permanent rules for licensed behavioral health agencies to approve these units as an extension of an existing OTP license and certification, though they must also register with the commission to possess controlled substances by obtaining the "other controlled substance registration."

The adopted rule amends WAC 246-945-060 Other controlled substance registrants—Requirements, and 246-945-250 Researcher and other controlled substance registration, to exempt mobile units from having to register separately with the commission, allowing an OTP to extend its other controlled substances registration to cover its mobile units. The adopted amendments also incorporate comprehensive facility requirements for all other controlled substance registrants, including analytical laboratories and dog handlers, focusing on enhancing drug security and product integrity. These amendments are to align with state and federal regulations and provide clarity to licensees and inspectors regarding the commission's expectations for the controlled substance registration.

Citation of Rules Affected by this Order: Amending WAC 246-945-060 and 246-945-250.

Statutory Authority for Adoption: RCW 18.64.005 and 69.50.302.

Adopted under notice filed as WSR 26-09-118 on April 21, 2026.

A final cost-benefit analysis is available by contacting Haleigh Mauldin, P.O. Box 47852, Olympia, WA 98504-7852, phone 360-236-4946, fax 360-236-2260, TTY 711, email PharmacyRules@doh.wa.gov, website https://doh.wa.gov/licenses-permits-and-certificates/facilities-z/pharmacies-and-pharmaceutical-firms/commission-information.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 2, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 2, Repealed 0.

Date Adopted: August 6, 2026.

Ann Wolken, PharmD, RPh, Chair
Pharmacy Quality Assurance Commission

RDS-6998.2

AMENDATORY SECTION (Amending WSR 20-12-072, filed 6/1/20, effective 7/1/20)

WAC 246-945-060 Other controlled substance registrants—Requirements. (1) All persons and firms, except persons exempt from registration, must register with the commission in order to legally possess or use controlled substances.

(2) Persons or firms which are not classified as pharmacies, wholesalers, manufacturers, or researchers will be classified as other controlled substance registrants. Examples of persons or firms in this classification include analytical laboratories, dog handlers/trainers who use dogs for drug detection purposes, school laboratories, opioid treatment programs (OTP), and other agencies which have a legitimate need to use precursor chemicals as defined in WAC 246-945-053.

(3) For the purposes of this section:

(a) "Mobile unit" means a component of an opioid treatment program that the DEA has approved to operate as a mobile narcotic treatment program pursuant to 21 C.F.R. § 1301.13.

(b) "Opioid treatment program(s)" or "OTP(s)" means a behavioral health agency that has been licensed by the department and certified as an opioid treatment program.

(4) The applicant for a controlled substance registration must complete and return an application form supplied by the commission. A list of the controlled substances to be used, the purpose for such use, and the names of the persons authorized to access the controlled substances must be listed on the application or on an addendum. An applicant for a controlled substance registration who is an OTP must also identify any mobile units operated by the agency, if any, in the application or in an addendum.

((~~(4) All controlled substances must be stored in a substantially constructed locked cabinet. The registrant shall maintain records in sufficient detail in order to account for the receipt, use, and disposition of all controlled substances. The registrant shall inventory all controlled substances in the possession of the registrant every two years on the anniversary of the issuances of the registration and shall maintain the inventory list for two years. The registrant shall return unwanted, outdated, or unusable controlled substances to the~~

~~source from which it was obtained or surrendered to the DEA.~~)) (5) An other controlled substance registrant shall:

(a) Ensure all controlled substances are stored in a substantially constructed locked cabinet to prevent unauthorized access;

(b) Maintain records in sufficient detail in order to account for the receipt, use, and disposition of all controlled substances;

(c) Inventory all controlled substances in the possession of the registrant every two years on the anniversary of the issuance of the registration and shall maintain the inventory for two years;

(d) Return unwanted, outdated, or unusable controlled substances to the source from which it was obtained, surrendered to the DEA, or as otherwise permitted by state and federal law; and

(e) Affix a label to every box, bottle, jar, tube, or other container that is dispensed and delivered to an ultimate user that meets the labeling requirements in RCW 69.41.050.

(6) Other controlled substance registrants that are OTPs, who have notified the department that they will be operating a mobile unit must:

(a) Notify the local DEA office and receive explicit written approval from the local DEA office prior to operating the mobile opioid treatment program unit;

(b) Possess valid county/city and Washington state vehicle licensing and registration prior to transporting controlled substances;

(c) Not reverse distribute, share, or transfer controlled substances from one mobile component to another mobile component while deployed away from the registered location;

(d) Establish policies and procedures to ensure, if the mobile unit becomes inoperable, that all controlled substances on the inoperable mobile unit are accounted for, removed, and secured at the registered location of the OTP;

(e) Return to the registered location at the completion of each operation and remove all controlled substances to secure within the registered location; and

(f) Notify the commission of any changes to the information provided on the application, including the addition or removal of a mobile unit.

AMENDATORY SECTION (Amending WSR 20-12-072, filed 6/1/20, effective 7/1/20)

WAC 246-945-250 Researcher and other controlled substance registration. (1) Applicants for initial registration and renewal for researcher or other controlled substance registrations shall submit to the commission a complete application, as described in WAC 246-945-060(4), with fees relevant to the registration type.

(a) Researcher:

(i) Noncontrolled legend drugs; or

(ii) Researchers requiring to purchase, possess, administer or dispense controlled substances shall apply for a controlled substance authority on its license with the commission and register with the DEA.

(b) Other controlled substance registrations:

(i) Opioid treatment programs;

(ii) Analytical laboratories;

(iii) Dog handler; and

(iv) Other agencies who have demonstrated a legitimate need to use precursor chemicals.

(2) ((~~The application shall:~~

~~(a) List all legend drugs and controlled substances to be used and the purpose for its use;~~

~~(b) Name the primary registrant; and~~

~~(c) List the names of the individuals authorized to access the controlled substances.~~

~~(3) Applicants~~)) An OTP who has notified the department they will be operating a mobile unit pursuant to chapter 246-341 WAC is not required to obtain a separate controlled substance registration for each mobile unit if the OTP's main fixed location has obtained an other controlled substance registration from the commission.

(3) Researcher and other controlled substance registrants shall notify the commission within 30 days of any changes to the information provided on their application.

(4) An applicant for initial registration and closure for researcher and other controlled substance registrations, including when an OTP removes a mobile unit from its registration, shall undergo an ((~~initial~~)) inspection ((~~and~~)). A registrant will be subject to periodic inspections as deemed appropriate by the commission.

(5) Researcher and other controlled substance registrants shall notify the commission and pay an inspection fee, as established in WAC 246-945-990 (5)(a), if any of the following occur:

(a) Changes to structural element(s) such as walls, floors, and load bearing elements that negatively impact security as determined by the registrant;

(b) Changes impacting square footage that negatively impact security as determined by the registrant;

(c) Changes to access to controlled substances that negatively impact security as determined by the registrant;

(d) Changes of location; or

(e) Adding a mobile unit to an OTP registration.

(6) For the purposes of this section:

(a) "Mobile unit" means a component of an opioid treatment program that the DEA has approved to operate as a mobile narcotic treatment program pursuant to 21 C.F.R. § 1301.13.

(b) "Opioid treatment program(s)" or "OTP(s)" means a behavioral health agency that has been licensed by the department and certified as an opioid treatment program.

WSR 26-17-011
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 6, 2026, 9:20 a.m., effective January 1, 2027]

Effective Date of Rule: January 1, 2027.

Purpose: Effective January 1, 2027, the American Medical Association is replacing the global obstetrics codes with itemized billing. The health care authority amended this chapter to update language references to global services and fees and made additional housekeeping changes. Changes to WAC are effective January 1, 2027.

Citation of Rules Affected by this Order: Amending WAC 182-533-0400.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Adopted under notice filed as WSR 26-14-035 on June 24, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: August 6, 2026.

Wendy Barcus
Rules Coordinator

RDS-7245.1

AMENDATORY SECTION (Amending WSR 26-07-034, filed 3/11/26, effective 4/11/26)

WAC 182-533-0400 Maternity care and newborn delivery. (1) The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter.

(a) **"Birthing center"** means a specialized facility licensed as a childbirth center by the department of health (DOH) under chapter 246-329 WAC.

(b) ((~~**"Bundled services"** means services integral to the major procedure that are included in the fee for the major procedure. Under this chapter, certain services which are customarily bundled must be billed separately (unbundled) when the services are provided by different providers.~~

~~(c)~~)) **"Facility fee"** means the portion of the medicaid agency's payment for the hospital or birthing center charges. This does not include the agency's payment for ((~~the~~)) professional fees.

((~~(d) **"Global fee"** means the fee the agency pays for total obstetrical care. Total obstetrical care includes all bundled antepartum care, delivery services and postpartum care.~~

~~(e)~~)) (c) **"High-risk"** pregnancy means any pregnancy that poses a significant risk of a poor ((~~birth~~)) outcome for the pregnant or birthing person, the fetus(es) or both.

((~~(f)~~)) (d) **"Professional fee"** means the portion of the agency's payment for services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. (See WAC 182-531-1850 for reimbursement methodology.)

(2) The agency covers ((~~full scope~~)) medical maternity care and newborn delivery services for fee-for-service and managed care clients as described under WAC 182-501-0060 and in agency-published provider guide.

(3) The agency does not provide maternity care and delivery services to clients who are eligible for:

(a) Family planning only programs ((~~(a pregnant client under these programs should be referred to the Washington healthplanfinder via www.wahealthplanfinder.org for eligibility review)~~)); or

(b) Any other program not listed in this section.

(4) The agency requires providers of maternity care and newborn delivery services to meet all the following requirements:

(a) Providers must be currently licensed:

(i) By the state of Washington's department of health (DOH), or department of licensing, or both; or

(ii) According to the laws and rules of any other state, if exempt under federal law.

(b) Providers must have a signed core provider agreement with the agency;

(c) Providers must be practicing within the scope of their licensure; and

(d) Providers must have valid certifications from the appropriate federal or state agency, if such is required to provide these services (e.g., federally qualified health centers (FQHCs), laboratories certified through the Clinical Laboratory Improvement Amendment (CLIA)).

(5) The agency covers ((~~total~~)) obstetrical care services ((~~(paid under a global fee). Total obstetrical care includes all~~)) including, but not limited to, the following:

(a) ((~~Routine~~)) Antepartum care that begins in any trimester of a pregnancy;

(b) Delivery care (intrapartum care and birth) services; and

(c) Postpartum care. ((~~This includes family planning counseling.~~

~~(6) When an eligible client receives all the services listed in subsection (5) of this section from one provider, the agency pays that provider a global obstetrical fee.~~

~~(7) When an eligible client receives services from more than one provider, the agency pays each provider for the services furnished. The separate services that the agency pays appear in subsection (5) of this section.~~

~~(8) The agency pays for antepartum care services in one of the following two ways:~~

~~(a) Under a global fee; or~~

~~(b) Under antepartum care fees.~~

~~(9) The agency's fees for antepartum care include all the following:~~

~~(a) Completing an initial and any subsequent patient history;~~

~~(b) Completing all physical examinations;~~

~~(c) Recording and tracking the client's weight and blood pressure;~~

~~(d) Recording fetal heart tones;~~

~~(e) Performing a routine chemical urinalysis (including all urine dipstick tests); and~~

~~(f) Providing maternity counseling.~~

~~(10) The agency covers certain antepartum services in addition to the bundled services listed in subsection (9) of this section as follows:~~

~~(a) The agency pays for either of the following, but not both:~~

~~(i) An enhanced prenatal management fee (a fee for medically necessary increased prenatal monitoring). The agency provides a list of diagnoses, or conditions, or both, that the agency identifies as justification for more frequent monitoring visits; or~~

~~(ii) A prenatal management fee for "high-risk" maternity clients. This fee is payable to either a physician or a certified nurse midwife.~~

~~(b) The agency pays for both of the following:~~

~~(i) Necessary prenatal laboratory tests except routine chemical urinalysis, including all urine dipstick tests, as described in subsection (9)(e) of this section; and~~

~~(ii) Treatment of medical problems that are not related to the pregnancy. The agency pays these fees to physicians or advanced registered nurse practitioners (ARNP).~~

~~(11) The agency covers high-risk pregnancies. The agency considers a pregnant client to have a high-risk pregnancy when the client:~~

~~(a) Has any high-risk medical condition (whether or not it is related to the pregnancy); or~~

~~(b) Has a diagnosis of multiple births.~~

~~(12) The agency covers delivery services for clients with high-risk pregnancies, described in subsection (11) of this section, when the delivery services are provided in a hospital.~~

~~(13)~~)) (6) The agency pays a facility fee for delivery services in the following settings:

(a) Inpatient hospital; or

(b) Birthing centers.

((~~(14)~~)) (7) The agency pays a professional fee for delivery services in the following settings:

(a) Hospitals, to a provider who meets the criteria in subsection (4) of this section and who has privileges in the hospital;

(b) Planned home births and birthing centers.

((~~(15) The agency covers hospital delivery services for an eligible client as defined in subsection (2) of this section. The agency's bundled payment for the professional fee for hospital delivery services include:~~

~~(a) The admissions history and physical examination; and~~

~~(b) The management of uncomplicated labor (intrapartum care); and~~

~~(c) The vaginal delivery of the newborn (with or without episiotomy or forceps); or~~

~~(d) Cesarean delivery of the newborn.~~

~~(16) The agency pays only a labor management fee to a provider who begins intrapartum care and unanticipated medical complications prevent that provider from following through with the birthing services.~~

~~(17) In addition to the agency's payment for professional services in subsection (15) of this section, the agency may pay separately for services provided by any of the following professional staff:~~

~~(a) A physician assistant or registered nurse "first assist" when delivery is by cesarean section;~~

~~(b) A physician, ARNP, or licensed midwife for newborn examination as the delivery setting allows; and~~

~~(c) An obstetrician, or gynecologist specialist, or both, for external cephalic version and consultation.~~

~~(18) In addition to the professional delivery services fee in subsection (15) or the global/total fees (i.e., those that include the hospital delivery services) in subsections (5) and (6) of this section, the agency allows additional fees for any of the following:~~

~~(a) High-risk vaginal delivery;~~

~~(b) Multiple vaginal births. The agency's typical payment covers delivery of the first child. For each subsequent child, the agency pays at 50 percent of the provider's usual and customary charge, up to the agency's maximum allowable fee; or~~

~~(c) High-risk cesarean section delivery.~~

~~(19) The agency does not pay separately for any of the following:~~

~~(a) More than one child delivered by cesarean section during a surgery. The agency's cesarean section surgery fee covers one or multiple surgical births;~~

~~(b) Postoperative care for cesarean section births. This is included in the surgical fee. Postoperative care is not the same as, or part of, postpartum care.~~

~~(20)~~)) (8) The agency pays for an early delivery, including induction or cesarean section, before 39 weeks of gestation only if medically necessary. The agency considers an early delivery to be medically necessary:

(a) If the ((~~mother~~)) pregnant person or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation; or

(b) If the provider documents a clinical situation that supports medical necessity.

((~~(21)~~)) (9) The agency will ((~~only~~)) pay only for antepartum and postpartum professional services for an early elective delivery as defined in WAC 182-500-0030.

((~~(22)~~)) (10) The hospital will receive no payment for an early elective delivery as defined in WAC 182-500-0030.

((~~(23) In addition to the services listed in subsection (10) of this section,~~)) (11) The agency covers counseling for tobacco/nicotine cessation for eligible clients who are pregnant or in the postpartum period as defined in 42 C.F.R. 435.170. See WAC 182-531-1720.

((~~(24)~~)) (12) For clients age 20 and younger, see the rules for the early periodic screening, diagnosis, and treatment (EPSDT) program described in chapter 182-534 WAC.

WSR 26-17-035
PERMANENT RULES
DEPARTMENT OF
RETIREMENT SYSTEMS

[Filed August 11, 2026, 11:53 a.m., effective August 12, 2026]

Effective Date of Rule: One business day after filing.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: The federal requirements that the department of retirement systems (DRS) is implementing are already in effect, so DRS is putting the rules into effect one business day after filing the CR-103P.

Purpose: Complying with Internal Revenue Service regulations governing nonspousal survivor benefits from a retirement plan.

Citation of Rules Affected by this Order: Amending WAC 415-02-380, 415-103-225, 415-104-215, 415-106-600, 415-108-326, 415-110-610, 415-112-504, and 415-112-505.

Statutory Authority for Adoption: RCW 41.50.050.

Adopted under notice filed as WSR 26-14-122 on July 1, 2026.

Changes Other than Editing from Proposed to Adopted Version: Change One: In the proposed rule, DRS anticipated revising WAC 415-104-202. However, this WAC applies to law enforcement officers' and firefighters' [Plan] 1 members, and state law does not permit them to designate nonspousal beneficiaries. As a result, there is no need for DRS to update this WAC, so the final rule does not contain revisions to WAC 415-104-202.

Change Two: In the final rule, DRS revised WAC 415-104-215 (4)(c) to match the language in the other affected WAC sections by adding the phrase "Option 3" and enclosing the term "50 percent" in parentheses.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 8, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 8, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 11, 2026.

Kathryn Leathers
Director

RDS-7210.3

AMENDATORY SECTION (Amending WSR 20-06-040, filed 2/27/20, effective 3/29/20)

WAC 415-02-380 How will my retirement benefit be affected if I choose a survivor option? If you choose a survivor benefit option, your benefit will be affected as described in this section.

(1) **What is a survivor benefit option?** A survivor benefit option will pay a lifetime monthly benefit to your survivor beneficiary after your death.

(2) **What is a survivor beneficiary?** A survivor beneficiary is the person you designate to receive a lifetime monthly benefit after your death.

(3) **What benefit options are available?** All available benefit options, including survivor benefit options, are described in detail for each system and plan in the following state laws and agency rules:

LEOFF Plan 1:	RCW 41.26.164	WAC 415-104-202
LEOFF Plan 2:	RCW 41.26.460	WAC 415-104-215
PERS Plan 1:	RCW 41.40.188	WAC 415-108-326
PERS Plan 2:	RCW 41.40.660	WAC 415-108-326
PERS Plan 3:	RCW 41.40.845	WAC 415-108-326
PSERS:	RCW 41.37.170	WAC 415-106-600
SERS Plans 2 and 3:	RCW 41.35.220	WAC 415-110-610
TRS Plan 1:	RCW 41.32.530	WAC 415-112-504
TRS Plan 2:	RCW 41.32.785	WAC 415-112-505
TRS Plan 3:	RCW 41.32.851	WAC 415-112-505
WSPRS Plan 1:	RCW 43.43.278	WAC 415-103-215
WSPRS Plan 2:	RCW 43.43.271	WAC 415-103-225

(4) **How will selecting a survivor benefit option affect my monthly retirement benefit?** If you select a survivor benefit option your monthly retirement benefit will be reduced to offset the cost of potentially paying the benefit for a longer period of time. The reduction will be based on survivor option factors that are available on the DRS website.

(5) **Does my survivor beneficiary's age affect how much my monthly retirement benefit will be reduced?** Yes. Your survivor beneficiary's age is used in determining the amount of your monthly retirement benefit and the benefit of your survivor beneficiary. The younger the survivor beneficiary, the longer they are expected to receive a benefit. Your monthly benefit will be reduced accordingly.

(a) **Example:**

Kendra, a PERS Plan 2 member, chooses Option 3 (joint and 50 percent survivorship) at retirement. Her monthly Option 1 nonsurvivor benefit amount, which would stop at the time of her death, is $2,000.00. She names her nephew, Steve, as her survivor beneficiary. This means, if Kendra dies before Steve, Steve will receive a monthly benefit equal to half the amount Kendra was receiving. Steve is 30 years younger than Kendra. The department will reduce Kendra's monthly retirement benefit using the survivor option factor for a member who is 30 years older than the beneficiary. For illustration purposes in this example only, we will use 0.776 as the corresponding Option 3 benefit factor (actuarial factors change periodically). As a result, Kendra's Option 3 monthly benefit amount will be $1,552.00 ($2,000.00 x 0.776).

(b) **Example:**

Mark, a LEOFF Plan 2 member, chooses Option 2 (joint and 100 percent survivorship) at retirement. His monthly Option 1 nonsurvivor

benefit amount, which would stop at the time of his death, is $2,000.00. He names his wife, Susan, as his survivor beneficiary. This means, if Mark dies before Susan, Susan will receive a monthly benefit equal to the amount Mark was receiving. Mark is five years younger than Susan. The department will reduce Mark's monthly retirement benefit using the survivor option factor for a member who is five years younger than the beneficiary. For illustration purposes in this example only, we will use 0.898 as the corresponding Option 2 benefit factor (actuarial factors change periodically). As a result, Mark's Option 2 monthly benefit amount will be $1,796.00 ($2,000.00 x 0.898).

(6) **How will naming a nonspousal survivor beneficiary affect my benefit options?** When you name a nonspouse survivor, your benefit options may be limited when your survivor is 11 or more years younger than you. Your available options are based on the age difference between you and your survivor.

(a) **Age difference: Less than 11 years:** Eligible for Option 2 (100 percent), Option 3 (50 percent), or Option 4 (66.67 percent) survivor benefit option. These options are also all available if the age difference is 11 years or more, but the survivor's age is the higher number.

(b) **Age difference: 11-24 years:** Eligible for Option 3 (50 percent) or Option 4 (66.67 percent) survivor benefit options.

(c) **Age difference: 25 or more years:** Eligible for Option 3 (50 percent) survivor benefit option.

(d) If you retire before the age the IRS requires your required minimum distributions (RMDs) to begin, the age difference between you and your survivor will be reduced by the number of years between your age at retirement and your RMD age.

(i) If you were born before July 1, 1949, your RMD age is 70.

(ii) If you were born between July 1, 1949, and December 31, 1950, your RMD age is 72.

(iii) If you were born between January 1, 1951, and December 31, 1959, your RMD age is 73.

(iv) If you were born on or after January 1, 1960, your RMD age is 75.

If you retire after your RMD age, there is no adjustment to the age difference between you and your nonspouse survivor.

(e) **Example:** Janet was born January 5, 1961, and will retire September 1, 2026. She plans to name her son, born April 14, 1985, as her survivor beneficiary. The age difference between Janet and her son is 24 years. Janet's RMD age is 75, and she is retiring at age 65 so the age difference is reduced by 10 years (75 minus 65) for an adjusted age difference of 14 (24 minus 10) years. Janet is eligible to choose between survivor Option 3 (50 percent) and Option 4 (66.67 percent) for her son.

(7) **What if my survivor beneficiary passes away before I do?** If you are receiving a reduced benefit with a survivor option and your survivor passes away before you do, you may request to have your benefit increased to the Option 1 nonsurvivor amount. Your benefit increase will be effective the first of the month following your survivor's passing. DRS may require a copy of your survivor's certified death certificate.

(a) **How will my new benefit amount be calculated?**

(i) If you retired on or after January 1, 1996, and are not a member of LEOFF Plan 1, or if you are a member of WSPRS Plan 1 regardless of your retirement date, your new benefit amount will be calculated as follows:

Your original Option 1 nonsurvivor benefit amount
+ the sum of Cost of Living Adjustments (COLAs) added to your benefit prior to your survivor's death

(ii) If you retired prior to January 1, 1996, and are not a member of WSPRS Plan 1, or if you are a member of LEOFF Plan 1 regardless of your retirement date, your new benefit amount will be calculated as follows:

Benefit Amount ÷ the Administrative Factor

The "benefit amount" is your retirement benefit as of July 1, 1998, or as of the date of your survivor's death, whichever is later.

The "administrative factor" is the rate that was used to calculate your reduced benefit for the continuing survivor option. If you retired prior to January 1, 1996, the administrative factor is the rate that was in effect on July 1, 1998, and is available for reference on the DRS website.

(b) If you are a PERS Plan 1 member receiving "state-funded long-term care services" as defined in RCW 41.40.189, you are not eligible for the increase described in this subsection if it would make you ineligible for the state-funded long-term care services. You must notify DRS to waive the increase if this applies to you.

RDS-7211.3

AMENDATORY SECTION (Amending WSR 25-18-099, filed 9/2/25, effective 10/3/25)

WAC 415-103-225 What are my WSPRS Plan 2 retirement benefit options? This section applies to WSPRS Plan 2 members. Upon retirement for service under RCW 43.43.250, you must choose to have your monthly retirement benefit paid to you by one of the options described in this section.

(1) **Which option will pay my beneficiary a monthly benefit after my death?** Options described in subsection (2)(b) through (d) of this section include a survivor option. The person you name at the time of retirement to receive a monthly benefit after your death is referred to as your "survivor beneficiary." Upon your death your survivor beneficiary will be entitled to receive a monthly benefit for the duration of his or her life. Your monthly retirement benefit will be actuarially reduced to offset the cost of the survivor option. See WAC 415-02-380 for more information on how your monthly benefit is affected by choosing a survivor option.

(2) **What are my benefit options?**

(a) **Option one: Standard benefit (nonsurvivor option).** The department will pay you a monthly retirement benefit throughout your life. Your monthly benefit will cease upon your death.

(b) **Option two: Joint and 100 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to your gross monthly benefit.

(c) **Option three: Joint and 50 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout

your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to 50 percent of your gross monthly benefit.

(d) **Option four: Joint and two-thirds survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to two-thirds (66.667 percent) of your gross monthly benefit.

(3) **Do I need my spouse's consent on the option I choose?** The option you select will determine whether spousal consent is required. For purposes of this section, a registered domestic partnership is treated the same as a spousal relationship.

(a) If you are married and select a nonsurvivor benefit option, you must submit your spouse's consent, verified by notarization or other means acceptable to the department. If you do not provide verified spousal consent, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 43.43.271(2).

(b) If you are married and select a survivor benefit option for your spouse, spousal consent is not required. The department will pay you a monthly benefit based on the option you selected.

(c) If you are married and select a survivor benefit option for someone other than your spouse, verified spousal consent is required. If you do not provide spousal consent, verified by notarization or other means acceptable to the department, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 43.43.271(2).

(d) If your survivor beneficiary has been designated by a dissolution order according to subsection (4) of this section, which was filed with the department at least 30 days before your retirement date, spousal consent is not required.

(4) **How will naming a nonspousal survivor beneficiary affect my benefit options?** When you name a nonspouse survivor, your benefit options may be limited when your survivor is 11 or more years younger than you. Your available options are based on the adjusted age difference between you and your survivor:

(a) **Age difference: Less than 11 years:** Eligible for Option 2 (100 percent), Option 3 (50 percent), or Option 4 (66.67 percent) survivor benefit option. These options are also all available if the age difference is 11 years or more, but the survivor's age is the higher number.

(b) **Age difference: 11-24 years:** Eligible for Option 3 (50 percent) or Option 4 (66.67 percent) survivor benefit options.

(c) **Age difference: 25 or more years:** Eligible for Option 3 (50 percent) survivor benefit option.

(d) If you retire before the age the IRS requires your required minimum distributions (RMDs) to begin, the age difference between you and your survivor will be reduced by the number of years between your age at retirement and your RMD age.

(i) If you were born before July 1, 1949, your RMD age is 70.

(ii) If you were born between July 1, 1949, and December 31, 1950, your RMD age is 72.

(iii) If you were born between January 1, 1951, and December 31, 1959, your RMD age is 73.

(iv) If you were born on or after January 1, 1960, your RMD age is 75.

If you retire after your RMD age, there is no adjustment to the age difference between you and your nonspouse survivor.

(e) **Example:** Janet was born January 5, 1961, and will retire September 1, 2026. She plans to name her son, born April 14, 1985, as her survivor beneficiary. The age difference between Janet and her son is 24 years. Janet's RMD age is 75, and she is retiring at age 65 so the age difference is reduced by 10 years (75 minus 65) for an adjusted age difference of 14 years (24 minus 10). Janet is eligible to choose between survivor Option 3 (50 percent) and Option 4 (66.67 percent) for her son.

(5) **Can a dissolution order require that a former spouse be designated as a survivor beneficiary?** Yes. A dissolution order may require that a former spouse be designated as a survivor beneficiary. The department is required to pay survivor benefits to a former spouse pursuant to a dissolution order that complies with RCW 41.50.790.

((~~(5)~~)) (6) **What happens if I choose a benefit with a survivor option and my survivor beneficiary dies before I do?** If your survivor beneficiary dies before you do, you may request to have your benefit increased as described in WAC 415-02-380.

((~~(6)~~)) (7) **May I change my benefit option after retirement?** Your choice of a benefit option is irrevocable with the following four exceptions:

(a) **Return to membership.** If you retire and then return to membership, you may choose a different retirement option upon your subsequent retirement.

(b) **Postretirement marriage option.** If you select the standard benefit option at the time of retirement and marry after retirement, you may select a benefit option with a survivor option and name your current spouse as survivor, provided that:

(i) Your benefit is not subject to a property division obligation pursuant to a dissolution order. See WAC 415-02-500;

(ii) The selection is made during a one-year window, on or after the date of the first anniversary and before the second anniversary of your postretirement marriage;

(iii) You provide a copy of your certified marriage certificate to the department; and

(iv) You provide proof of your current spouse's birthdate.

(c) **Removal of a nonspouse survivor option.** If you select a benefit option with a survivor option and name a nonspouse as survivor beneficiary at the time of retirement, you may remove that survivor beneficiary designation and have your benefit adjusted to a standard benefit. You may exercise this option one time only.

(d) **One-time change of survivor.** You may change your benefit option and/or designated survivor one time within 90 days from the date your first benefit payment is issued. Your change request must be in writing, and must comply with other requirements as described in this section. Your new benefit amount will be effective the first of the month following the receipt of your request by the department.

((~~(7)~~)) (8) **Who will receive the balance of my accumulated contributions, if any, after my death?**

(a) If you do not have a survivor beneficiary at the time of your death, and you die before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(i) To the person or entity (i.e., trust, organization, or estate) you have nominated by written designation, executed and filed with the department.

(ii) If you have not designated a beneficiary, or if your designated beneficiary is no longer living or in existence, then to your surviving spouse.

(iii) If not paid according to (a)(i) or (ii) of this subsection, then to your estate.

(b) If you have a survivor beneficiary at the time of your death, and your survivor beneficiary dies before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(i) To the person or entity (i.e., trust, organization, or estate) your survivor beneficiary has nominated by written designation, executed and filed with the department.

(ii) If your survivor beneficiary has not designated a beneficiary, or if the designated beneficiary is no longer living or in existence, then to your survivor beneficiary's spouse.

(iii) If not paid according to (b)(i) or (ii) of this subsection, then to your survivor beneficiary's estate.

((~~(8)~~)) (9) For more information, see RCW 43.43.271.

RDS-7212.6

AMENDATORY SECTION (Amending WSR 25-18-099, filed 9/2/25, effective 10/3/25)

WAC 415-104-215 What are my LEOFF Plan 2 retirement benefit options? If you retire for service under RCW 41.26.430 or nonduty disability under RCW 41.26.470, or if you choose to receive a monthly benefit for duty disability under RCW 41.26.470, you must choose to have your monthly retirement benefit paid to you by one of the options described in this section.

(1) **Which option will pay my beneficiary a monthly benefit after my death?** Options described in subsection (2)(b) through (d) of this section will pay a monthly benefit to your survivor after your death. The person you name at the time of retirement to receive a monthly benefit after your death is referred to as your "survivor beneficiary." After your death, your survivor beneficiary will receive a monthly benefit for the duration of their life. Your monthly retirement benefit will be reduced to offset the cost of the survivor option. See WAC 415-02-380 for more information on how your monthly benefit will be affected if you choose a survivor option.

(2) **What are my benefit options?**

(a) **Option one: Standard benefit (nonsurvivor option).** The department will pay you a monthly retirement benefit throughout your lifetime. Your monthly benefit will cease upon your death.

(b) **Option two: Joint and 100 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to your gross monthly benefit.

(c) **Option three: Joint and 50 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to 50 percent of your gross monthly benefit.

(d) **Option four: Joint and two-thirds benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to two-thirds (66.667((~~%~~)) percent) of your gross monthly benefit.

(3) **Do I need my spouse's consent on the option I choose?** The option you select will determine whether spousal consent is required. For purposes of this section, a registered domestic partnership is treated the same as a spousal relationship.

(a) If you are married and select a nonsurvivor benefit option, you must provide your spouse's consent, verified by notarization or other means acceptable to the department. If you do not provide verified spousal consent, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.26.460(2).

(b) If you are married and select a survivor benefit option for your spouse, spousal consent is not required. The department will pay you a monthly benefit based on the option you selected.

(c) If you are married and select a survivor benefit option for someone other than your spouse, verified spousal consent is required. If you do not provide spousal consent, verified by notarization or other means acceptable to the department, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.26.460(2).

(d) If your survivor beneficiary has been designated by a dissolution order according to subsection ((~~(4)~~)) (5) of this section, which was filed with the department at least 30 days before your retirement date, spousal consent is not required.

(4) **How will naming a nonspousal survivor beneficiary affect my benefit options?** When you name a nonspouse survivor, your benefit options may be limited when your survivor is 11 or more years younger than you. Your available options are based on the adjusted age difference between you and your survivor:

(a) **Age difference: Less than 11 years:** Eligible for Option 2 (100 percent), Option 3 (50 percent), or Option 4 (66.67 percent) survivor benefit option. These options are also all available if the age difference is 11 years or more, but the survivor's age is the higher number.

(b) **Age difference: 11-24 years:** Eligible for Option 3 (50 percent) or Option 4 (66.67 percent) survivor benefit options.

(c) **Age difference: 25 or more years:** Eligible for Option 3 (50 percent) survivor benefit option.

(d) If you retire before the age the IRS requires your required minimum distributions (RMDs) to begin, the age difference between you and your survivor will be reduced by the number of years between your age at retirement and your RMD age.

(i) If you were born before July 1, 1949, your RMD age is 70.

(ii) If you were born between July 1, 1949, and December 31, 1950, your RMD age is 72.

(iii) If you were born between January 1, 1951, and December 31, 1959, your RMD age is 73.

(iv) If you were born on or after January 1, 1960, your RMD age is 75.

If you retire after your RMD age, there is no adjustment to the age difference between you and your nonspouse survivor.

(e) **Example:** Janet was born January 5, 1961, and will retire September 1, 2026. She plans to name her son, born April 14, 1985, as her survivor beneficiary. The age difference between Janet and her son is 24 years. Janet's RMD age is 75, and she is retiring at age 65 so the age difference is reduced by 10 years (75 minus 65) for an adjusted age difference of 14 years (24 minus 10). Janet is eligible to choose between survivor Option 3 (50 percent) and Option 4 (66.67 percent) for her son.

(5) **Do I have a benefit enhancements choice between the tiered multiplier and lump-sum benefit?**

(a) If you were a LEOFF Plan 2 member on or before February 1, 2021, and are retiring with more than 15 years of service credit, you have a choice between the tiered multiplier and the lump-sum benefit. If you are retiring with 15 years or less service credit, you do not have a choice and will receive the lump-sum benefit.

(b) If you elect the lump-sum benefit and it is $20,000 or more, you are eligible to purchase an annuity with all or a portion of the lump-sum benefit. The minimum annuity purchase price is $20,000.

(c) If you became a LEOFF Plan 2 member after February 1, 2021, and are retiring with more than 15 years of service credit, you will receive the tiered multiplier benefit enhancement. Members retiring with 15 years of service credit or less will receive the standard retirement benefit calculation and not an enhanced benefit.

((~~(5)~~)) (6) **Can a dissolution order require that a former spouse be designated as a survivor beneficiary?** Yes. A dissolution order may require that a former spouse be designated as a survivor beneficiary. The department is required to pay survivor benefits to a former spouse pursuant to a dissolution order that complies with RCW 41.50.790.

((~~(6)~~)) (7) **What happens if I choose a benefit option with a survivor option and my survivor beneficiary dies before I do?** If your survivor beneficiary dies before you do, you may request to have your benefit increased as described in WAC 415-02-380.

((~~(7)~~)) (8) **May I change my benefit option after retirement?** Your choice of a benefit option is irrevocable with the following five exceptions:

(a) **Return to membership.** If you retire and then return to membership, you may choose a different retirement option upon your subsequent retirement.

(b) **Postretirement marriage option.** If you select the standard benefit option at the time of retirement and marry after retirement, you may select a benefit option with a survivor option and name your current spouse as survivor beneficiary, provided that:

(i) Your benefit is not subject to a property division obligation pursuant to a dissolution order. See WAC 415-02-500;

(ii) The selection is made during a one-year window, on or after the date of the first anniversary and before the second anniversary of your postretirement marriage;

(iii) You provide a copy of your certified marriage certificate to the department; and

(iv) You provide proof of your current spouse's birthdate.

(c) **Removal of a nonspouse survivor option.** If you select a benefit option with a survivor option and name a nonspouse as survivor beneficiary at the time of retirement, you may remove that survivor beneficiary designation and have your benefit adjusted to a standard benefit. You may exercise this option one time only.

(d) **One-time change of survivor.** You may change your benefit option and/or designated survivor one time within 90 days from the date

your first benefit payment is issued. Your change request must be in writing, and must comply with other requirements as described in this section. Your new benefit amount will be effective the first of the month following the receipt of your request by the department.

(e) **Retirement type changes.** If your retirement status changes due to the acceptance of a new retirement application from service retirement to a nonduty, duty or catastrophic retirement, or duty to catastrophic retirement, you may select a different survivor benefit option. Your benefit will be recalculated to reflect your new survivor option in accordance with WAC 415-104-483.

((~~(8)~~)) (9) **Who will receive the balance of my accumulated contributions, if any, after my death?**

(a) If you do not have a survivor beneficiary at the time of your death, and you die before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(i) To the person or entity (i.e., trust, organization, or estate) you have nominated by written designation, executed and filed with the department.

(ii) If you have not designated a beneficiary, or if the designated beneficiary is no longer living or in existence, then to your surviving spouse.

(iii) If not paid according to (a)(i) or (ii) of this subsection, then to your estate.

(b) If you have a survivor beneficiary at the time of your death, and your survivor beneficiary dies before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(i) To the person or entity (i.e., trust, organization, or estate) your survivor beneficiary has nominated by written designation, executed and filed with the department.

(ii) If your survivor beneficiary has not designated a beneficiary, or if the designated beneficiary is no longer living or in existence, then to your survivor beneficiary's spouse.

(iii) If not paid according to (b)(i) or (ii) of this subsection, then to your survivor beneficiary's estate.

((~~(9)~~)) (10) For more information, see RCW 41.26.460.

RDS-7213.2

AMENDATORY SECTION (Amending WSR 25-18-099, filed 9/2/25, effective 10/3/25)

WAC 415-106-600 What are my retirement benefit options? Upon retirement for service under RCW 41.37.210 or retirement for disability under RCW 41.37.230, you must choose to have your retirement benefit paid to you by one of the options described in this section.

(1) **Which option will pay my beneficiary a monthly benefit after my death?** Options described in subsection (2)(b) through (d) of this section will pay a monthly benefit to your survivor after your death. The person you name at the time of retirement to receive a monthly benefit after your death is referred to as your "survivor beneficiary." After your death, your survivor beneficiary will receive a month-

ly benefit for the duration of their life. Your monthly retirement benefit will be reduced to offset the cost of the survivor option. See WAC 415-02-380 for more information on how your monthly benefit will be affected if you choose a survivor option.

(2) **What are my benefit options?**

(a) **Option one: Standard benefit (nonsurvivor option).** The department will pay you a monthly retirement benefit throughout your lifetime. Your monthly benefit will cease upon your death.

(b) **Option two: Joint and 100 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to your gross monthly benefit.

(c) **Option three: Joint and 50 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to 50 percent of your gross monthly benefit.

(d) **Option four: Joint and two-thirds survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to two-thirds (66.667((%)) percent) of your gross monthly benefit.

(3) **Do I need my spouse's consent on the option I choose?** The option you select will determine whether spousal consent is required. For purposes of this section, a registered domestic partnership is treated the same as a spousal relationship.

(a) If you are married and select a nonsurvivor benefit option, you must provide your spouse's consent, verified by a notarized signature or other means acceptable to the department. If you do not provide verified spousal consent, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.37.170(2).

(b) If you are married and select a survivor benefit option for your spouse, spousal consent is not required. The department will pay you a monthly benefit based on the option you selected.

(c) If you are married and select a survivor benefit option for someone other than your spouse, spousal consent is required. If you do not provide spousal consent, verified by a notarized signature or other means acceptable to the department, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.37.170(2).

(d) If your survivor beneficiary has been designated by a dissolution order according to subsection ((~~(4)~~)) (5) of this section, which was filed with the department at least 30 days before your retirement date, spousal consent is not required.

(4) **How will naming a nonspousal survivor beneficiary affect my benefit options?** When you name a nonspouse survivor, your benefit options may be limited when your survivor is 11 or more years younger than you. Your available options are based on the adjusted age difference between you and your survivor:

(a) **Age difference: Less than 11 years:** Eligible for Option 2 (100 percent), Option 3 (50 percent), or Option 4 (66.67 percent) survivor benefit option. These options are also all available if the age difference is 11 years or more, but the survivor's age is the higher number.

(b) **Age difference: 11-24 years:** Eligible for Option 3 (50 percent) or Option 4 (66.67 percent) survivor benefit options.

(c) **Age difference: 25 or more years:** Eligible for Option 3 (50 percent) survivor benefit option.

(d) If you retire before the age the IRS requires your required minimum distributions (RMDs) to begin, the age difference between you and your survivor will be reduced by the number of years between your age at retirement and your RMD age.

(i) If you were born before July 1, 1949, your RMD age is 70.

(ii) If you were born between July 1, 1949, and December 31, 1950, your RMD age is 72.

(iii) If you were born between January 1, 1951, and December 31, 1959, your RMD age is 73.

(iv) If you were born on or after January 1, 1960, your RMD age is 75.

If you retire after your RMD age, there is no adjustment to the age difference between you and your nonspouse survivor.

(e) **Example:** Janet was born January 5, 1961, and will retire September 1, 2026. She plans to name her son, born April 14, 1985, as her survivor beneficiary. The age difference between Janet and her son is 24 years. Janet's RMD age is 75, and she is retiring at age 65 so the age difference is reduced by 10 years (75 minus 65) for an adjusted age difference of 14 years (24 minus 10). Janet is eligible to choose between survivor Option 3 (50 percent) and Option 4 (66.67 percent) for her son.

(5) **Can a dissolution order require that a former spouse be designated as a survivor beneficiary?** Yes. A dissolution order may require that a former spouse be designated as a survivor beneficiary. The department is required to pay survivor benefits to a former spouse pursuant to a dissolution order that complies with RCW 41.50.790.

((~~(5)~~)) (6) **What happens if I choose a benefit with a survivor option and my survivor beneficiary dies before I do?** If your survivor beneficiary dies before you do, you may request to have your benefit increased as described in WAC 415-02-380.

((~~(6)~~)) (7) **May I change my benefit option after retirement?** Your choice of a benefit option is irrevocable with the following five exceptions:

(a) **Return to membership.** If you retire and then return to membership for at least two years of uninterrupted service, you may choose a different retirement option upon your subsequent retirement. See RCW 41.37.050(3).

(b) **Postretirement marriage option.** If you select the standard benefit option at the time of retirement and marry after retirement, you may select a survivor benefit option and name your current spouse as survivor beneficiary, provided that:

(i) Your benefit is not subject to a property division obligation pursuant to a dissolution order. See WAC 415-02-500;

(ii) The selection is made during a one-year window, on or after the date of the first anniversary and before the second anniversary of your postretirement marriage;

(iii) You provide a copy of your certified marriage certificate to the department; and

(iv) You provide proof of your current spouse's birthdate.

(c) **Removal of a nonspouse survivor option.** If you select a survivor benefit option and name a nonspouse as your survivor beneficiary at the time of retirement, you may remove that survivor beneficiary

designation and have your benefit adjusted to a standard benefit. You may exercise this option one time only.

(d) **One-time change of survivor.** You may change your benefit option and/or designated survivor one time within 90 days from the date your first benefit payment is issued. Your change request must be in writing, and must comply with other requirements as described in this section. Your new benefit amount will be effective the first of the month following the receipt of your request by the department.

(e) **Retirement type changes.** If your retirement status changes due to the acceptance of a new retirement application from service retirement to a disability or catastrophic retirement, or disability to catastrophic retirement, you may select a different survivor benefit option. Your benefit will be recalculated to reflect your new survivor option in accordance with WAC 415-106-530.

((~~(7)~~)) (8) **Who will receive the balance of my accumulated contributions, if any, after my death?**

(a) If you do not have a survivor beneficiary at the time of your death, and you die before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(i) To the person or entity (i.e., trust, organization, or estate) you have nominated by written designation, executed and filed with the department.

(ii) If you have not designated a beneficiary, or if your designated beneficiary is no longer living or in existence, then to your surviving spouse.

(iii) If not paid according to (a)(i) or (ii) of this subsection, then to your estate.

(b) If you have a survivor beneficiary at the time of your death, and your survivor beneficiary dies before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(i) To the person or entity (i.e., trust, organization, or estate) your survivor beneficiary has nominated by written designation, executed and filed with the department.

(ii) If your survivor beneficiary has not designated a beneficiary, or if the designated beneficiary is no longer living or in existence, then to your survivor beneficiary's spouse.

(iii) If not paid according to (b)(i) or (ii) of this subsection, then to your survivor beneficiary's estate. See RCW 41.37.170.

RDS-7214.2

AMENDATORY SECTION (Amending WSR 25-18-099, filed 9/2/25, effective 10/3/25)

WAC 415-108-326 What are my retirement benefit options? Upon retirement for service under RCW 41.40.180, 41.40.630, or 41.40.820, or for disability under RCW 41.40.210, 41.40.230, 41.40.670, or 41.40.825, you must choose to have the defined benefit portion of your retirement benefit paid to you by one of the options described in this section. If you are a Plan 1 member, you may also select an optional supplemental cost of living adjustment (COLA).

(1) **Which option will pay my beneficiary a monthly benefit after my death?** Options described in subsection (2)(b) through (d) of this section will pay a monthly benefit to your survivor after your death. The person you name at the time of retirement to receive a monthly benefit after your death is referred to as your "survivor beneficiary." After your death, your survivor beneficiary will receive a monthly benefit for the duration of their life. Your monthly retirement benefit will be reduced to offset the cost of the survivor option. See WAC 415-02-380 for more information on how your monthly benefit will be affected if you choose a survivor option.

(2) **What are my benefit options?**

(a) **Option one: Standard benefit (nonsurvivor option).** The department will pay you a monthly retirement benefit throughout your lifetime. Your monthly benefit will cease upon your death.

(b) **Option two: Joint and 100 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to your gross monthly benefit.

(c) **Option three: Joint and 50 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to 50 percent of your gross monthly benefit.

(d) **Option four: Joint and two-thirds survivor benefit.**[1] The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to two-thirds (66.667((%)) percent) of your gross monthly benefit.

(3) **Do I need my spouse's consent on the option I choose?** The option you select will determine whether spousal consent is required. For purposes of this section, a registered domestic partnership is treated the same as a spousal relationship.

(a) If you are married and select a nonsurvivor benefit option, you must provide your spouse's consent, verified by a notarized signature or other means acceptable to the department. If you do not provide spousal consent, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.40.188, 41.40.660 and 41.40.845.

(b) If you are married and select a survivor benefit option for your spouse, spousal consent is not required. The department will pay you a monthly benefit based on the option you selected.

(c) If you are married and select a survivor benefit option for someone other than your spouse, spousal consent is required. If you do not provide spousal consent, verified by a notarized signature or other means acceptable to the department, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.40.188, 41.40.660 and 41.40.845.

(d) If your survivor beneficiary has been designated by a dissolution order according to subsection ((~~(4)~~)) (5) of this section, which was filed with the department at least 30 days before your retirement date, spousal consent is not required.

(4) **How will naming a nonspousal survivor beneficiary affect my benefit options?** When you name a nonspouse survivor, your benefit options may be limited when your survivor is 11 or more years younger

than you. Your available options are based on the adjusted age difference between you and your survivor:

(a) **Age difference: Less than 11 years:** Eligible for Option 2 (100 percent), Option 3 (50 percent), or Option 4 (66.67 percent) survivor benefit option. These options are also all available if the age difference is 11 years or more, but the survivor's age is the higher number.

(b) **Age difference: 11-24 years:** Eligible for Option 3 (50 percent) or Option 4 (66.67 percent) survivor benefit options.

(c) **Age difference: 25 or more years:** Eligible for Option 3 (50 percent) survivor benefit option.

(d) If you retire before the age the IRS requires your required minimum distributions (RMDs) to begin, the age difference between you and your survivor will be reduced by the number of years between your age at retirement and your RMD age.

(i) If you were born before July 1, 1949, your RMD age is 70.

(ii) If you were born between July 1, 1949, and December 31, 1950, your RMD age is 72.

(iii) If you were born between January 1, 1951, and December 31, 1959, your RMD age is 73.

(iv) If you were born on or after January 1, 1960, your RMD age is 75.

If you retire after your RMD age, there is no adjustment to the age difference between you and your nonspouse survivor.

(e) **Example:** Janet was born January 5, 1961, and will retire September 1, 2026. She plans to name her son, born April 14, 1985, as her survivor beneficiary. The age difference between Janet and her son is 24 years. Janet's RMD age is 75, and she is retiring at age 65 so the age difference is reduced by 10 years (75 minus 65) for an adjusted age difference of 14 years (24 minus 10). Janet is eligible to choose between survivor Option 3 (50 percent) and Option 4 (66.67 percent) for her son.

(5) **Can a dissolution order require that a former spouse be designated as a survivor beneficiary?** Yes. A dissolution order may require that a former spouse be designated as a survivor beneficiary. The department is required to pay survivor benefits to a former spouse pursuant to a dissolution order that complies with RCW 41.50.790.

((~~(5)~~)) (6) **What is the supplemental COLA option for Plan 1 members?** If you are a Plan 1 member, in addition to choosing a retirement benefit option described in subsection (2) of this section, you may choose to receive a supplemental annual COLA. If you select this option, your monthly retirement benefit will be actuarially reduced to offset the cost of this benefit.

((~~(6)~~)) (7) **What happens if I choose a benefit with a survivor option and my survivor beneficiary dies before I do?** If your survivor beneficiary dies before you do, you may request to have your benefit increased as described in WAC 415-02-380.

((~~(7)~~)) (8) **May I change my benefit option after retirement?** Your choice of a benefit option is irrevocable with the following four exceptions:

(a) **Return to membership.** If you retire and then return to membership for at least two years of uninterrupted service, you may choose a different retirement option upon your subsequent retirement. See RCW 41.40.037.

(b) **Postretirement marriage option.** If you select the standard benefit option at the time of retirement and marry after retirement,

you may select a survivor benefit option and name your current spouse as survivor beneficiary, provided that:

(i) Your benefit is not subject to a property division obligation pursuant to a dissolution order. See WAC 415-02-500;

(ii) The selection is made during a one-year window, on or after the date of the first anniversary and before the second anniversary of your postretirement marriage;

(iii) You provide a copy of your certified marriage certificate to the department; and

(iv) You provide proof of your current spouse's birthdate.

(c) **Removal of a nonspouse survivor option.** If you select a survivor benefit option and name a nonspouse as your survivor beneficiary at the time of retirement, you may remove that survivor beneficiary designation and have your benefit adjusted to a standard benefit. You may exercise this option one time only.

(d) **One-time change of survivor.** You may change your benefit option and/or designated survivor one time within 90 days from the date your first benefit payment is issued. Your change request must be in writing, and must comply with other requirements as described in this section. Your new benefit amount will be effective the first of the month following the receipt of your request by the department.

((~~(8)~~)) (9) **Who will receive the balance of my accumulated contributions, if any, after my death?**

(a) **Plan 1 and 2 members:**

(i) If you do not have a survivor beneficiary at the time of your death, and you die before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(A) To the person or entity (i.e., trust, organization, or estate) you have nominated by written designation, executed and filed with the department.

(B) If you have not designated a beneficiary, or if your designated beneficiary is no longer living or in existence, then to your surviving spouse.

(C) If not paid according to (a)(i)(A) or (B) of this subsection, then to your estate.

(ii) If you have a survivor beneficiary at the time of your death, and your survivor beneficiary dies before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(A) To the person or entity (i.e., trust, organization, or estate) your survivor beneficiary has nominated by written designation, executed and filed with the department.

(B) If your survivor beneficiary has not designated a beneficiary, or if the designated beneficiary is no longer living or in existence, then to your survivor beneficiary's spouse.

(C) If not paid according to (a)(ii)(A) or (B) of this subsection, then to your survivor beneficiary's estate.

(b) **Plan 3 members:** The defined benefit stops upon your death or upon the death of your survivor beneficiary, if applicable. As a Plan 3 member, you do not contribute to the defined benefit portion of your retirement benefit. The defined contribution portion of your benefit will be distributed according to WAC 415-111-310.

((~~(9)~~)) (10) For more information, see RCW 41.40.188 (Plan 1), RCW 41.40.660 (Plan 2) and RCW 41.40.845 (Plan 3).

[1] Available to members retiring on or after January 1, 1996.

RDS-7215.2

AMENDATORY SECTION (Amending WSR 25-18-099, filed 9/2/25, effective 10/3/25)

WAC 415-110-610 What are my retirement benefit options? Upon retirement for service under RCW 41.35.420 or 41.35.680, or for disability under RCW 41.35.440 or 41.35.690, you must choose to have the defined benefit portion of your retirement benefit paid to you by one of the options described in this section.

(1) **Which option will pay my beneficiary a monthly benefit after my death?** Options described in subsection (2)(b) through (d) of this section will pay a monthly benefit to your survivor after your death. The person you name at the time of retirement to receive a monthly benefit after your death is referred to as your "survivor beneficiary." After your death, your survivor beneficiary will receive a monthly benefit for the duration of their life. Your monthly retirement benefit will be reduced to offset the cost of the survivor option. See WAC 415-02-380 for more information on how your monthly benefit will be affected if you choose a survivor option.

(2) **What are my benefit options?**

(a) **Option one: Standard benefit (nonsurvivor option).** The department will pay you a monthly retirement benefit throughout your lifetime. Your monthly benefit will cease upon your death.

(b) **Option two: Joint and 100 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to your gross monthly benefit.

(c) **Option three: Joint and 50 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to 50 percent of your gross monthly benefit.

(d) **Option four: Joint and two-thirds survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to two-thirds (66.667((%)) percent) of your gross monthly benefit.

(3) **Do I need my spouse's consent on the option I choose?** The option you select will determine whether spousal consent is required. For purposes of this section, a registered domestic partnership is treated the same as a spousal relationship.

(a) If you are married and select a nonsurvivor benefit option, you must provide your spouse's consent, verified by a notarized signature or other means acceptable to the department. If you do not provide verified spousal consent, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.35.220.

(b) If you are married and select a survivor benefit option for your spouse, spousal consent is not required. The department will pay you a monthly benefit based on the option you selected.

(c) If you are married and select a survivor benefit option for someone other than your spouse, spousal consent is required, verified by a notarized signature or other means acceptable to the department. If you do not provide verified spousal consent, the department will

pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.35.220.

(d) If your survivor beneficiary has been designated by a dissolution order according to subsection ((~~(4)~~)) (5) of this section, which was filed with the department at least 30 days before your retirement date, spousal consent is not required.

(4) **How will naming a nonspousal survivor beneficiary affect my benefit options?** When you name a nonspouse survivor, your benefit options may be limited when your survivor is 11 or more years younger than you. Your available options are based on the adjusted age difference between you and your survivor:

(a) **Age difference: Less than 11 years:** Eligible for Option 2 (100 percent), Option 3 (50 percent), or Option 4 (66.67 percent) survivor benefit option. These options are also all available if the age difference is 11 years or more, but the survivor's age is the higher number.

(b) **Age difference: 11-24 years:** Eligible for Option 3 (50 percent) or Option 4 (66.67 percent) survivor benefit options.

(c) **Age difference: 25 or more years:** Eligible for Option 3 (50 percent) survivor benefit option.

(d) If you retire before the age the IRS requires your required minimum distributions (RMDs) to begin, the age difference between you and your survivor will be reduced by the number of years between your age at retirement and your RMD age.

(i) If you were born before July 1, 1949, your RMD age is 70.

(ii) If you were born between July 1, 1949, and December 31, 1950, your RMD age is 72.

(iii) If you were born between January 1, 1951, and December 31, 1959, your RMD age is 73.

(iv) If you were born on or after January 1, 1960, your RMD age is 75.

If you retire after your RMD age, there is no adjustment to the age difference between you and your nonspouse survivor.

(e) **Example:** Janet was born January 5, 1961, and will retire September 1, 2026. She plans to name her son, born April 14, 1985, as her survivor beneficiary. The age difference between Janet and her son is 24 years. Janet's RMD age is 75, and she is retiring at age 65 so the age difference is reduced by 10 years (75 minus 65) for an adjusted age difference of 14 years (24 minus 10). Janet is eligible to choose between survivor Option 3 (50 percent) and Option 4 (66.67 percent) for her son.

(5) **Can a dissolution order require that a former spouse be designated as a survivor beneficiary?** Yes. A dissolution order may require that a former spouse be designated as a survivor beneficiary. The department is required to pay survivor benefits to a former spouse pursuant to a dissolution order that complies with RCW 41.50.790.

((~~(5)~~)) (6) **What happens if I choose a benefit option with a survivor option and my survivor beneficiary dies before I do?** If your survivor beneficiary dies before you do, you may request to have your benefit increased as described in WAC 415-02-380.

((~~(6)~~)) (7) **May I change my benefit option after retirement?** Your choice of a benefit option is irrevocable with the following four exceptions:

(a) **Return to membership.** If you retire and then return to membership for at least two years of uninterrupted service, you may

choose a different retirement option upon your subsequent retirement. See RCW 41.35.060.

(b) **Postretirement marriage option.** If you select the standard benefit option at the time of retirement and marry after retirement, you may select a survivor benefit option and name your current spouse as survivor beneficiary, provided that:

(i) Your benefit is not subject to a property division obligation pursuant to a dissolution order. See WAC 415-01-500;

(ii) The selection is made during a one-year window, on or after the date of the first anniversary and before the second anniversary of your postretirement marriage;

(iii) You provide a copy of your certified marriage certificate to the department; and

(iv) You provide proof of your current spouse's birthdate.

(c) **Removal of a nonspouse survivor option.** If you select a survivor benefit option and name a nonspouse as your survivor beneficiary at the time of retirement, you may remove that survivor beneficiary designation and have your benefit adjusted to a standard benefit. You may exercise this option one time only.

(d) **One-time change of survivor.** You may change your benefit option and/or designated survivor one time within 90 days from the date your first benefit payment is issued. Your change request must be in writing, and must comply with other requirements as described in this section. Your new benefit amount will be effective the first of the month following the receipt of your request by the department.

((~~(7)~~)) (8) **Who will receive the balance of my accumulated contributions, if any, after my death?**

(a) **Plan 2 members:**

(i) If you do not have a survivor beneficiary at the time of your death, and you die before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(A) To the person or entity (i.e., trust, organization, or estate) you have nominated by written designation, executed and filed with the department.

(B) If you have not designated a beneficiary, or if your designated beneficiary is no longer living or in existence, then to your surviving spouse.

(C) If not paid according to (a)(i)(A) or (B) of this subsection, then to your estate.

(ii) If you have a survivor beneficiary at the time of your death, and your survivor beneficiary dies before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(A) To the person or entity (i.e., trust, organization, or estate) your survivor beneficiary has nominated by written designation, executed and filed with the department.

(B) If your survivor beneficiary has not designated a beneficiary, or if the designated beneficiary is no longer living or in existence, then to your survivor beneficiary's spouse.

(C) If not paid according to (a)(ii)(A) or (B) of this subsection, then to your survivor beneficiary's estate.

(b) **Plan 3 members:** The defined benefit stops upon your death or upon the death of your survivor beneficiary, if applicable. As a Plan 3 member, you do not contribute to the defined benefit portion of your retirement benefit. The defined contribution portion of your benefit will be distributed according to WAC 415-111-310.

((~~(8)~~)) (9) For more information, see RCW 41.35.220.

RDS-7216.3

AMENDATORY SECTION (Amending WSR 20-13-065, filed 6/15/20, effective 7/16/20)

WAC 415-112-504 What are my TRS Plan 1 retirement benefit options? Upon retirement from Plan 1 for service under RCW 41.32.480 or disability under RCW 41.32.550 (1)(c), you must choose to have your retirement benefit paid to you by one of the options described in this section. You may also select an optional supplemental cost-of-living (COLA) adjustment.

(1) **May I withdraw any of my contributions?** You may withdraw some or all of your accumulated contributions as follows:

(a) If you retire according to the provisions of RCW 41.32.498, you may withdraw some or all of your accumulated contributions at the time of retirement. Your monthly retirement benefit will be reduced according to the amount you withdraw.

(b) If you terminate service due to a disability under the conditions of RCW 41.32.550 (1)(a), you may withdraw all your accumulated contributions in a lump sum payment. You will receive no monthly retirement benefit.

(2) **Which option will pay my beneficiary a monthly benefit after my death?** Options described in subsection (3)(c) through (e) of this section will pay a monthly benefit to your survivor after your death. The person you name at the time of retirement to receive a monthly benefit after your death is referred to as your "survivor beneficiary." After your death, your survivor beneficiary will receive a monthly benefit for the duration of their life. Your monthly retirement benefit will be reduced to offset the cost of the survivor option. See WAC 415-02-380 for more information on how your monthly benefit will be affected if you choose a survivor option.

(3) **What are my benefit options?**

(a) **Maximum benefit (nonsurvivor option).** The department will pay you the maximum benefit allowed by statute. Under this option you will receive a monthly retirement benefit throughout your lifetime. Your monthly benefit will cease upon your death, and any remaining balance of accumulated contributions will be:

(i) Retained by the retirement fund if you retired for service under RCW 41.32.497 or 41.32.498; or

(ii) Paid according to subsection ((~~(9)~~)) (10) of this section if you retired because of disability and were receiving a monthly retirement benefit under RCW 41.32.550 (1)(c).

(b) **Option one: Standard benefit for service retirement (nonsurvivor option).** The department will pay you a monthly retirement benefit throughout your lifetime. Your monthly benefit will cease upon your death, and any remaining balance of accumulated contributions will be paid according to subsection ((~~(9)~~)) (10) of this section.

(i) This benefit option has a lower monthly benefit than the **maximum benefit** in (a) of this subsection because, with this option, any remaining accumulated contributions will be paid to your beneficiaries upon your death.

(ii) If you are retiring because of disability under RCW 41.32.550 (1)(c), you will not benefit from this option because your beneficiaries will receive any remaining accumulated contributions under the maximum benefit in (a) of this subsection.

(c) **Option two: Joint and ((~~one hundred~~)) 100 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to your gross monthly benefit.

(d) **Option three: Joint and ((~~fifty~~)) 50 percent benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to ((~~fifty~~)) 50 percent of your gross monthly benefit.

(e) **Option four: Joint and two-thirds benefit.**[1] The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to two-thirds (66.667((~~%~~)) percent) of your gross monthly benefit.

(4) **Do I need my spouse's consent on the option I choose?** The option you select will determine whether spousal consent is required.

(a) If you are married and select a nonsurvivor benefit option, you must provide your spouse's consent, verified by a notarized signature or other means acceptable to the department. If you do not provide verified spousal consent, the department will pay you a monthly retirement benefit based on option three (joint and ((~~fifty~~)) 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.32.530(2).

(b) If you are married and select a survivor benefit option for your spouse, spousal consent is not required. The department will pay you a monthly benefit based on the option you selected.

(c) If you are married and select a survivor benefit option for someone other than your spouse, spousal consent is required. If you do not provide spousal consent, verified by a notarized signature or other means acceptable to the department, the department will pay you a monthly retirement benefit based on option three (joint and ((~~fifty~~)) 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.32.530(2).

(d) If your survivor beneficiary has been designated by a dissolution order according to subsection ((~~(5)~~)) (6) of this section, which was filed with the department at least ((~~thirty~~)) 30 days before your retirement date, spousal consent is not required.

(5) **How will naming a nonspousal survivor beneficiary affect my benefit options?** When you name a nonspouse survivor, your benefit options may be limited when your survivor is 11 or more years younger than you. Your available options are based on the adjusted age difference between you and your survivor:

(a) **Age difference: Less than 11 years:** Eligible for Option 2 (100 percent), Option 3 (50 percent), or Option 4 (66.67 percent) survivor benefit option. These options are also all available if the age difference is 11 years or more, but the survivor's age is the higher number.

(b) **Age difference: 11–24 years:** Eligible for Option 3 (50 percent) or Option 4 (66.67 percent) survivor benefit options.

(c) **Age difference: 25 or more years:** Eligible for Option 3 (50 percent) survivor benefit option.

(d) If you retire before the age the IRS requires your required minimum distributions (RMDs) to begin, the age difference between you and your survivor will be reduced by the number of years between your age at retirement and your RMD age.

(i) If you were born before July 1, 1949, your RMD age is 70.

(ii) If you were born between July 1, 1949, and December 31, 1950, your RMD age is 72.

(iii) If you were born between January 1, 1951, and December 31, 1959, your RMD age is 73.

(iv) If you were born on or after January 1, 1960, your RMD age is 75.

If you retire after your RMD age, there is no adjustment to the age difference between you and your nonspouse survivor.

(e) **Example:** Janet was born January 5, 1961, and will retire September 1, 2026. She plans to name her son, born April 14, 1985, as her survivor beneficiary. The age difference between Janet and her son is 24 years. Janet's RMD age is 75, and she is retiring at age 65 so the age difference is reduced by 10 years (75 minus 65) for an adjusted age difference of 14 years (24 minus 10). Janet is eligible to choose between survivor Option 3 (50 percent) and Option 4 (66.67 percent) for her son.

(6) **Can a dissolution order require that a former spouse be designated as a survivor beneficiary?** Yes. A dissolution order may require that a former spouse be designated as a survivor beneficiary. The department is required to pay survivor benefits to a former spouse pursuant to a dissolution order that complies with RCW 41.50.790.

((~~(6)~~)) (7) **What is the supplemental COLA option?** In addition to choosing a retirement benefit option described in subsection (3) of this section, you may choose a supplemental annual COLA. If you select this option, your monthly retirement benefit will be reduced to offset the cost of this benefit.

((~~(7)~~)) (8) **What happens if I choose a benefit option with a survivor option and my survivor beneficiary dies before I do?** If your survivor beneficiary dies before you do, you may request to have your benefit increased as described in WAC 415-02-380.

((~~(8)~~)) (9) **May I change my benefit option after retirement?** Your choice of a benefit option is irrevocable with the following three exceptions:

(a) **Return to membership.** If you retire and then return to membership, you may choose a different retirement option upon your subsequent retirement. See RCW 41.32.044.

(b) **Postretirement marriage option.** If you select the maximum benefit option or the standard benefit option at the time of retirement and marry after retirement, you may select a benefit option with a survivor option and name your current spouse as survivor beneficiary, provided that:

(i) Your benefit is not subject to a property division obligation pursuant to a dissolution order. See WAC 415-02-500;

(ii) The selection is made during a one-year window, on or after the date of the first anniversary and before the second anniversary of your postretirement marriage;

(iii) You provide a copy of your certified marriage certificate to the department; and

(iv) You provide proof of your current spouse's birthdate.

(c) **Removal of a nonspouse survivor option.** If you select a survivor benefit option and name a nonspouse as survivor beneficiary at the time of retirement, you may remove that survivor beneficiary des-

ignation and have your benefit adjusted to a standard benefit. You may exercise this option one time only.

((~~(9)~~)) (10) **Who will receive the balance of my accumulated contributions, if any, after my death?**

(a) If you do not have a survivor beneficiary at the time of your death, and you die before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid according to this subsection.

(i) Except as provided in (a)(ii) of this subsection, any remaining balance will be paid to the person or entity (i.e., trust, organization, or estate) you have nominated by written designation, executed and filed with the department.

(ii) If you retired for service and chose the maximum benefit option, any remaining balance will be retained by the retirement fund.

(b) If you have a survivor beneficiary at the time of your death, and your survivor beneficiary dies before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid to the person or entity (i.e., trust, organization, or estate) your survivor beneficiary has nominated by written designation, executed and filed with the department.

((~~(10)~~)) (11) For more information, see RCW 41.32.530 and 41.32.550.

[1] Available to members retiring on or after January 1, 1996.

AMENDATORY SECTION (Amending WSR 25-18-099, filed 9/2/25, effective 10/3/25)

WAC 415-112-505 What are my TRS Plan 2 or Plan 3 retirement benefit options? Upon retirement for service under RCW 41.32.765 or 41.32.875, or disability under RCW 41.32.790 or 41.32.880, you must choose to have the defined benefit portion of your retirement benefit paid to you by one of the options described in this section.

(1) **Which option will pay my beneficiary a monthly benefit after my death?** Options described in subsection (2)(b), (c), and (d) of this section will pay a monthly benefit to your survivor after your death. The person you name at the time of retirement to receive a monthly benefit after your death is referred to as your "survivor beneficiary." After your death, your survivor beneficiary will receive a monthly benefit for the duration of their life. Your monthly retirement benefit will be reduced to offset the cost of the survivor option. See WAC 415-02-380 for more information on how your monthly benefit will be affected if you choose a survivor option.

(2) **What are my benefit options?**

(a) **Option one: Standard benefit for service retirement (nonsurvivor option).** The department will pay you a monthly retirement benefit throughout your lifetime. Your monthly benefit will cease upon your death, and any remaining balance of accumulated contributions will be paid according to subsection ((~~(7)~~)) (8) of this section.

(b) **Option two: Joint and 100 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to your gross monthly benefit.

(c) **Option three: Joint and 50 percent survivor benefit.** The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to 50 percent of your gross monthly benefit.

(d) **Option four: Joint and two-thirds survivor benefit.**[1] The department will pay you a reduced monthly retirement benefit throughout your lifetime. After your death, your survivor beneficiary will receive a gross monthly benefit equal to two-thirds (66.667((%)) percent) of your gross monthly benefit.

(3) **Do I need my spouse's consent on the option I choose?** The option you select will determine whether spousal consent is required. For purposes of this section, a registered domestic partnership is treated the same as a spousal relationship.

(a) If you are married and select a nonsurvivor benefit option, you must provide your spouse's consent, verified by a notarized signature or other means acceptable to the department. If you do not provide verified spousal consent, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.32.785(2) and 41.32.851(2).

(b) If you are married and select a survivor benefit option for your spouse, spousal consent is not required. The department will pay you a monthly benefit based on the option you selected.

(c) If you are married and select a survivor benefit option for someone other than your spouse, spousal consent is required. If you do not provide spousal consent, verified by a notarized signature or other means acceptable to the department, the department will pay you a monthly retirement benefit based on option three (joint and 50 percent benefit) with your spouse as the survivor beneficiary as required by RCW 41.32.785(2) and 41.32.851(2).

(d) If your survivor beneficiary has been designated by a dissolution order under RCW 41.50.790, which was filed with the department at least 30 days before your retirement date, spousal consent is not required.

(4) **How will naming a nonspousal survivor beneficiary affect my benefit options?** When you name a nonspouse survivor, your benefit options may be limited when your survivor is 11 or more years younger than you. Your available options are based on the adjusted age difference between you and your survivor:

(a) **Age difference: Less than 11 years:** Eligible for Option 2 (100 percent), Option 3 (50 percent), or Option 4 (66.67 percent) survivor benefit option. These options are also all available if the age difference is 11 years or more, but the survivor's age is the higher number.

(b) **Age difference: 11–24 years:** Eligible for Option 3 (50 percent) or Option 4 (66.67 percent) survivor benefit options.

(c) **Age difference: 25 or more years** Eligible for 50 percent survivor benefit option.

(d) If you retire before the age the IRS requires your required minimum distributions (RMDs) to begin, the age difference between you and your survivor will be reduced by the number of years between your age at retirement and your RMD age.

(i) If you were born before July 1, 1949, your RMD age is 70.

(ii) If you were born between July 1, 1949, and December 31, 1950, your RMD age is 72.

(iii) If you were born between January 1, 1951, and December 31, 1959, your RMD age is 73.

(iv) If you were born on or after January 1, 1960, your RMD age is 75.

If you retire after your RMD age, there is no adjustment to the age difference between you and your nonspouse survivor.

(e) **Example:** Janet was born January 5, 1961, and will retire September 1, 2026. She plans to name her son, born April 14, 1985, as her survivor beneficiary. The age difference between Janet and her son is 24 years. Janet's RMD age is 75, and she is retiring at age 65 so the age difference is reduced by 10 years (75 minus 65) for an adjusted age difference of 14 years (24 minus 10). Janet is eligible to choose between survivor Option 3 (50 percent) and Option 4 (66.67 percent) for her son.

(5) **Can a dissolution order require that a former spouse be designated as a survivor beneficiary?** Yes. A dissolution order may require that a former spouse be designated as a survivor beneficiary. The department is required to pay survivor benefits to a former spouse pursuant to a dissolution order that complies with RCW 41.50.790.

((~~(5)~~)) (6) **What happens if I choose a benefit option with a survivor option and my survivor beneficiary dies before I do?** If your survivor beneficiary dies before you do, you may request to have your benefit increased as described in WAC 415-02-380.

((~~(6)~~)) (7) **May I change my benefit option after retirement?** Your choice of a benefit option is irrevocable with the following four exceptions:

(a) **Return to membership.** If you retire and then return to membership, you may choose a different retirement option upon your subsequent retirement. See RCW 41.32.044.

(b) **Postretirement marriage option.** If you select the standard benefit option at the time of retirement and marry after retirement, you may select a benefit option with a survivor option and name your current spouse as survivor beneficiary, provided that:

(i) Your benefit is not subject to a property division obligation pursuant to a dissolution order. See WAC 415-02-500;

(ii) The selection is made during a one-year window, on or after the date of the first anniversary and before the second anniversary of your postretirement marriage;

(iii) You provide a copy of your certified marriage certificate to the department;

(iv) You provide proof of your current spouse's birthdate; and

(v) You exercise this option one time only.

(c) **Removal of a nonspouse survivor option.** If you select a benefit option with a survivor option and name a nonspouse as survivor beneficiary at the time of retirement, you may remove that survivor beneficiary designation and have your benefit adjusted to a standard benefit. You may exercise this option one time only.

(d) **One-time change of survivor.** You may change your benefit option and/or designated survivor one time within 90 days from the date your first benefit payment is issued. Your change request must be in writing, and must comply with other requirements as described in this section. Your new benefit amount will be effective the first of the month following the receipt of your request by the department.

((~~(7)~~)) (8) **Who will receive the balance of my accumulated contributions, if any, after my death?**

(a) **Plan 2:**

(i) If you do not have a survivor beneficiary at the time of your death, and you die before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(A) To the person or entity (i.e., trust, organization, or estate) you have nominated by written designation, executed and filed with the department.

(B) If you have not designated a beneficiary, or if your designated beneficiary is no longer living, then to your surviving spouse.

(C) If not paid according to (a)(i)(A) or (B) of this subsection, then to your estate.

(ii) If you have a survivor beneficiary at the time of your death, and your survivor beneficiary dies before the total of the retirement benefit paid equals the amount of your accumulated contributions at the time of retirement, the balance will be paid:

(A) To the person or entity (i.e., trust, organization, or estate) your survivor beneficiary has nominated by written designation, executed and filed with the department.

(B) If your survivor beneficiary has not designated a beneficiary, or if the designated beneficiary is no longer living, then to your survivor beneficiary's spouse.

(C) If not paid according to (a)(ii)(A) or (B) of this subsection, then to your survivor beneficiary's estate.

(b) **Plan 3:** The defined benefit stops upon your death or upon the death of your survivor beneficiary, if applicable. As a Plan 3 member, you do not contribute to the defined benefit portion of your retirement benefit. The defined contribution portion of your benefit will be distributed according to WAC 415-111-310.

((~~(8)~~)) (9) For more information, see RCW 41.32.785 and 41.32.790 (Plan 2) and RCW 41.32.851 (Plan 3).

[1] Available to members retiring on or after January 1, 1996.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

WSR 26-17-036
PERMANENT RULES
DEPARTMENT OF ECOLOGY

[Order 26-03—Filed August 11, 2026, 2:27 p.m., effective September 11, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The department of ecology (ecology) is adopting amendments to three rules to support implementation of the governor's Executive Order 25-03 Improving transparency and building efficiency in the state's permitting and licensing process. These amendments make changes to two air quality permits, six air quality general orders, and environmental laboratory accreditation to clarify application fee language and update out-of-date information. The total fee amounts, eligibility criteria, and requirements for these permits, general orders, and accreditations will not change as a result of this rule making.

The amendments to the air quality rules in WAC 173-455-120 New source review and other air permitting fees, and 173-400-111 Processing notice of construction applications for sources, stationary sources, and portable sources, include:

- Clarifying the definition of "application fee."
- Clarifying that any fee refunds can't exceed the amount of the application fee that was originally paid.
- Clarifying that ecology will not charge additional fees to recover the costs of a refund.
- Removing outdated fee language in WAC 173-455-120.
- Removing language about the rescinded general order of approval for dairy anaerobic digesters in WAC 173-455-120.

The amendment to WAC 173-50-190 Fee structure, which provides the fee structure for the environmental laboratory accreditation program, removes language prohibiting refunds for application fees.

For more information on this rule making, visit https://ecology.wa.gov/regulations-permits/laws-rules-rulemaking/rulemaking/wac-173-455-400-50.

Citation of Rules Affected by this Order: Amending WAC 173-455-120, 173-400-111, and 173-50-190.

Statutory Authority for Adoption: Chapter 43.21A RCW, Department of ecology; chapter 70A.15 RCW, Washington Clean Air Act; and RCW 43.21A.230 Certification of environmental laboratories authorized—Fees—Use of certified laboratories by persons submitting data or results to department.

Other Authority: Ecology has completed an environmental justice assessment in accordance with RCW 70A.02.060 as a part of this rule making.

Adopted under notice filed as WSR 26-11-061 on May 20, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 3, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 3, Repealed 0.

Date Adopted: August 11, 2026.

Casey D. Sixkiller
Director

RDS-7154.1

AMENDATORY SECTION (Amending WSR 23-18-059, filed 9/1/23, effective 10/2/23)

WAC 173-50-190 Fee structure. (1) Fees in this chapter are in U.S. dollars and are established to cover costs of administering the WA ELAP. The department shall assess fees for each parameter or method within each matrix, except as noted in subsection (3) of this section. Laboratories are charged using the fee structure of the fiscal year covering the effective date the department issues a determination on a laboratory's accreditation application, renewal of its accreditation, or a revision of a laboratory's scope of accreditation. The fee schedule per parameter or method for each category are identified in:

(a) Table 1 - Fee schedule through June 30, 2024.

(b) Table 2 - Fee schedule from July 1, 2024, through June 30, 2025.

(c) Table 3 - Fee schedule from July 1, 2025, through June 30, 2026.

(2) Examples of parameters or methods for each category are published in the procedural manual. Accreditation may be requested for parameters in addition to those listed in the procedural manual.

(3) When a fee is assessed for a specific drinking water parameter or method, the laboratory may be accredited for the same parameter or method in nonpotable water without paying an additional fee.

Table 1 - Fee Schedule through June 30, 2024

Category	Fee Per Parameter	Fee Per Method	Max Fee Per Category
General Chemistry	$80	-	$1,600
Trace Metals	-	$400	-
Organics I	-	$200	-
Organics II	-	$500	-
Microbiology	$200	-	-
Radiochemistry	$250	-	-
Bioassay	$300	-	$3,000
Immunoassay	$80	-	-
Physical	$80	-	-

Table 2 - Fee Schedule from July 1, 2024, through June 30, 2025

Category	Fee Per Parameter	Per Parameter Addition Fee	Fee Per Method
General Chemistry	$150	-	-
Trace Metals	-	$30	$745
Organics I	-	$15	$375

Category	Fee Per Parameter	Per Parameter Addition Fee	Fee Per Method
Organics II	-	$35	$930
Microbiology	$375	-	-
Radiochemistry	$555	-	-
Bioassay	-	$15	$375
Immunoassay	$150	-	-
Physical	$150	-	-

Table 3 - Fee Schedule from July 1, 2025, through June 30, 2026

Category	Fee Per Parameter	Per Parameter Addition Fee	Fee Per Method
General Chemistry	$220	-	-
Trace Metals	-	$55	$1,085
Organics I	-	$30	$545
Organics II	-	$70	$1,355
Microbiology	$545	-	-
Radiochemistry	$680	-	-
Bioassay	-	$25	$445
Immunoassay	$220	-	-
Physical	$220	-	-

(4) Starting July 1, 2026, Equation 1 below will be used to calculate the fees:

Equation 1

$$Fee_2 = Fee_1 \times (1 + FGF)$$

Where:

Fee_1 = The current fiscal year fees for each category.

Fee_2 = The fee for each category for the fiscal year following the fiscal year in which Fee_1 was in effect, rounded up to the nearest whole $5 increment. The updated fee table is then posted on the department's website.

FGF = An annual fiscal growth factor expressed as a percentage, as determined under chapter 43.135 RCW.

(a) Fiscal year begins July 1st and ends June 30th of the following calendar year. For example, fiscal year 2027 is July 1, 2026, through June 30, 2027.

(b) Ecology will provide annual notice of the next fiscal year's fees by March 31st.

(5) The minimum fee for accreditation, either direct or through recognition of a third-party accreditation, is $500.

(6) In addition to paying the fee indicated in Table 1, Table 2, Table 3, or as updated by Equation 1: Out-of-state laboratories must pay the department for the actual cost of travel associated with on-site audits. The department invoices the laboratory for such costs after completion of the on-site audit.

(7) For laboratories that have not been accredited for any parameter by the department in the previous 12 months, the laboratory must pay a processing fee of $300 before:

(a) Its quality assurance manual and applicable SOPs are reviewed by the department;

(b) The audit is conducted if applicable; and

(c) Interim, provisional, or full accreditation is granted.

((~~The application fee is not refundable.~~))

(8) Once accreditation is granted the laboratory will be invoiced annually by the department for the requested parameters.

(9) When a laboratory applies for renewal of their accreditation, an application fee is not required. The applicable accreditation fees per Table 1, Table 2, Table 3, or as updated by Equation 1 do not need to be payed prior to processing of the application.

(10) The fee for recognition of a third-party accreditation (WAC 173-50-170) is three-fourths (75 percent) of the fee indicated in Table 1, Table 2, Table 3, or as updated by Equation 1.

(11) If a laboratory requests to add or reinstate a parameter to an existing method on their scope of accreditation outside of their initial application or renewal process, the laboratory will be invoiced a fee based on the type and number of requested parameters according to the "Per Parameter Addition Fee" column of Table 1, Table 2, Table 3, or as updated by Equation 1.

(12) If a laboratory withdraws from the accreditation process after the audit has been completed, the department may retain the entire fee including reimbursement of travel costs if applicable.

(13) Accreditation fees are waived for laboratories operated by the Washington state departments of ecology and health. Accreditation fees are also waived for drinking water parameters certified by EPA Region 10 at designated principal laboratories.

RDS-7185.2

AMENDATORY SECTION (Amending WSR 16-12-099, filed 5/31/16, effective 7/1/16)

WAC 173-400-111 Processing notice of construction applications for sources, stationary sources and portable sources. WAC 173-400-110, 173-400-111, 173-400-112, and 173-400-113 apply statewide except where a permitting authority has adopted its own new source review regulations.

(1) Completeness determination.

(a) Within ((~~thirty~~)) 30 days after receiving a notice of construction application, the permitting authority must either notify the applicant in writing that the application is complete or notify the applicant in writing of all additional information necessary to complete the application.

(b) A complete application contains all the information necessary for processing the application. At a minimum, the application must provide information on the nature and amounts of emissions to be emitted by the proposed new source or increased as part of a modification, as well as the location, design, construction, and operation of the new source as needed to enable the permitting authority to determine that the construction or modification will meet the requirements of WAC 173-400-113. Designating an application complete for purposes of permit processing does not preclude the reviewing authority from requesting or accepting any additional information.

(c) For a project subject to the special protection requirements for federal Class I areas under WAC 173-400-117(2), a completeness determination includes a determination that the application includes all

information required for review of that project under WAC 173-400-117(3). The applicant must send a copy of the application and all amendments to the application to the EPA and the responsible federal land manager.

(d) For a project subject to the major new source review requirements in WAC 173-400-800 through 173-400-860, the completeness determination includes a determination that the application includes all information required for review under those sections.

(e) An application is not complete until any ((~~permit application~~)) initial fee required by the permitting authority has been paid.

(2) Coordination with chapter 173-401 WAC, operating permit regulation. A person seeking approval to construct or modify a source that requires an operating permit may elect to integrate review of the operating permit application or amendment required under chapter 173-401 WAC and the notice of construction application required by this section. A notice of construction application designated for integrated review must be processed in accordance with operating permit program procedures and deadlines in chapter 173-401 WAC and must comply with WAC 173-400-171.

(3) Criteria for approval of a notice of construction application. An order of approval cannot be issued until the following criteria are met as applicable:

(a) The requirements of WAC 173-400-112;

(b) The requirements of WAC 173-400-113;

(c) The requirements of WAC 173-400-117;

(d) The requirements of WAC 173-400-171;

(e) The requirements of WAC 173-400-200 and 173-400-205;

(f) The requirements of WAC 173-400-700 through 173-400-750;

(g) The requirements of WAC 173-400-800 through 173-400-860;

(h) The requirements of chapter 173-460 WAC; and

(i) All fees required under chapter 173-455 WAC (or the applicable new source review fee table of the local air pollution control authority) have been paid.

(4) Final determination - Time frame and signature authority.

(a) Within ((~~sixty~~)) 60 days of receipt of a complete notice of construction application, the permitting authority must either:

(i) Issue a final decision on the application; or

(ii) Initiate notice and comment for those projects subject to WAC 173-400-171 followed as promptly as possible by a final decision.

(b) Every final determination on a notice of construction application must be reviewed and signed prior to issuance by a professional engineer or staff under the direct supervision of a professional engineer in the employ of the permitting authority.

(5) Distribution of the final decision.

(a) The permitting authority must promptly provide copies of each order approving or denying a notice of construction application to the applicant and to any other party who submitted timely comments on the application, along with a notice advising parties of their rights of appeal to the pollution control hearings board.

(b) If the new source is a major stationary source or the change is a major modification subject to the requirements of WAC 173-400-800 through 173-400-860, the permitting authority must:

(i) Submit any control technology (LAER) determination included in a final order of approval to the RACT/BACT/LAER clearinghouse maintained by EPA; and

(ii) Send a copy of the final approval order to EPA.

(6) Appeals. Any conditions contained in an order of approval, or the denial of a notice of construction application may be appealed to the pollution control hearings board as provided under chapters 43.21B RCW and 371-08 WAC.

(7) Construction time limitations.

(a) Approval to construct or modify a stationary source becomes invalid if construction is not commenced within eighteen months after receipt of the approval, if construction is discontinued for a period of ((~~eighteen~~)) 18 months or more, or if construction is not completed within a reasonable time. The permitting authority may extend the ((~~eighteen~~)) 18-month period upon a satisfactory showing by the permittee that an extension is justified.

(b) The extension of a project that is either a major stationary source, as defined in WAC 173-400-810, in a nonattainment area or a major modification, as defined in WAC 173-400-810, of a major stationary source in a nonattainment area must also require LAER, for the pollutants for which the area is classified as nonattainment, as LAER exists at the time of the extension for the pollutants that were subject to LAER in the original approval.

(c) This provision does not apply to the time period between construction of the approved phases of a phased construction project. Each phase must commence construction within ((~~eighteen~~)) 18 months of the projected and approved commence construction date.

(8) Change of conditions or revisions to orders of approval.

(a) The owner or operator may request, at any time, a change in the conditions of an approval order and the permitting authority may approve the request provided the permitting authority finds that:

(i) The change in conditions will not cause the source to exceed an emissions standard set by regulation or rule;

(ii) No ambient air quality standard will be exceeded as a result of the change;

(iii) The change will not adversely impact the ability of the permitting authority to determine compliance with an emissions standard;

(iv) The revised order will continue to require BACT for each new source approved by the order except where the Federal Clean Air Act requires LAER; and

(v) The revised order meets the requirements of WAC 173-400-111, 173-400-112, 173-400-113, 173-400-720, 173-400-830, and 173-460-040, as applicable.

(b) Actions taken under this subsection are subject to the public involvement provisions of WAC 173-400-171 or the permitting authority's public notice and comment procedures.

(c) The applicant must consider the criteria in 40 C.F.R. 52.21 (r)(4) (in effect on the date in WAC 173-400-025) or 173-400-830(3), as applicable, when determining which new source review approvals are required.

(9) Fees. Chapter 173-455 WAC lists the required fees payable to ecology for various permit actions.

(10) Enforcement. All persons who receive an order of approval must comply with all approval conditions contained in the order of approval.

RDS-7186.1

AMENDATORY SECTION (Amending WSR 23-07-014, filed 3/3/23, effective 7/1/23)

WAC 173-455-120 New source review and other air permitting fees. (1) General requirements.

(a) The fees in this section apply to:

(i) Permit applications received on or after July 1, 2023.

(ii) Requests for ecology review of other actions covered by this section received by ecology on or after July 1, 2023.

(b) Components of permitting fees. Permit fees include initial fees and may include an additional hourly fee. The initial fee covers up to the number of review hours specified for each fee in this section.

(i) A portion of the initial fee is considered the application fee.

(ii) The 2026 application fee amount is $400 for notice of construction applications, $200 for applications for coverage under a general order, and $1,100 for prevention of significant deterioration applications. After 2026 ecology will post the amount of the application portion with the new fee schedule in accordance with WAC 173-455-031.

(iii) No application fee refund may exceed the amount of the application portion of the initial fee paid.

(c) A project may be subject to multiple fees set forth in this section. For example, a project may be subject to both minor and major new source review permit fees and second or third tier review. In addition a project may be subject to fees under WAC 173-455-050 and 173-455-100.

(d) An applicant must submit initial fees with the associated permit application, notice, or request. An application, notice or request is incomplete until initial fees have been paid.

(i) ((~~For purposes of WAC 173-400-111 (1)(e), application fees are considered initial fees under this section.~~

~~(ii)~~)) If ecology determines a project is complex after an applicant paid the basic project initial fee, then the application is incomplete until the applicant has paid the initial complex project fee.

((~~(iii)~~)) (ii) If ecology determines that a higher initial fee is due after an applicant submitted an application or request, the application or request is considered incomplete until the applicant has paid the higher initial fee.

(e) Additional hourly fee. If the initial fee paid by an applicant does not cover the cost of processing the application, notice, or request, then ecology must assess an additional fee based on the actual costs for review in excess of the hours specified for the initial fee. The additional fee must be assessed at ((~~a rate of $119 per hour of ecology staff time expended, or~~)) the rate established under WAC 173-455-031 per hour of ecology staff time expended. If any refund of fees is issued, ecology will not assess a second additional fee solely to recover the refunded fee amount.

(f) Ecology cannot finalize an action covered under this section until all fees have been paid. (WAC 173-400-111 (3)(i).)

(g) For fees assessed by invoice from ecology, the applicant must pay fees that are due within 30 days from the date of the invoice. Ecology will cease processing all applications for which the required fees have not been received within 30 days of an invoice.

(h) At the time of filing a permit application, notice, or request, an applicant must pay all delinquent air quality fees associ-

ated with the facility in addition to the fees required by this section. Delinquent fees may include, but are not limited to, registration fees, civil penalties issued by ecology, or other outstanding fees due under this section.

(i) All fees collected under this section must be made payable to the department of ecology.

(j) Fees assessed under this section apply without regard to whether ecology approves or denies the underlying permit application, notice, or request.

Permit fees.

Minor new source review.

(2) Fees for review of a permit application for a new source or for the modification of an existing source with an emissions increase. (WAC 173-400-110(3).)

(a) Table 1 lists the ((~~2023 fees~~)) fee structure for review of an application for a new source or for the modification of an existing source with an emissions increase.

Table 1: ((~~2023 Fees~~)) Fee structure for review of a permit application for a new source or for the modification of an existing source with an emissions increase (WAC 173-400-110(3))

Action	Initial Fee	Hourly Rate
Basic Project	((~~$1,904.00 for up to~~)) Covers the first 16 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 17 hours
Complex Project	((~~$12,614.00 for up to~~)) Covers the first 106 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 107 hours

(b) A project is considered complex if the emissions associated with the application include at least one pollutant for which emissions increases are greater than the levels in Table 2.

Table 2: Emission Threshold Table (WAC 173-400-030)

Pollutant	Annual Emission Rate
Carbon monoxide	100 tons per year
Nitrogen oxides	40 tons per year
Sulfur dioxide	40 tons per year
Particulate matter (PM)	25 tons per year of PM emissions
	15 tons per year of PM_{10} emissions
	10 tons per year of $PM_{2.5}$ emissions
Volatile organic compounds	40 tons per year
Fluorides	3 tons per year
Lead	0.6 tons per year
Sulfuric acid mist	7 tons per year
Hydrogen sulfide (H_2S)	10 tons per year
Total reduced sulfur (including H_2S)	10 tons per year
Reduced sulfur compounds (including H_2S)	10 tons per year

(c) Ecology may also determine that a project is complex based on consideration of factors that include, but are not limited to:

(i) Number and complexity of emission units;

(ii) Volume of emissions, including toxicity of emissions;

(iii) Amount and complexity of modeling; or

(iv) Number and kind of applicable state and federal requirements.

(d) Ecology will post a new fee schedule for the fees in this section starting in 2024 in accordance with WAC 173-455-031.

(3) Fees for review of a requested change to an existing order of approval. (WAC 173-400-111 (7) and (8).)

(a) Ecology will not charge a fee for correcting a mistake by ecology in a permit.

(b) "Administrative or simple change" means:

(i) An action not subject to a mandatory public comment period under WAC 173-400-171; and

(ii) The modified approval order requires one hour or less of engineering evaluation by ecology and does not authorize physical modification of equipment; and

(iii) Changes in permit conditions are based on actual operating conditions and review of the operating conditions requires one hour or less of engineering evaluation by ecology and the modification does not cause a change in allowable emissions.

(c) Complex changes:

(i) This fee does not apply to an administrative or simple change or to the modification of an existing permit that results in an emissions increase.

(ii) Examples of complex changes include, but are not limited to:

(A) Changes requiring more than one hour of engineering review by ecology;

(B) Consolidation of permits not allowed under simple change;

(C) Request for review of whether a proposed action is exempt from new source review under WAC 173-400-110(5) (Table 110(5) emission-based exemption levels); or

(D) Changes requiring mandatory public comment under WAC 173-400-171(3).

(d) Table 3 lists the ((~~2023 fees~~)) fee structure for review of a requested change to an existing order of approval.

Table 3: ((~~2023 Fees~~)) Fee structure for review of a requested change to an existing order of approval (WAC 173-400-111 (7) and (8))

Action	Initial Fee	Hourly Rate
Correcting a mistake by ecology in a permit	No fee	No fee
Administrative or simple change	((~~$357.00 for up to~~)) Covers the first 3 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 4 hours
Complex change	((~~$1,190.00 for up to~~)) Covers the first 10 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 11 hours
Permit extension request (WAC 173-400-111(7))	((~~$119.00~~)) Covers 1 hour of review	Not applicable

(e) Ecology will post a new fee schedule for the fees in this section starting in 2024 in accordance with WAC 173-455-031.

(4) Fees for review of an application for coverage under a general order of approval (WAC 173-400-560).

(a) Category A consists of the following general order of approval, including any subsequent updating or replacement:

(i) Concrete batch plants (No. 08-AQG-002);

(ii) Perchloroethylene dry cleaners using less than 2100 gallons per year (No. 06-AQG-003);

(iii) Stationary and portable rock crushers (No. 11AQ-GO-001);

(iv) Small water heaters and steam generating boilers (No. 08-AQ-G003); and

(v) Automobile body repair and refinishing shops (No. 08-AQG-001).

(b) Category B includes a general order of approval developed on or after January 1, 2011. Category B covers, but is not limited to, the following general order of approval, including any subsequent updating or replacement:

(i) Portable and stationary asphalt plants (No. 10AQ-GO-01)((~~; and~~

~~(ii) Dairy manure anaerobic digesters (No. 12AQ-GO-01)~~)).

(c) ((~~Table 4 lists the 2023 fees for Category A and B reviews of applications for coverage under a general order of approval.~~

~~Table 4: 2023 Fees for review of an application for coverage under a general order of approval (WAC 173-400-560)~~

~~Type of source seeking coverage under a general order of approval~~	~~SEPA review complete~~	~~SEPA review required~~
~~Portable and stationary concrete batch plants (No. 08-AQG-002)~~	~~$625.00~~	~~$981.00~~
~~Perchloroethylene dry cleaners using less than 2,100 gallons per year (No. 06-AQG-003)~~	~~$625.00~~	~~$981.00~~
~~Stationary and portable rock crushers (No. 11AQ-GO-001)~~	~~$625.00~~	~~$981.00~~
~~Small water heaters and steam generating boilers (No. 08-AQ-G003)~~	~~$625.00~~	~~$981.00~~
~~Automobile body repair and refinishing shops (No. 08-AQG-001)~~	~~$625.00~~	~~$981.00~~
~~Portable and stationary asphalt plants (No. 10AQ-GO-01)~~	~~$1,093.00~~	~~$1,450.00~~
~~Dairy manure anaerobic digesters (No. 12AQ-GO-01)~~	~~$1,093.00~~	~~$1,450.00~~
~~Any other source seeking coverage under a general order of approval~~	~~$1,093.00~~	~~$1,450.00~~

~~(d)~~)) Ecology will post a new fee schedule for the fees in this section starting in 2024 in accordance with WAC 173-455-031.

(5) Fees for review of a relocation notice for a portable source in ecology's jurisdiction under WAC 173-400-036.

((~~(a) Table 5 lists the 2023 fees for review of a relocation notice for a portable source.~~

~~Table 5: 2023 Fees for review of a relocation notice for a portable source (WAC 173-400-036)~~

~~Action~~	~~SEPA Review Complete~~	~~SEPA Review Required~~
~~Portable source has approval order issued by a clean air agency~~	~~$187.00~~	~~$543.00~~
~~Portable source has approval order issued by ecology~~	~~No fee~~	~~$365.00~~

~~(b)~~)) Ecology will post a new fee schedule for the fees in this section starting in 2024 in accordance with WAC 173-455-031.

(6) Fees for review of a request to establish a voluntary emission limit (WAC 173-400-091).

(a) This fee applies to a regulatory order issued under WAC 173-400-091 that places a limit on emissions.

(i) This fee applies to the review of a request to establish the emission limit in a stand-alone regulatory order.

(ii) This fee does not apply when an emission limit is included as a condition in an approval order for a notice of construction application.

(b) Table ((~~6~~)) 4 lists the ((~~2023 fees~~)) fee structure to establish a voluntary emission limit.

Table ((~~6: 2023 Fees~~)) 4: Fee structure for review of a request to establish a voluntary emission limit (WAC 173-400-091)

Action	Initial Fee	Hourly Rate
Review of request to establish a voluntary emission limit (WAC 173-400-091)	((~~$714.00 for up to~~)) Covers the first 6 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 7 hours

(c) Ecology will post a new fee schedule for the fees in this section starting in 2024 in accordance with WAC 173-455-031.

(7) Fees for review of a request to replace or substantially alter control technology without an increase in emissions (RCW 70A.15.2220).

(a) Table ((~~7~~)) 5 lists the ((~~2023 fees~~)) fee structure for review of a request to replace or substantially alter control technology without an increase in emissions.

Table ((~~7: 2023 Fees~~)) 5: Fee structure for review of a request to replace or substantially alter control technology without an increase in emissions (RCW 70A.15.2220)

Action	Initial Fee	Hourly Rate
Review notice of construction application	No initial fee	((~~$119.00~~)) Hourly rate charged per hour
Review RACT analysis and determination for affected emission unit	No initial fee	((~~$119.00~~)) Hourly rate charged per hour

(b) Ecology will post a new fee schedule for the fees in this section starting in 2024 in accordance with WAC 173-455-031.

Major new source review preapplication and permit fees.

(8) Fees for review of a prevention of significant deterioration (PSD) determination (WAC 173-400-720, 173-400-730, and 173-400-750).

(a) Table ((~~8~~)) 6 lists the ((~~2023 fees~~)) fee structure for the review of a request for prevention of significant deterioration (PSD) determination.

Table ((~~8: 2023 Fees~~)) 6: Fee structure for review of a request for prevention of significant deterioration (PSD) determination

Action	Initial Fee	Hourly Rate
Written PSD applicability determination (WAC 173-400-720)	((~~$4,760.00 for up to~~)) Covers the first 40 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 41 hours
Preapplication assistance beyond the application assistance meeting ecology provides	((~~$714.00 for up to~~)) Covers the first 6 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 7 hours
PSD permit application - New (WAC 173-400-720 and 173-400-730)	((~~$18,802.00 for up to~~)) Covers the first 158 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 159 hours

Action	Initial Fee	Hourly Rate
PSD permit application - Limited to greenhouse gases	((~~$9,401.00 for up to~~)) Covers the first 79 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 80 hours
PSD permit revision - Administrative (as defined in WAC 173-400-750(3))	((~~$2,380.00 for up to~~)) Covers the first 20 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 21 hours
PSD permit revisions - Revision not administrative or major modification	((~~$4,760.00 for up to~~)) Covers the first 40 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 41 hours
PSD permit revision - Major modification (WAC 173-400-720)	((~~$18,802.00 for up to~~)) Covers the first 158 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 159 hours
Permit extension request (WAC 173-400-730(5))	$625.00	No hourly fee

(b) Ecology will post a new fee schedule for the fees in this section starting in 2024 in accordance with WAC 173-455-031.

(9) Fees for nonattainment area major new source review.

(a) Table ((~~9~~)) 7 lists the ((~~2023 fees~~)) fee structure for nonattainment area major new source review.

Table ((~~9: 2023 Fees~~)) 7: Fee structure for nonattainment area major new source review

Action	Initial Fee	Hourly Rate
Notice of construction application (WAC 173-400-830)	((~~$18,802.00 for up to~~)) Covers the first 158 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 159 hours
Change in permit conditions - Major modifications for an order issued under WAC 173-400-830	((~~$18,802.00 for up to~~)) Covers the first 158 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 159 hours
Change in permit conditions under WAC 173-400-111(8) - Action not subject to mandatory public comment under WAC 173-400-171(3)	((~~$2,380.00 for up to~~)) Covers the first 20 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 21 hours
Changes in permit conditions - All other changes	((~~$9,401.00 for up to~~)) Covers the first 79 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 80 hours
Permit extension request (WAC 173-400-111(7))	$625.00	No hourly fee

(b) Ecology will post a new fee schedule for the fees in this section starting in 2024 in accordance with WAC 173-455-031.

(10) Fees for review of plant-wide applicability limits (WAC 173-400-720).

(a) Table ((~~10~~)) 8 lists the ((~~2023 fees~~)) fee structure for review of requests to establish plant-wide applicability limits.

Table ((~~10: 2023 Fees~~)) 8: Fee structure for review of plant-wide applicability limits (WAC 173-400-720)

Action	Initial Fee	Hourly Rate
Plant-wide applicability limits - Establish new limits	((~~$18,802.00 for up to~~)) Covers the first 158 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 159 hours
Plant-wide applicability limits - All other requests	((~~$9,401.00 for up to~~)) Covers the first 79 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 80 hours

(b) Ecology will post a new fee schedule for the fees in this section starting in 2024 in accordance with WAC 173-455-031.

Other fees.

(11) Table ((~~11~~)) 9 lists the ((~~2023 fees~~)) fee structure for all other permitting actions, including second and third tier reviews.

(a) A second tier petition (WAC 173-460-090) that becomes subject to third tier review during the course of evaluation continues as a

second tier petition for billing purposes. Staff must sum the time spent on this petition and bill the applicant if the total hours exceed 85 hours.

(b) The fee listed in Table ((~~11~~)) 9 for third tier review (WAC 173-460-100) does not apply to a second tier petition that becomes a third tier petition under (a) of this subsection.

Table ((~~11~~)) 9: Fee structure for other fees ((~~for 2023~~))

Action	Initial Fee	Hourly Rate
Second tier review (WAC 173-460-090)	((~~$9,996.00 for up to~~)) Covers the first 84 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 85 hours
Third tier review (WAC 173-460-100)	((~~$9,996.00 for up to~~)) Covers the first 84 hours of review	((~~$119.00~~)) Hourly rate charged per hour starting at 85 hours
Cost reimbursement agreement as provided in RCW 70A.15.1570	No initial fee	((~~$119.00~~)) Hourly rate charged per hour
Review of a request for a variance under WAC 173-400-180	No initial fee	((~~$119.00~~)) Hourly rate charged per hour
Review of a notification of intent to operate under WAC 173-400-035	No initial fee	((~~$119.00~~)) Hourly rate charged per hour
Hourly rate for other permitting actions	No initial fee	((~~$119.00~~)) Hourly rate charged per hour

(c) Ecology will post a new fee schedule for the fees in this section starting in 2024 in accordance with WAC 173-455-031.

(12) Fee reductions for small businesses. Ecology may reduce the permitting fees identified in subsections (2) through (6) of this section for a small business as provided in this subsection.

(a) Small business reduction.

(i) To qualify for a small business permitting fee reduction, a business must meet the requirements of "small business" as defined in RCW 19.85.020.

(ii) To receive a small business fee reduction, the owner or operator of a small business must include sufficient information in an application submitted in accordance with (c) of this section, demonstrating that the business meets the requirements of a small business as required under subsection (1)(a) of this section.

(iii) For small businesses that ecology determines are eligible for a small business fee reduction under (a)(ii) of this subsection, ecology shall reduce the permitting fee to the greater of:

(A) Fifty percent of the permitting fee; or

(B) Three hundred twelve dollars.

(iv) No application fee refund may exceed the amount of the application fee portion of the initial fee paid.

(b) Extreme hardship reduction.

(i) If the fee assessed after a reduction granted under (a)(iii) of this subsection imposes an extreme hardship on a small business due to special economic circumstances, the small business may request an extreme hardship fee reduction.

(ii) To receive an extreme hardship reduction, the owner or operator of a small business must provide sufficient evidence to support a claim of special economic circumstances and extreme hardship in an application submitted in accordance with (c) of this subsection.

(iii) Ecology may consider the following factors in determining whether an owner or operator has demonstrated special economic circumstances and extreme hardship, and in determining the amount of the fee reduction:

(A) Annual sales;

(B) Labor force size;

(C) Market conditions which affect the owner's or operator's ability to pass the cost of the permitting fees through to customers; and

(D) Average annual profits.

(iv) No application fee refund may exceed the amount of the application fee portion of the initial fee paid.

(c) Application for fee reduction.

(i) One of the following representatives of the small business must sign the application:

(A) An authorized corporate officer in the case of a corporation;

(B) An authorized partner in the case of a limited or general partnership; or

(C) The proprietor in the case of a sole proprietorship.

(ii) Ecology may request additional information as needed to verify the application information. If ecology determines the owner or operator has made false statements in the application, ecology may deny the fee reduction request and revoke any previously granted fee reductions for that business.

(d) In no case will ecology reduce a permitting fee below $125.

(13) Fee reductions for pollution prevention initiatives. Ecology may reduce the permitting fees identified in subsections (2) through (6) of this section where the owner or operator of the proposed source demonstrates that approved pollution prevention measures will be used.

(14) Tracking revenues, time, and expenditures. Ecology must track revenues from the fees collected under this subsection on a source-specific basis.

WSR 26-17-040
PERMANENT RULES
DEPARTMENT OF
RETIREMENT SYSTEMS

[Filed August 12, 2026, 9:08 a.m., effective September 12, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Providing additional clarity regarding the department of retirement systems' use of administrative factors.

Citation of Rules Affected by this Order: New WAC 415-02-305; and amending WAC 415-02-030 and 415-02-300.

Statutory Authority for Adoption: RCW 41.50.050 and 41.45.030.

Adopted under notice filed as WSR 26-14-056 on June 25, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 2, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 2, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 1, Amended 2, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 12, 2026.

Kathryn Leathers
Director

RDS-7200.2

AMENDATORY SECTION (Amending WSR 23-24-091, filed 12/5/23, effective 12/7/23)

WAC 415-02-030 Definitions. This section contains definitions of words and phrases commonly used in the department of retirement systems' rules. It also serves as a directory for finding definitions within the RCW and WAC.

(1) **Accumulated contributions** means the sum of all contributions paid into a member's defined benefit account, including interest.

(2) **Administrative factors** means the actuarial factors, calculated by the office of the state actuary and adopted by the department, as described in WAC 415-02-300. Administrative factors include, but may not be limited to, annuity and service credit purchase factors, early retirement factors, establishing or restoring service credit factors, joint and survivor options factors, monthly benefit per $1.00 of accumulation factors, public employees retirement Plan 1 and teachers' retirement system Plan 1 cost of living adjustment factors, total allocation portfolio (TAP) annuity factors, 415(b) factors, teachers' retirement system Plan 1 option 1 factors, and Washington state patrol retirement system Plan 1 optional survivor factors.

(3) **Appeal** means the proceeding through which a party obtains review of a department action in an adjudicative proceeding conducted under chapter 34.05 RCW (the Administrative Procedure Act) and chapter 415-08 WAC (the department's appeal rules).

((~~(3)~~)) (4) **Average final compensation** is defined in RCW 41.32.010 (TRS); RCW 41.35.010 (SERS); RCW 41.40.010 (PERS); and RCW 41.37.010 (PSERS).

((~~(4)~~)) (5) **Average final salary** for WSPRS is defined in RCW 43.43.120.

((~~(5)~~)) (6) **Cafeteria plan** means a "qualified" employee benefit program under IRC section 125, such as certain health and welfare plans.

((~~(6)~~)) (7) **Calendar month.**

(a) Refers to one of the 12 named months of the year, extending from the first day of the named month through the last day. For example: January 1st through January 31st is a calendar month. February 1st through February 29th is a calendar month in a leap year. March 13th through April 12th is ***not*** a calendar month.

(b) Exception: For the purpose of administering the break in employment required by RCW 41.32.570, 41.32.802, 41.32.862, 41.35.060, 41.37.050 and 41.40.037 for retirees returning to work, one calendar month means 30 consecutive calendar days. For example: Kim's retirement date is August 1st. August 31st would be the earliest Kim could return to work and meet the requirement for a one calendar month break in employment.

((~~(7)~~)) (8) **Compensation earnable or earnable compensation** definitions can be found in RCW 41.32.010 and 41.32.345 (TRS); RCW 41.35.010 (SERS); RCW 41.37.010 (PSERS); and RCW 41.40.010 (PERS).

((~~(8)~~)) (9) **Contribution rate** is:

(a) For employees: The fraction (percent) of compensation a member contributes to a retirement system each month.

(b) For employers: The fraction (percent) of payroll a member's employer contributes to a retirement system each month. Contribution rates vary for the different systems and plans.

((~~(9)~~)) (10) **Deferred compensation** refers to the amount of the participant's compensation, which the participant voluntarily defers from earnings before taxes to a deferred compensation program.

((~~(10)~~)) (11) **Defined benefit plan** is a pension plan in which a lifetime retirement allowance is available, based on the member's service credit and compensation.

((~~(11)~~)) (12) **Defined contribution plan** is a plan in which part of members' or participants' earnings are deferred into investment accounts in which tax is deferred until funds are withdrawn. The benefit is based on the contributions and the amount of return from the investment of the contributions. Members or participants receive the full market rate of return minus expenses. There is no guaranteed rate of return and the value of an account will increase or decrease based upon market fluctuations.

((~~(12)~~)) (13) **Department** means the department of retirement systems.

((~~(13)~~)) (14) **Director** means the director of the department of retirement systems.

((~~(14)~~)) (15) **Employee** means a worker who performs labor or services for a retirement systems employer under the control and direction of the employer as determined under WAC 415-02-110(2). An employee may be eligible to participate as a member of one of the state-adminis-

tered retirement systems according to eligibility requirements specified under the applicable retirement system.

((~~(15)~~)) (16) **Employer** is defined in RCW 41.26.030 (LEOFF), 41.32.010 (TRS), 41.34.020 (Plan 3), 41.35.010 (SERS), 41.37.010 (PSERS) and 41.40.010 (PERS).

((~~(16)~~)) (17) **Ex-spouse** refers to a person who is a party to a "dissolution order" as defined in RCW 41.50.500.

((~~(17)~~)) (18) **Final average salary for LEOFF** is defined in RCW 41.26.030.

((~~(18)~~)) (19) **First employed by an eligible employer in an eligible position** means, for purposes of plan default, first employment with an employer, in an eligible position, with which a member has fully exhausted their plan choice rights.

((~~(19)~~)) (20) **HERPs** mean higher education retirement plans described in chapter 28B.10 RCW, which are non-DRS retirement plans offered by institutions of higher education, such as, but not limited to, University of Washington retirement plan (UWRP) and Western Washington University retirement plan (WWURP).

((~~(20)~~)) (21) **Independent contractor** means a contract worker who is not under the direction or control of the employer as determined under WAC 415-02-110 (2) and (3).

((~~(21)~~)) (22) **IRC** means the Federal Internal Revenue Code of 1986, as subsequently amended.

((~~(22)~~)) (23) **Indexed retirement allowance** means a defined benefit retirement allowance from an indexed retirement plan, payable to a member who separates after having completed at least 20 service credit years, that is increased by 0.0025 percent, compounded for each month from the date of separation to the date that the retirement allowance commences.

((~~(23)~~)) (24) **Indexed retirement plan** means one of the following retirement plans, which are administered by the department of retirement systems and provide an indexed retirement allowance: Law Enforcement Officers' and Firefighters Retirement System Plan 2 (RCW 41.26.530), Public Employees' Retirement System Plan 3 (RCW 41.40.790), School Employees' Retirement System Plan 3 (RCW 41.35.620), and Teachers' Retirement System Plan 3 (RCW 41.32.840).

((~~(24)~~)) (25) **JRF** means the judges' retirement fund created by chapter 2.12 RCW.

((~~(25)~~)) (26) **JRS** means the Washington judicial retirement system created by chapter 2.10 RCW.

((~~(26)~~)) (27) **LEOFF** means the Washington law enforcement officers' and firefighters' retirement system created by chapter 41.26 RCW.

((~~(27)~~)) (28) **Member** means a person who is included in the membership of one of the retirement systems created by chapters 2.10, 2.12, 41.26, 41.32, 41.34, 41.35, 41.37, 41.40, or 43.43 RCW.

((~~(28)~~)) (29) **Nonadministrative position or nonadministrative capacity** refers to retirees returning to work:

(a) In a position at a school district, charter school, educational service district, state school for the deaf, state school for the blind, or tribal school which:

(i) Does not require an administrative certification, as defined by the office of the superintendent of public instruction, (currently positions requiring the certification include: Principal, vice principal, program administrator, conditional administrator, superintendent or program administrator certifications); or

(ii) Does not evaluate staff.

(b) In a position at a state agency or a public institution of higher education as a nonadministrative licensed nurse whose primary responsibility is to provide nursing care as described under WAC 415-106-010(7).

((~~(29)~~)) (30) **Normal retirement** means qualifying for retirement based on the standard age and service credit requirements as specified in RCW 2.10.100 (JRS), 2.12.020 (JRF), 41.26.090 (LEOFF Plan 1), 41.26.430(1) (LEOFF Plan 2), 41.32.470 (TRS Plan 1), 41.32.765(1) (TRS Plan 2), 41.32.875(1) (TRS Plan 3), 41.35.420(1) (SERS Plan 2), 41.35.680(1) (SERS Plan 3), 41.37.210(1) (PSERS), 41.40.180 (PERS Plan 1), 41.40.630(1) (PERS Plan 2), 41.40.820(1) (PERS Plan 3), or 43.43.250 (WSPRS).

((~~(30)~~)) (31) **Participant** means an eligible employee who participates in a deferred compensation plan.

((~~(31)~~)) (32) **Participation agreement** means an agreement that an eligible employee signs to become a participant in a deferred compensation plan.

((~~(32)~~)) (33) **Pension plan** is a plan that provides a lifelong post retirement payment of benefits to employees.

((~~(33)~~)) (34) **PERS** means the Washington public employees' retirement system created by chapter 41.40 RCW.

((~~(34)~~)) (35) **Petition** means the method by which a party requests a review of an administrative determination prior to an appeal to the director. The department's petitions examiner performs the review under chapter 415-04 WAC.

((~~(35)~~)) (36) **Plan 1** means the retirement plans in existence prior to the enactment of chapters 293, 294 and 295, Laws of 1977 ex. sess.

((~~(36)~~)) (37) **Plan 2** means the retirement plans established by chapters 293, 294 and 295, Laws of 1977 ex. sess., chapter 341, Laws of 1998, and chapter 329, Laws of 2001.

((~~(37)~~)) (38) **Plan 3** means the retirement plans established by chapter 239, Laws of 1995, chapter 341, Laws of 1998, and chapter 247, Laws of 2000.

((~~(38)~~)) (39) **Plan choice rights** refers to a member's right, within a 90-day period, to make an irrevocable choice to become a member of Plan 2 or Plan 3 or be defaulted into a plan after the full 90-day period has expired.

(a) A member will be reported in Plan 2 until plan choice rights have been exercised.

(b) A member must make a choice within 90 calendar days (computed as described in RCW 1.12.040) from the first day of employment in an eligible position.

(c) A member will be defaulted into a plan if they continue employment in an eligible position past the 90-day plan choice period without making a choice.

(d) A member may exercise plan choice rights only once per system.

(e) Once a member makes a plan choice, that choice cannot be changed, even if the member is still within 90 days of hire.

((~~(39)~~)) (40) **Plan year** is the 12-month period that begins on January 1st and ends on December 31st of the same calendar year.

((~~(40)~~)) (41) **Portability** is the ability to use membership in more than one Washington state retirement system in order to qualify for retirement benefits. See chapters 41.54 RCW and 415-113 WAC.

((~~(41)~~)) (42) **PSERS** means the Washington public safety employees' retirement system created by chapter 41.37 RCW.

((~~(42)~~)) (43) **Public record** is defined in RCW 42.56.010.

((~~(43)~~)) (44) **Restoration** is the process of restoring a member's service credit for prior periods.

((~~(44)~~)) (45) **Retirement system employer - See "employer."**

((~~(45)~~)) (46) **Rollover** means a distribution that is paid to or from an eligible retirement plan within the statutory time limit allowed.

((~~(46)~~)) (47) **Separation date** is the date a member ends employment in a position eligible for retirement.

((~~(47)~~)) (48) **SERS** means the Washington school employees' retirement system created by chapter 41.35 RCW.

((~~(48)~~)) (49) **Split account** is the account the department establishes for a member or retiree's ex-spouse.

((~~(49)~~)) (50) **Surviving spouse** refers to a person who was married to the member at the time of the member's death and who is receiving or is eligible to receive a survivor benefit.

((~~(50)~~)) (51) **Survivor beneficiary** means a person designated by the member to receive a monthly benefit allowance after the member dies.

((~~(51)~~)) (52) **Survivor benefit** is a feature of a retirement plan that provides continuing payments to a designee after the death of a member or retiree.

((~~(52)~~)) (53) **TRS** means the Washington state teachers' retirement system created by chapter 41.32 RCW.

((~~(53)~~)) (54) **The Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)** is the federal law that requires employers to reemploy and preserve job security, pension and welfare benefits for qualified employees who engage in military service.

((~~(54)~~)) (55) **WSPRS** means the Washington state patrol retirement system created by chapter 43.43 RCW.

AMENDATORY SECTION (Amending WSR 13-18-034, filed 8/28/13, effective 10/1/13)

WAC 415-02-300 How does the department adopt ((~~and use actuarial~~)) administrative factors? (1) The department ((~~uses actuarial factors for, but not limited to, benefit calculations, annuitizing benefits, and calculating cost to purchase service credit for members, retirees, and beneficiaries.~~

~~(2) The department adopts actuarial factors upon the office of the state actuary's (OSA) recommendation, following OSA's investigation into the mortality, service, compensation, and other experience of retirement plan members, retirees, and beneficiaries.~~

~~(3) The actuarial factors may be amended from time to time, based upon subsequent actuarial investigations.~~

~~(a) Prior to any amendment, the department will post OSA's recommended changes on its website. The process and timeline for public comment before adoption of the new factors will also be posted.~~

~~(b) If the department adopts new factors, they will be available in the department's systems before the effective date, so that benefit estimates can be provided to assist members in retirement planning.~~

~~(c) Actuarial factors displayed on the department's website will be updated with new factors when they become effective.~~)) adopts administrative factors following recommendations by the office of the state actuary (OSA). When underlying economic or demographic assump-

tions for the covered retirement systems change, OSA reviews administrative factors.

(2) Every two years, the following process applies to all retirement systems administered by the department except law enforcement officers' and fire fighters' retirement system (LEOFF) Plan 2:

(a) OSA publishes an economic experience study in the fall of odd-numbered years.

(b) The pension funding council reviews OSA's published study and may adopt updated economic assumptions in fall of odd-numbered years.

(c) If new economic assumptions are adopted, OSA recommends updated factors to the department in the spring of even-numbered years.

(d) In spring of even-numbered years, the department determines whether to adopt updated factors.

(e) If factors are adopted, the department will post them to its website and begin using them in benefit estimate calculations starting in the summer of even-numbered years.

(f) New factors take effect during the first quarter of the following year.

(3) Every two years, the following process applies to LEOFF Plan 2:

(a) OSA publishes an economic experience study in the fall of odd-numbered years.

(b) The LEOFF Plan 2 retirement board reviews OSA's published study and may adopt updated economic assumptions in fall of odd-numbered years.

(c) If new economic assumptions are adopted, OSA notifies the LEOFF Plan 2 retirement board and the department in the spring of even-numbered years of the impact the new economic assumptions have on LEOFF Plan 2 factors.

(d) Upon notification of new LEOFF Plan 2 factors, the department will post them to its website and begin using them in benefit estimate calculations starting in the summer of even-numbered years.

(e) New factors take effect during the first quarter of the following year.

(4) Any adjustments to administrative factors resulting from a demographic experience study conducted by OSA every five to six years are incorporated into the applicable schedule described in subsections (2) and (3) of this section.

NEW SECTION

WAC 415-02-305 How are administrative factors used? The department uses administrative factors in benefit and bill calculation formulas to adjust baseline pension benefits amounts, annuity benefits amounts, and other member billings to account for impacts to the retirement trust funds caused by events including, but not limited to, early retirements, joint and survivor benefit options, and purchasing additional service credits.

WSR 26-17-043
PERMANENT RULES
SUPERINTENDENT OF
PUBLIC INSTRUCTION

[Filed August 12, 2026, 10:35 a.m., effective September 12, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The office of superintendent of public instruction (OSPI) is adopting rule making to address school districts' budgeting practices. Additionally, OSPI is adopting rule making concerning the sale of real property by school districts who are in binding conditions and to address the charging of interest when districts in binding conditions or under enhanced financial oversight for temporary interfund loan from their capital projects fund in alignment with SSB 5412 (2025).

Citation of Rules Affected by this Order: New WAC 392-123-121 and 392-123-171; and amending WAC 392-123-049, 392-123-060, 392-123-071, 392-123-072, 392-123-076, 392-123-078, 392-123-079, 392-123-080, 392-123-095, 392-123-100, 392-123-105, and 392-123-150.

Statutory Authority for Adoption: SSB 5412 (chapter 384, Laws of 2025); and RCW 28A.65.465, 28A.150.290, 28A.335.135, 28A.505.040, 28A.505.090, 28A.505.140, and 28A.710.220.

Adopted under notice filed as WSR 26-13-073 on June 15, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 2, Amended 12, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 12, 2026.

Chris P.S. Reykdal
State Superintendent of Public Instruction

RDS-7241.2

AMENDATORY SECTION (Amending WSR 15-18-078, filed 8/28/15, effective 9/28/15)

WAC 392-123-049 Basis of budgeting and accounting. All school districts and charter schools must utilize the following methods of revenue and expenditure recognition in budgeting, accounting, and financial reporting:

(1) Recognize revenue as defined in WAC 392-123-047: Provided, That school districts that elect the cash basis of expenditure recognition as defined below shall recognize revenue on the cash basis.

(2) Recognition of expenditures for all funds shall be on the accrual basis: Provided, That school districts with under one thousand full time equivalent students for the preceding fiscal year may make a uniform election for all funds, except debt service funds, to be on the cash basis of expenditure recognition. Notification of such election shall be given to the state superintendent of public instruction in the budget of the school district and shall remain in effect for one full fiscal year((~~: Provided further, That~~)).

(3) Charter schools may not elect to make a uniform election for any funds to be on the cash basis of expenditure recognition.

((~~(3)~~)) (4) School districts subject to binding restrictions may not elect to make a uniform election for any funds to be on the cash basis of expenditure recognition until the fiscal year following the district's release from binding restrictions by the superintendent of public instruction.

(5) Expenditures for activities prior to September 1st, but within the school year as defined in WAC 392-121-031, are considered expenditures of the school year commencing September 1st.

AMENDATORY SECTION (Amending WSR 24-22-049, filed 10/28/24, effective 11/28/24)

WAC 392-123-060 Petition to budget receivables collectible in future fiscal periods. When a school district or charter school is unable to prepare a budget or a budget extension in which the estimated revenues for the budgeted fiscal period plus the estimated fund balance or actual fund balance in case of a budget extension, at the beginning of the budgeted fiscal period less the ending reserved fund balance for the budgeted fiscal year do not at least equal the estimated expenditures for the budgeted fiscal period, the school district board of directors or charter school board may deliver a petition in writing at least 20 days before the budget or budget extension is scheduled for adoption to the superintendent of public instruction requesting permission to include receivables collectible in future periods beyond the fiscal period being budgeted in order to balance the budget or budget extension for the fiscal period being budgeted. Said petition shall include a resolution of the school board requesting permission to budget receivables collectible in future fiscal periods and other such information as the superintendent of public instruction shall deem as necessary.

If such permission is granted, it shall be in writing, and it shall contain conditions, binding on the district or charter school, designed to improve the district's or charter school's financial condition.

For the 2024-2025 ((~~and~~)), 2025-2026, 2026-2027, and 2027-2028 budget periods, accepting binding conditions due to a negative fund balance position is not required for school districts or charter schools that have an interfund loan for more than the amount of the negative position in the receiving fund. This time-bound exception is provided in RCW 28A.505.130 so long as the transaction date on the loan occurs on or before June 30, 2024.

For districts already subject to binding conditions or subject to enhanced financial oversight, interfund loans may be used to balance the budget of the borrowing fund when the loan is consistent with the

financial plan submitted by the district and approved by the superintendent or financial oversight committee.

Any second-class school district subject to binding conditions will be required to account for revenues and expenditures in the same manner as a first-class school district.

AMENDATORY SECTION (Amending WSR 93-17-006, filed 8/5/93, effective 9/5/93)

WAC 392-123-071 Budget extensions—First-class school districts. ((~~Upon the happening of any emergency in a first-class school district caused by fire, flood, explosion, storm, earthquake, epidemic, riot, insurrection, or for the restoration to a condition of usefulness of any school district property, the usefulness of which has been destroyed by accident, and no provision has~~)) Before incurring expenditures in excess of current budgeted appropriations, the board of directors in a first-class school district shall adopt a budget extension resolution by the vote of the majority of all board members:

(1) When the budget extension is needed in the event of an emergency:

(a) When no provisions have been made for such expenditures in the adopted appropriation, the board of directors((~~, upon the adoption by the vote of the majority of all board members of a resolution stating~~)) shall state the facts constituting the emergency((~~,~~)) and the board of directors may make an appropriation therefor without notice or hearing.

(b) For the purpose of this section, an emergency is defined as events caused by fire, flood, explosion, storm, earthquake, epidemic, riot, insurrections, or for the restoration to a condition of usefulness of any school district property, the usefulness of which has been destroyed by accident.

(2) When a budget extension is needed, and the reason is not one of emergencies enumerated above:

(a) If ((~~in first-class districts~~)) it becomes necessary to increase the amount of the appropriation, ((~~and if the reason is not one of the emergencies specifically enumerated above~~)) the school district board of directors, before incurring expenditures in excess of expenditures therefor, shall adopt a resolution stating the facts and the estimated amount of appropriation to meet it.

(b) Such resolution shall be voted on at a public meeting, notice to be given in the manner provided in WAC 392-123-054. Its introduction and passage shall require the vote of a majority of all members of the school district board of directors.

(c) Any person may appear at the meeting at which the appropriation resolution is to be voted on and be heard for or against the adoption thereof.

Two copies of all adopted appropriation resolutions shall be filed with the educational service district, who shall forward one copy to the superintendent of public instruction. One copy shall be retained by the educational service district. The final date for adopting appropriation resolutions extending budgets shall be the close of business on August 31st or the last business day prior to August 31st if August 31st occurs on a nonbusiness day. Each copy of all appropriation resolutions filed shall have attached a copy of the

school district's latest budget status report. The revised budget shall be in the format prescribed by the superintendent of public instruction and shall be prepared in accordance with instructions provided by the superintendent of public instruction.

Any appropriation resolution adopted after the date specified in this section shall be null and void. Any appropriation resolution adopted after the current appropriation level has been exceeded shall be null and void to the extent that the current appropriation level has been exceeded.

AMENDATORY SECTION (Amending WSR 93-17-006, filed 8/5/93, effective 9/5/93)

WAC 392-123-072 Budget extensions—Second-class school districts. If a second-class school district needs to increase the amount of the appropriation from any fund the school district board of directors before incurring expenditures in excess of appropriations shall obtain approval from the superintendent of public instruction in the following manner: The school district board of directors shall adopt a resolution stating the specific reason(s) for extending the budget, the estimated amount of additional appropriation needed and the source(s) of funds.

Such resolution shall be voted on at a public meeting, notice to be given in the manner provided by WAC 392-123-054. Introduction and passage shall require the vote of a majority of all members of the school district board of directors.

Any person may appear at the meeting at which the appropriation resolution is to be voted on and be heard for or against the adoption thereof.

Upon passage of the appropriation resolution the school district shall petition the superintendent of public instruction for approval to increase the amount of its appropriations. Such petition to be made in the format prescribed by the superintendent of public instruction. The request for budget extension document shall be prepared in ((~~accordance with current instructions contained in bulletins now or hereafter published~~)) the format prescribed by the superintendent of public instruction and attached to each copy shall be a copy of the latest budget status report and a copy of the board resolution.

The request for budget extension shall be forwarded to the educational service district for approval by the educational service district superintendent.

If approved, the request for budget extension shall be forwarded by the educational service district to the superintendent of public instruction for final approval. The final date for receiving budget extension requests shall be the close of business on August 31st or the last business day prior to August 31st if August 31st occurs on a nonbusiness day.

Any request for budget extension shall not be approved by the educational service district or the superintendent of public instruction to the extent that the current appropriation has been exceeded prior to the request for budget extension.

Copies of all appropriation resolutions approved by the superintendent of public instruction shall be returned by the superintendent of public instruction to the educational service district. The educa-

tional service district shall retain one copy and shall return one copy to the school district.

AMENDATORY SECTION (Amending WSR 15-18-078, filed 8/28/15, effective 9/28/15)

WAC 392-123-076 Identification of balanced budget. For each fund contained in the school district or charter school budget the estimated expenditures for the budgeted fiscal period must not be greater than the total of the estimated revenues for the budgeted fiscal period, plus the estimated fund balance at the beginning of the budgeted fiscal period, less the estimated ((~~reserved~~)) nonspendable and restricted fund balance at the end of the budgeted fiscal period and, where appropriate, the projected revenue from receivables collectible in future periods as approved by the superintendent of public instruction for inclusion in the budget.

The proceeds of any loan must not be used to balance the budget of the borrowing fund.

When the prior year financial statements are submitted to the superintendent of public instruction, the school district must review their current year budget to determine if actual beginning fund balance amounts result in an unbalanced budget. In any case where the district has adopted a budget that does not have sufficient resources for the fiscal year due to a change in the beginning fund balance, the district must submit a budget extension with the procedures outlined in this chapter.

AMENDATORY SECTION (Amending WSR 96-09-001, filed 4/3/96, effective 5/4/96)

WAC 392-123-078 Review of first-class school district budgets and budget ((~~extensions~~)) revisions. Annual budgets of first-class school districts shall be reviewed by the educational service district prior to adoption by the school district board of directors.

The educational service district shall notify each of its first-class school districts of any problems noted during the review prior to adoption of the budget by the school district.

Budgets and budget ((~~extensions~~)) revisions adopted by first-class school districts shall be reviewed by the educational service district prior to filing these documents with the superintendent of public instruction.

Said reviews shall include, but not be limited to, completion of data entry and edit, review of revenues and ((~~reserved and unreserved~~)) the classification of fund balances for accuracy, appropriateness of expenditures and determination of whether or not the budget or budget ((~~extension~~)) revision is in compliance with this chapter, state statutory law and budget instructions issued by the superintendent of public instruction.

The educational service district shall notify the district of all problems noted in the review and the due date for correction of the problems. Should the school district fail to meet the due date for correction, the educational service district shall notify the superintendent of public instruc-

tion shall proceed in the manner prescribed in WAC 392-123-080 through 392-123-105.

AMENDATORY SECTION (Amending WSR 96-09-001, filed 4/3/96, effective 5/4/96)

WAC 392-123-079 Review of second-class district budgets and budget ((~~extensions~~)) revisions. Annual budgets of second-class school districts shall be reviewed by the educational service district prior to adoption by the school district board of directors.

Educational service districts shall notify each of its second-class school districts of any problems noted during the review prior to adoption of the budget by the board of directors.

Review of second-class school district adopted budgets shall be performed by the educational service districts. Said reviews shall include, but not be limited to, completion of data entry and edit, review of revenues and ((~~reserved and unreserved~~)) the classification of fund balances for accuracy, appropriateness of expenditures and determination of whether or not the budget is in compliance with this chapter, state statutory law, and budget instructions issued by the superintendent of public instruction.

The educational service district will notify the district of all problems noted during the review. The educational service district shall attempt to have the problems corrected prior to submission of the budget to the superintendent of public instruction.

The superintendent of public instruction shall conduct meetings with representatives of the educational service district and/or school district as deemed necessary to correct problems and to fix and approve the amount of appropriation from each fund of the budget as prescribed in RCW 28A.505.070 and WAC 392-123-054.

Review of budget ((~~extensions~~)) revisions shall consist of data entry and edit, review of revenues and ((~~reserved and unreserved~~)) the classification of fund balances for accuracy, appropriateness of expenditures, and determination of whether or not the budget ((~~extension~~)) revision is in compliance with this chapter, state statutory law, and budget instructions issued by the superintendent of public instruction. Approval of budget ((~~extensions~~)) revisions shall be in accordance with WAC 392-123-072.

AMENDATORY SECTION (Amending WSR 15-18-078, filed 8/28/15, effective 9/28/15)

WAC 392-123-080 Budget determined to be unsound after superintendent's review. If the superintendent of public instruction determines that the budget of any school district to be unsound or does not comply with this chapter and/or the provisions of state statutory law applicable to school district budgets, the superintendent shall provide written notice of such determination to the board of directors of the district.

If the superintendent of public instruction determines that the budget of any charter school to be unsound or does not comply with this chapter and/or the provisions of state statutory law applicable to charter school budgets, the superintendent shall provide written

notice of such determination to the charter school board and the charter school's authorizer.

AMENDATORY SECTION (Amending WSR 83-21-027, filed 10/10/83)

WAC 392-123-095 Budget as noncompliant and unsound. A school district shall submit a revised budget within ((~~thirty~~)) 30 days following the date the superintendent of public instruction issues a written notice requiring the district to do so. The revised budget shall remedy the deficiencies identified by the superintendent of public instruction and shall comply with state statutory law and this chapter.

AMENDATORY SECTION (Amending WSR 15-18-078, filed 8/28/15, effective 9/28/15)

WAC 392-123-100 Revised budget as not submitted or noncompliant. If a school district fails or refuses to submit a revised budget at the direction of the superintendent of public instruction which complies with state statutory law and this chapter, the ((~~matter shall be submitted to the state board of education~~)) superintendent of public instruction will consult with the educational service district where the district is located to determine whether it is necessary to convene a financial oversight committee in accordance with RCW 28A.315.211.

Written notification of the superintendent's intention to ((~~submit the matter to the state board~~)) convene a financial oversight committee shall be made to the board of directors and administration of the school district and to the educational service district superintendent.

If a charter school fails or refuses to submit a revised budget at the direction of the superintendent of public instruction which complies with state statutory law and this chapter, the superintendent will provide written notice of the charter school's failure or refusal to the charter school's authorizer.

AMENDATORY SECTION (Amending Order 8-76, filed 7/23/76)

WAC 392-123-105 ((~~State board of education~~)) Superintendent of public instruction action regarding missing or noncompliant budget. ((~~The state board of education shall be provided written notification of the superintendent of public instruction's determination and shall~~)) Pursuant to RCW 28A.505.090, budgets that are missing or noncompliant shall not be official and will have no legal effect.

During the interim while the budget is being settled, pursuant to RCW 28A.505.140, the board of directors shall not be prohibited from incurring expenditures for the payment of regular employees, for the necessary repairs and upkeep of the school plant, for the purchase of books and supplies, and for their participation in joint purchasing agencies authorized in RCW 28A.320.080.

Any other expenses are considered in excess of appropriations. In accordance with RCW 28A.505.150, directors, officers, or employees who knowingly or negligently violate or participate in the incurring of expenditures in excess of any appropriation(s) shall be held civilly liable, jointly and severally, for such expenditures in excess of such appropriation(s) and be subject to other consequences outlined in that and other statutes and this chapter.

The superintendent of public instruction shall convene a financial oversight committee to meet to adopt a financial plan to operate the district. The plan adopted by the ((~~state board~~)) financial oversight committee shall be in effect until a revised budget which complies with state statutory law and this chapter is adopted and submitted by the district.

NEW SECTION

WAC 392-123-121 Financial condition determined to be unsound after superintendent's review. (1) At any time during the year, the superintendent of public instruction may require districts to submit monthly financial statements, budget status reports, and other financial information to determine if the adopted budget is in compliance with applicable laws and regulations. This includes, but is not limited to, assessment of:

(a) Whether the district budget is balanced after adjusting the estimated fund balance at the beginning of the budgeted fiscal year to the actual beginning fund balance;

(b) Whether the district budget is balanced after adjusting for actual enrollment; and

(c) Whether the district budget is balanced after adjusting for changes in contracts or other significant expenditure assumptions.

(2) If the superintendent of public instruction determines that the financial information provided by the district indicates that the district budget is not balanced and will either end in a negative position in any fund or will require budgeting receivables from a subsequent period to be in balance, the superintendent will provide written notice to the superintendent of the school district, the board president of the school district, and the superintendent of the appropriate educational service district. This notice will summarize:

(a) The condition identified in the assessment;

(b) The cause identified that led to the condition identified; and

(c) The date which the school board must submit a revised budget to the educational service district and the office of the superintendent of public instruction for review and approval; and

(d) The date which the school board must submit a two-year financial plan.

(3) If the district submits a revised budget for review that requires the use of receivables collectible in future years to balance the budget, the superintendent will only grant permission in writing with specific binding conditions designed to improve the district's financial health.

(4) If the district:

(a) Does not submit a revised budget; or

(b) The financial plan submitted by the district demonstrates that the district will not have an adequate fund balance at the end of

the plan period or will be financially insolvent in accordance with RCW 28A.315.025.

The office of the superintendent of public instruction will consult with the educational service district where the district is located and convene a financial oversight committee in accordance with RCW 28A.315.221.

AMENDATORY SECTION (Amending Order 8-76, filed 7/23/76)

WAC 392-123-150 Interfund loans—Payment of interest. (1) Interest shall be charged by the loaning fund to be paid by the borrowing fund. The rate of interest shall be not less than the current warrant interest rate prevailing in the county in which the school district is considered to be located. The interest shall be credited to the loaning fund and shall not be transferred to any other fund.

(2) When a school district that is in binding conditions pursuant to RCW 28A.505.110 or under enhanced financial oversight pursuant to RCW 28A.315.221 takes a temporary interfund loan from its capital projects fund, the loaning capital projects fund may not charge interest on the amounts loaned.

NEW SECTION

WAC 392-123-171 Proceeds from the sale of school district real property when the district is subject to binding conditions. (1) A school district that is subject to binding conditions designed to improve the district's financial stability may request from the superintendent authorization to sell real property to alleviate the financial burdens that caused or contributed to the imposition of binding conditions or to repay an interfund loan.

(2) Districts must submit a written request to the superintendent of public instruction that includes the following:

(a) The legal and common property description of the real property proposed for sale.

(b) An estimate of the property value.

(c) Confirmation of an appraisal or date when an appraisal will be secured.

(d) A request for the amount that would be redirected for use to repay an interfund loan.

(e) A request for the amount that would be redirected to alleviate the financial burden that caused or contributed to the binding conditions.

(f) A date that the real property was declared surplus and a copy of the approved board resolution.

(g) An acknowledgment that the district will be prohibited from any further sales of real property for this purpose for a minimum of 10 years.

(3) The superintendent of public instruction will review the request and notify the district superintendent and board of the decision in writing. If approved, the district will hold one additional public hearing prior to approving a resolution authorizing the sale of real property.

(4) Pursuant to RCW 28A.335.135, any proceeds from the sale of real property permitted by the superintendent of public instruction to be utilized to alleviate financial burdens are restricted for use to the following purposes:

(a) To address costs associated with unanticipated actual changes in annual average full-time equivalent enrollment that exceed 2.5 percent from the prior school year.

(b) For temporary cash flow needs in the general fund within the school year.

(c) For emergencies or as necessary for the preservation of life, health, and safety.

(d) To repay an interfund loan.

(e) For one-time expenses as preapproved by the office of the superintendent of public instruction.

(5) A school district will not use the proceeds provided from the sale of real property for ongoing salaries or benefits.

WSR 26-17-044
PERMANENT RULES
SUPERINTENDENT OF
PUBLIC INSTRUCTION

[Filed August 12, 2026, 10:35 a.m., effective September 12, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The office of superintendent of public instruction (OSPI) is adopting rule making to update the types of educational programs that meet the definition of a course of study and to clarify that a course of study must be provided or supervised by a certificated instructor.

Citation of Rules Affected by this Order: Amending WAC 392-121-107.

Statutory Authority for Adoption: RCW 28A.44.230, 28A.150.290, 28A.545.110, 28A.710.040, 84.52.053, and 84.52.0531.

Adopted under notice filed as WSR 26-13-071 on June 15, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 12, 2026.

Chris P.S. Reykdal
State Superintendent of Public Instruction

RDS-7249.1

AMENDATORY SECTION (Amending WSR 24-14-074, filed 6/28/24, effective 7/29/24)

WAC 392-121-107 Definition—Course of study. As used in this chapter, "course of study" means those activities for which students enrolled pursuant to chapters 180-16, 180-51, 392-169, 392-134, and 392-410 WAC may be counted as enrolled students for the purpose of full-time equivalent student enrollment counts.

(1) Course of study includes:

(a) Instruction - Teaching/learning experiences conducted by school district staff as directed by the administration and the board of directors of the school district, or teaching/learning experiences conducted by charter school staff as directed by the charter school administration and charter school board, inclusive of intermissions for class changes, recess and teacher/parent-guardian conferences that are planned and scheduled by the district or charter school for the

purpose of discussing students' educational needs or progress, and exclusive of time for meals.

(b) Alternative learning experience - Alternative learning experience provided by the school district or charter school in conformance with WAC 392-121-182.

(c) Instruction provided by a contractor - Instruction provided by a contractor in conformance with WAC 392-121-188 or 392-121-1885.

(d) National guard - Participation in a national guard high school career training program for which credit is being given toward either required or elective high school credits pursuant to RCW 28A.300.165 and WAC 392-410-320.

(e) ((~~Ancillary service - Any cocurricular service or activity, any health care service or activity, and any other services or activities, for or in which enrolled students are served by appropriate school district or charter school staff. The term shall include, but not be limited to, counseling, psychological services, testing, remedial instruction, speech and hearing therapy, health care services, and if such service is provided by the district or charter school, certificated contact time pursuant to RCW 28A.225.010 (4)(a) with students who are in a home-based instruction program. The term shall exclude all extracurricular activities and all other courses of study defined in this section. In conformance with WAC 392-134-025, school districts and charter schools report the actual number of student contact hours of ancillary service for part-time, private school, and home-based students to the superintendent of public instruction.~~

~~(f)~~)) Worksite learning - Training provided in accordance with WAC 392-410-315 and reported as provided in WAC 392-121-124.

((~~(g)~~)) (f) Paid work experience - Training provided in accordance with WAC 392-410-316 and reported as provided in WAC 392-121-139.

(g) Transition to kindergarten - Pursuant to RCW 28A.300.072 and chapter 392-425 WAC.

(h) Enrollment in state institutions, i.e., state operated group homes, county juvenile detention centers, state institutions for juvenile delinquents, county and city adult jails, and state residential habilitation centers;

(i) Ancillary service - Any cocurricular service or activity, any health care service or activity, and any other services or activities, for or in which enrolled students are served by appropriate school district or charter school staff. The term shall include, but not be limited to, counseling, psychological services, testing, remedial instruction, speech and hearing therapy, health care services, and if such service is provided by the district or charter school, certificated contact time pursuant to RCW 28A.225.010 (4)(a) with students who are in a home-based instruction program. The term shall exclude all extracurricular activities and all other courses of study defined in this section. In conformance with WAC 392-134-025, school districts and charter schools report the actual number of student contact hours of ancillary service for part-time, private school, and home-based students to the superintendent of public instruction.

(j) Youth reengagement program - Enrollment in a state approved youth reengagement program pursuant to RCW 28A.175.100 and chapter 392-700 WAC.

(k) Running start - Attendance at an institution of higher education pursuant to RCW 28A.600.300 through 28A.600.400, chapter 392-169 WAC.

((~~(h)~~)) (l) Transition school - Participation in the University of Washington's transition school and early entrance program pursuant

to RCW 28A.185.040, and chapter 392-120 WAC. Such participation shall be reported by the University of Washington and shall not be reported by a school district or charter school.

((~~(i)~~)) (m) Technical college direct funding - Enrollment at a technical college high school program pursuant to RCW 28A.150.275 and WAC 392-121-187. Such participation shall be reported by the technical college and shall not be reported by a school district unless the technical college and the school district agree to have the school district report such enrollment.

((~~(j) Dropout reengagement program - Enrollment in a state approved dropout reengagement program pursuant to RCW 28A.175.100 and chapter 392-700 WAC.~~

~~(k) Paid work experience - Training provided in accordance with WAC 392-410-316 and reported as provided in WAC 392-121-139.~~

~~(l) Transition to kindergarten - Pursuant to RCW 28A.300.072 and chapter 392-425 WAC.~~))

For (a) through (h) of this subsection, instruction must be provided by a certificated instructor or supervised by a certificated instructor.

(2) Course of study does not include:

(a) Home-based instruction pursuant to RCW 28A.225.010(4): Education programs provided by a parent which do not meet the requirements of WAC 392-121-182 cannot be claimed for state funding;

(b) Private school instruction pursuant to chapter 28A.195 RCW;

(c) Adult education as defined in RCW 28B.50.030((~~(12)~~)) (1);

(d) ((~~Instruction provided to students who do not reside in Washington state (RCW 28A.225.260);~~

~~(e) Enrollment in state institutions, i.e., state operated group homes, county juvenile detention centers, state institutions for juvenile delinquents, county and city adult jails, and state residential habilitation centers;~~

~~(f)~~)) Instruction preparing a student for the general education development (GED) test if such instruction generates state or federal moneys for adult education and does not grant high school credit;

((~~(g)~~)) (e) Enrollment in education centers except as provided under contract with a school district pursuant to RCW 28A.150.305 and WAC 392-121-188 or 392-121-1885;

((~~(h)~~)) (f) Enrollment for residents of the Washington state school for the deaf and the Washington state school for the blind;

((~~(i)~~)) (g) Extracurricular activities including, but not limited to, before and after school activities such as classes, sports and other activities offered outside the regular curriculum or for which credit is not earned; or

((~~(j)~~)) (h) Attendance at universities, colleges, community colleges, or technical colleges of students not earning high school credit.

WSR 26-17-045
PERMANENT RULES
SUPERINTENDENT OF
PUBLIC INSTRUCTION

[Filed August 12, 2026, 10:35 a.m., effective September 12, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The office of superintendent of public instruction is adopting rule making regarding when emergency advances can be requested and when repayment will be due for better fiscal oversight and management of the state operating budget.

Citation of Rules Affected by this Order: Amending WAC 392-121-436, 392-121-438, and 392-121-443.

Statutory Authority for Adoption: RCW 28A.150.290, 28A.510.250, and 28A.710.220.

Adopted under notice filed as WSR 26-13-069 on June 15, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 3, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 12, 2026.

Chris P.S. Reykdal
State Superintendent of Public Instruction

RDS-7236.1

AMENDATORY SECTION (Amending WSR 24-22-051, filed 10/28/24, effective 11/28/24)

WAC 392-121-436 Emergency advance payments—School district application. The board of directors of a school district or a charter school board may apply for any emergency advance on the school district's or charter school's basic education allocation. The application shall take the form of a resolution adopted by the board setting forth the following:

(1) The nature of the unforeseen condition requiring the advance;

(2) The amount requested to be advanced;

(3) The net cash and investment balance of the general fund as of the date of the resolution;

(4) A forecast of the general fund receipts, disbursements, and net cash and investment balance for each month remaining in the fiscal year;

(5) A disclosure of any existing or planned general fund revenue anticipation notes;

(6) A disclosure of any existing or planned general fund loan to or from another fund of the school district or charter school; and

(7) A written acknowledgment that funds advanced will be repaid in accordance with WAC 392-121-443, subject to approval by the superintendent of public instruction.

The application must be received by the office of the superintendent of public instruction no later than April 15th.

AMENDATORY SECTION (Amending WSR 24-22-051, filed 10/28/24, effective 11/28/24)

WAC 392-121-438 Emergency advance payments—Approval criteria. The superintendent of public instruction shall approve requests for an emergency advance if the following conditions are met:

(1) The unforeseen condition causing the need for the emergency advance could not have been anticipated by a reasonably prudent person.

(2) It is probable that if the emergency advance is not made that the school district or charter school will be on:

(a) An interest-bearing, warrant-issuing basis within two months following the receipt of the resolution; and

(b) Warrant interest for at least three months from September through June.

(3) The school district or charter school shall not have:

(a) Cash investments of the general fund during the months it estimates that it would pay warrant interest except for the emergency advance; or

(b) Inter-fund loans from the general fund to any other funds during the months it estimates that it would pay warrant interest; or

(c) Any existing or anticipated general fund revenue anticipated notes.

Applications and payouts for apportionment advances can be processed only during the months of October through ((~~July~~)) May. Advance requests ((~~for the months of May and June~~)) shall not be approved if the superintendent of public instruction determines that the apportionment advance may result in any school district or charter school ((~~would be~~)) being short paid at the end of the fiscal year due to lack of appropriation of funds after considering transfer authority.

AMENDATORY SECTION (Amending WSR 24-22-051, filed 10/28/24, effective 11/28/24)

WAC 392-121-443 Emergency advance payments—Repayment of advances. Repayments of advances will be accomplished by a reduction in the school district's or charter school's apportionment payments. Under RCW 28A.510.250, all apportionment advances must be repaid during the apportionment year in which the funds are advanced. The repayment requirements are defined as follows:

(1) For advances received before June, at least ((~~50~~)) 80 percent of the amount advanced must be repaid ((~~in or before~~)) June 30th of the current school year, with the remaining balance repaid no later than August 31st of the current school year.

(2) ((~~For advances received in June, at least 50 percent of the amount advanced must be repaid in July of the current school year, with the remaining balance paid in August of the current school year.~~

~~(3) For advances received in July, the full balance must be repaid in August of the current school year.~~

~~(4)~~)) In no instance can an apportionment advance be repaid and reapproved in the subsequent month.

WSR 26-17-046
PERMANENT RULES
SUPERINTENDENT OF
PUBLIC INSTRUCTION

[Filed August 12, 2026, 10:35 a.m., effective September 12, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The office of superintendent of public instruction is adopting rule making regarding how special education staff will apply to K-3 class size; physical, social, and emotional support (PSES); and certificated instructional staff ratio compliance calculations after changes were made to the special education allocation in E2SSB 5263 (2025). Additionally, the rule making being proposed would change the months when K-3 class size and PSES compliances would be calculated and would add a new duty root for PSES compliance.

Citation of Rules Affected by this Order: Amending WAC 392-122-435, 392-122-440, 392-122-455, 392-122-500, 392-122-505, 392-122-510, 392-122-515, 392-122-520, and 392-127-045.

Statutory Authority for Adoption: E2SSB 5263 (chapter 368, Laws of 2025); and RCW 28A.150.260, 28A.150.290, and 28A.300.072.

Adopted under notice filed as WSR 26-13-072 on June 15, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 9, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 12, 2026.

Chris P.S. Reykdal
State Superintendent of Public Instruction

RDS-7239.1

AMENDATORY SECTION (Amending WSR 24-14-074, filed 6/28/24, effective 7/29/24)

WAC 392-122-435 Physical, social, and emotional support (PSES)—Student enrollment. (1) Grade level and transition to kindergarten enrollment reported on the P-223 will be considered in the compliance calculations ((~~for January, March, and June~~)).

(2) Only students in program 01 - Basic education and program 09 - Transition to kindergarten will be included in the calculation. Enrollment in career and technical education, skill center, alternative learning experience, open doors, and running start programs will be excluded from the calculation.

AMENDATORY SECTION (Amending WSR 24-14-074, filed 6/28/24, effective 7/29/24)

WAC 392-122-440 Physical, social, and emotional support (PSES)—Staff. (1) The superintendent of public instruction will include in the calculation of PSES compliance of those staff that are coded in programs 01, 09, or 97 to one of the following duty root and activity code combinations:

- Duty root 39 - All activities - Orientation and mobility specialist;
- Duty root 42 - All activities - Counselor;
- Duty root 43 - All activities - Occupational therapist;
- Duty root 44 - All activities - Social worker;
- Duty root 45 - All activities - Speech, language pathology/audio;
- Duty root 46 - All activities - Psychologists;
- Duty root 47 - All activities - Nurse;
- Duty root 48 - All activities - Physical therapist;
- Duty root 49 - All activities - Behavior therapist;
- Duty root 64 - All activities - Contractor ESA;
- Duty root 96 - Activity 24 - Family engagement coordinator;
- Duty roots 91 - 99 - Activity 25 - Pupil management ((~~and safety~~));
- Duty roots 91 - 99 - Activity 26 - Health/related services;
- Duty roots 91 - 99 - Activity 35 - Pupil safety.

(2) S-275 data as of the published apportionment cutoff dates in January, March, and June will be considered in the calculation.

(3) Districts must prioritize funding allocated for PSES staff to staff who hold a valid ESA certificate appropriate for that role.

(4) Staff coded to the above duty roots and activity codes in program 21 will be multiplied by the annual percentage of students receiving special education instruction ((~~used in the determination of 3121 revenue for inclusion in the compliance calculation~~)) not in the general education classroom as reported from the November special education federal child count.

AMENDATORY SECTION (Amending WSR 22-24-029, filed 11/30/22, effective 12/31/22)

WAC 392-122-455 Physical, social, and emotional support (PSES)—Penalty for noncompliance. (1) Penalty units identified by the calculations will be split between certificated instructional staff and classified staff based on the percentage that each contributes to the combined total of certificated instructional staff and classified staff in the physical, social, and emotional support staff for that school year at the state level.

(2) ((~~Any adjustments to those calculations will be made in January, March, and June apportionment payments.~~)) Calculations will be published in February and April. The final adjustment will be applied to the June apportionment payment.

AMENDATORY SECTION (Amending WSR 24-14-074, filed 6/28/24, effective 7/29/24)

WAC 392-122-500 K-3 class size—Apportionment of state moneys. (1) State moneys for K-3 class size including transition to kindergarten program 09 as defined in RCW 28A.300.072 and chapter 392-425 WAC shall be allocated as provided in this chapter.

(2) Elementary teacher allocations based on the prototypical schools formula provided in RCW 28A.150.260 and the Omnibus Appropriations Act for grades K-3 and transition to kindergarten program (grade T) will be based upon budgeted grades K-3 and grade T enrollment as stated in the F-203 revenue estimate from September through December for the year budgeted.

(3) School districts, charter schools, and tribal compact schools must input their estimated grades K-3 and grade T class size for purposes of funding from September through December.

(4) K-3 enrollment will not include student full-time equivalent (FTE) enrolled in alternative learning experience programs that meet the requirements of WAC 392-121-182.

(5) ((~~Funded class size starting with January apportionment will be based on the actual average annual FTE enrollment reported in the P-223.~~)) The final funded class size will be calculated in June apportionment and will be based on the actual average annual FTE enrollment reported in the P-223 as of June, the S275 reporting as of June, and any reported supplemental FTE teachers. Preliminary calculations will be provided in February and April.

(6) School districts, charter schools, and tribal compact schools must meet the legislative compliance requirements of K-3 class size funding in order to generate the full allotment.

AMENDATORY SECTION (Amending WSR 24-14-074, filed 6/28/24, effective 7/29/24)

WAC 392-122-505 K-3 class size—Student enrollment. (1) Grade level K-3 and transition to kindergarten program enrollment reported on the P-223 will be considered in the compliance calculations ((~~for the months of January, March, and June~~)).

(2) All students in alternative learning experience programs that meet the requirements of WAC 392-121-182 will be excluded from the compliance calculation.

AMENDATORY SECTION (Amending WSR 24-14-074, filed 6/28/24, effective 7/29/24)

WAC 392-122-510 K-3 class size—Teachers. (1) The superintendent of public instruction will include in the calculation of K-3 class size compliance those teachers reported on the S-275 that are coded in programs 01 to grade group K, 1, 2, or 3, and program 09 for transition to kindergarten (grade T), and are reported in one of the following duty roots:

- Duty root 31 - Elementary homeroom teacher;
- Duty root 33 - Other teacher;

• Duty root 34 - Elementary specialist teacher;
• Duty root 52 - Substitute teacher;
• Duty root 63 - Contractor teacher.

(2) S-275 data as of the published apportionment cutoff dates in January, March, and June will be considered in the calculation.

(3) Program 21 special education teachers coded to grade K, 1, 2, or 3, and grade T multiplied by the annual percentage of students receiving special education instruction ((~~used in determination of a district's, tribal compact school's, or charter school's 3121 revenue will be included~~)) not in the general education classroom as reported from the November special education federal child count.

(4) Teachers coded to program 02 alternative learning experience will be excluded.

AMENDATORY SECTION (Amending WSR 24-14-074, filed 6/28/24, effective 7/29/24)

WAC 392-122-515 K-3 class size compliance—Supplemental FTE teachers. (1) Supplemental teacher full-time equivalent (FTE) teachers must be reported to the superintendent of public instruction prior to the published S-275 apportionment cutoff dates in ((~~January, March~~)) February, April, and June to be considered. Supplemental teacher FTE must be reported by individual grade level K, 1, 2, 3, and transition to kindergarten (grade T).

(2) Supplemental FTE teacher reporting shows the net change in full-time equivalent teachers after October 1st of the school year not reflected in report S-275 under WAC 392-122-510. Supplemental full-time equivalent teachers are determined as follows:

(a) Determine the teacher FTE that would be reported for each employee for the school year on report S-275 if the current data were submitted for the October 1st snapshot as required in the S-275 instructions and subtract the teacher FTE as of October 1st actually reported for the employee on the most current report S-275.

(b) Include decreases as well as increases in staff after October 1st and not reflected in report S-275. Decreases include terminations, retirements, unpaid leave, and reassignment of staff.

AMENDATORY SECTION (Amending WSR 24-14-074, filed 6/28/24, effective 7/29/24)

WAC 392-122-520 K-3 class size—Calculation. Funded class size will be calculated by dividing the total teachers and supplemental teacher FTE across all grades K-3 and transition to kindergarten (grade T) collectively as provided in WAC 392-122-510 into the calculated combined total enrollment in grade levels of T, K, 1, 2, or 3.

The final funded class size will be calculated in June apportionment and will be based on the actual average annual FTE enrollment reported in the P-223 as of June, the S275 reporting as of June, and any reported supplemental FTE teachers. Preliminary calculations will be provided in February and April.

RDS-7242.1

AMENDATORY SECTION (Amending WSR 08-04-027, filed 1/29/08, effective 2/29/08)

WAC 392-127-045 FTE basic education certificated instructional employee—Definition. As used in this chapter, "full-time equivalent basic education certificated instructional employee" means the full-time equivalent calculated pursuant to WAC 392-121-215 for:

(1) A basic education certificated instructional employee as defined in WAC 392-121-210; and

(2) A special education certificated instructional employee, in program 21, as determined by the following:

(a) The total special education, program 21, certificated instructional staff assigned to grades kindergarten through ((~~twelve~~)) 12;

(b) ((~~Times the annual percentage used in determination of a district's 3121 revenue the special education cost accounting method required pursuant to section 507 (2)(b) of the 2007 supplemental operating budget~~)) Multiplied by the annual percentage of students receiving special education instruction not in the general education classroom as reported from the November special education federal child count.

WSR 26-17-047
PERMANENT RULES
SUPERINTENDENT OF
PUBLIC INSTRUCTION

[Filed August 12, 2026, 10:36 a.m., effective September 12, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The office of superintendent of public instruction is adopting rule making to expand state funding for students receiving special education services who turn 21 in alignment with SSB 5253 (2025).

Citation of Rules Affected by this Order: Amending WAC 392-121-106, 392-121-187, 392-122-220, and 392-700-035.

Statutory Authority for Adoption: SSB 5253 (2025); and RCW 28A.150.290, 28A.150.305, 28A.175.115, 28A.300.072, and 28A.710.040.

Adopted under notice filed as WSR 26-13-070 on June 15, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 4, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 12, 2026.

Chris P.S. Reykdal
State Superintendent of Public Instruction

RDS-7235.1

AMENDATORY SECTION (Amending WSR 24-14-074, filed 6/28/24, effective 7/29/24)

WAC 392-121-106 Definition—Enrolled student. As used in this chapter, "enrolled student" means a person residing in Washington state who:

(1) Is eligible to enroll in the school district's education programs because ((~~he or she~~)) the person:

(a) Resides in the school district with or without an address (RCW 28A.225.010, 28A.225.160 and 28A.225.215);

(b) Resides on a United States reservation, national park, national forest, or Indian reservation contiguous to the school district (RCW 28A.225.170);

(c) Resides in a school district not offering the grade for which they are eligible to enroll such as a nonhigh district (RCW 28A.225.210);

(d) Has been released from the school district ((~~he or she~~)) the person resides in and has been accepted by the school district claiming enrollment (RCW 28A.225.225 and 28A.225.230);

(e) Will be attending the school district as part of an interdistrict cooperative program (RCW 28A.225.250);

(f) Will be attending school in a school district in another state per a reciprocity agreement pursuant to RCW 28A.225.260; or

(g) Will be attending a public charter school, as defined by RCW 28A.710.010, located within Washington state.

(2) After the close of the prior school year has presented ((~~himself or herself~~)), or has been presented, to the school district's or charter school's appropriate official to be entered on the school district's or charter school's rolls for the purpose of attending school in grades kindergarten through 12 and transition to kindergarten program;

(3) Is under 21 years of age at the beginning of the school year. For a student receiving special education services, the person is under the age of 22 at the beginning of the school year;

(4) Actually participated on a school day during the first four school days of the current school term (semester or quarter), or on a school day during the current school year on or prior to the date being counted, in a course of study offered by the school district or charter school as defined in WAC 392-121-107; and

(5) Does not qualify for any of the enrollment exclusions set forth in WAC 392-121-108.

AMENDATORY SECTION (Amending WSR 13-02-004, filed 12/19/12, effective 1/19/13)

WAC 392-121-187 Technical college direct-funded enrollment. Enrollment in a technical college pursuant to an interlocal agreement with a school district as provided in RCW 28B.50.533 may be counted as course of study generating state moneys payable directly to the technical college as provided in this section.

(1) The technical college shall submit a written request to the superintendent of public instruction and for each school district whose students are to be claimed by the college shall provide a copy of the interlocal agreement signed by the school district superintendent and the technical college president or authorized officials of the school district and college.

(2) The technical college shall report enrolled students monthly (September through June) to the superintendent of public instruction pursuant to this chapter and instructions provided by the superintendent. A separate report shall be submitted for each school district whose students are reported. Reports of students eligible for state basic education support shall show the total number of students served and total nonvocational and vocational FTE students on the monthly count date. Reports shall also show the name of each student, hours of enrollment per week on the monthly count date, and the nonvocational and vocational full-time equivalent reported for the student on the count date. Technical colleges claiming direct state handicapped funding under the interlocal agreement shall also report the number of enrolled handicapped students by handicapping category on the count dates of October through June pursuant to WAC 392-122-160 and chapter 392-172A WAC.

(3) The technical college shall report monthly to each school district whose students are served pursuant to this section. The report shall include at a minimum the data reported to the superintendent of public instruction pursuant to subsection (2) of this section.

(4) The technical college shall report only students who:

(a) Were under ((~~twenty-one~~)) 21 years of age at the beginning of the school year. For students receiving special education services, those who are under the age of 22 at the beginning of the school year;

(b) Are enrolled tuition-free;

(c) Are enrolled in a school district with which the technical college has a signed interlocal agreement on file with the superintendent of public instruction pursuant to subsection (1) of this section;

(d) Are enrolled in the school district for the purpose of earning a high school diploma or certificate; and

(e) Have actually participated in instructional activity at the technical college during the current school year.

(5) Enrollments claimed for state basic education funding by the technical college:

(a) Shall be for courses for which the student is earning high school graduation credit through the school district or the technical college; and

(b) Shall not include:

(i) Enrollment which is claimed by the school district for state funding; or

(ii) Enrollment which generates state or federal moneys for higher education, adult education, or job training for the technical college.

(6) Full-time equivalent students reported by the technical college for state basic education funding shall be determined pursuant to WAC 392-121-106 through ((~~392-121-183~~)) 392-121-182 except that the enrollment count dates shall be for the months of September through June. If a student is enrolled in courses provided by the school district as well as courses provided by the technical college, the combined full-time equivalents reported by the school district and the technical college are limited by WAC 392-121-136.

(7) The superintendent of public instruction shall make quarterly payments to the technical college as follows:

(a) Basic education allocations shall be determined pursuant to chapter 392-121 WAC based on average enrollments reported by the technical college for each school district times the average allocation per full-time equivalent high school student of the school district: Provided, That allocations for students enrolled in school districts with no more than two high schools with enrollments of less than ((~~three hundred~~)) 300 annual average full-time equivalent students shall be at the incremental rate generated by students in excess of ((~~sixty~~)) 60 annual average full-time equivalent students. Allocations for nonvocational and vocational full-time equivalent enrollments shall be calculated separately.

(b) Handicapped allocations shall be determined pursuant to WAC ((~~392-122-100~~)) 392-122-106 through 392-122-165 based on average handicapped enrollments and the school district's average allocation per handicapped student in each handicapping category.

(c) Quarterly payments shall provide the following percentages of the annual allocation:

December	30%

March	30%
June	20%
August	20%

RDS-7238.1

AMENDATORY SECTION (Amending WSR 21-04-039, filed 1/26/21, effective 2/26/21)

WAC 392-122-220 State institutional education program—Enrolled institutional education program student. A student may be counted as an enrolled institutional education program student under the following conditions:

(1)(a) The student is in a program in a department of corrections facility and is either:

(i) Under ((~~eighteen~~)) 18 years of age; or

(ii) Eighteen years of age and is continuing in the institutional education program with the permission of the department of corrections and the education provider; or

(b) The student is under ((~~twenty-one~~)) 21 years of age at the beginning of the school year ((~~and~~)). For a student receiving special education services, the student is under the age of 22 at the beginning of the school year;

(c) The student is either:

(i) In a residential school as defined in RCW 28A.190.020; or

(ii) Confined in a county juvenile detention center within the meaning of confinement provided in RCW 13.40.020;

(2) The student is scheduled to engage in educational activity in the institutional education program during the current week under WAC 392-122-212;

(3) During the current school year, the student has engaged in educational activity in the institutional education program provided or supervised by educational certificated staff under WAC 392-122-212; and

(4) The student does not qualify for any of the enrollment exclusions in WAC 392-122-221.

RDS-7244.1

AMENDATORY SECTION (Amending WSR 22-15-119, filed 7/20/22, effective 8/20/22)

WAC 392-700-035 Student eligibility. (1) A student is eligible to enroll in a program when they meet the following criteria:

(a) Under 21 years of age at the beginning of the school year but whose 16th birthday occurs on or before September 1st. For a student receiving special education services, the person is under the age of 22 at the beginning of the school year;

(b) Has not yet met the high school graduation requirements of either the district, tribal compact school, charter school, or the college under RCW 28B.50.535; and

(c) At the time the student enrolls, the student is significantly behind in credits based on the student's cohort graduation date. The cohort graduation date is established as the end of the fourth school year after a student first enrolls in the ninth grade.

(i) A student who is more than 24 months from their cohort graduation date and has earned less than 65 percent of the high school credits expected to be earned by their cohort or has a ratio of earned credits to attempted credits that is less than 65 percent. A cohort is the group of students that enter the ninth grade in the same school year;

(ii) A student who is between 12 and 24 months from their cohort graduation date and has earned less than 70 percent of the high school credits expected to be earned by their cohort or has a ratio of earned credits to attempted credits that is less than 70 percent;

(iii) A student who is less than 12 months from their cohort graduation date or who has passed their cohort graduation date by less than 12 months and has earned less than 75 percent of the high school credits expected to be earned by their cohort or has a ratio of earned credits to attempted credits that is less than 75 percent;

(iv) A student who is passed their cohort graduation date by 12 months or more and has not met their district, tribal compact school, or charter school graduation requirements; or

(v) A student who has never attended the ninth grade and has earned zero high school credits.

(d) If determined not to be credit deficient as outlined in (c) of this subsection, has been recommended for enrollment by case managers from the department of social and health services, the juvenile justice system, a district, tribal compact school, or charter school designated school personnel, or staff from community agencies which provide educational advocacy services;

(e) Are not currently enrolled in any high school classes that receive state basic education funding, excluding an approved skill center program, a Jobs for Washington's Graduates program, running start program, or institutional education program under WAC 392-122-205;

(f) Students who are claimed for state funding by a district, tribal compact school, or charter school outside the district they live in, must be released by either a choice transfer or interdistrict agreement. When a choice transfer is in place, the student's resident district as defined in WAC 392-700-015(24) becomes the district operating the program.

(2) Once determined eligible for enrolling in the program, a student will retain eligibility, regardless of breaks in enrollment, until the student does one of the following:

(a) Earns a high school diploma;

(b) Earns an associate degree; or

(c) Becomes ineligible because of age which occurs when a student is 21 years of age as of September 1st. Students receiving special education services can continue until the end of the school year they turn 22.

(3) A student's eligibility does not guarantee enrollment or continued enrollment in specific programs if the program determines that the student does not meet the program's enrollment criteria or if, af-

ter enrollment, a student's academic performance or conduct does not meet established program guidelines.

WSR 26-17-080
PERMANENT RULES
HEALTH CARE AUTHORITY
[Filed August 17, 2026, 4:01 p.m., effective September 17, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The health care authority (HCA) is amending these rules to ensure alignment with HCA's current billing practices. The amendments standardize billing policies while maintaining compliance with applicable federal guidelines.

Citation of Rules Affected by this Order: Amending WAC 182-531-0200, 182-531-0600, 182-531-0750, 182-531-0800, 182-531-1050, 182-531-1300, 182-531-1450, 182-531-1650, and 182-531-1900.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Adopted under notice filed as WSR 26-10-083 on May 6, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 9, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 9, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 9, Repealed 0.

Date Adopted: August 17, 2026.

Wendy Barcus
Rules Coordinator

RDS-7102.3

AMENDATORY SECTION (Amending WSR 24-03-049, filed 1/10/24, effective 2/10/24)

WAC 182-531-0200 Physician-related and health care professional services requiring prior authorization. (1) The medicaid agency requires **prior authorization** (PA) for certain services. ((~~Prior authorization includes **expedited prior authorization (EPA)** and **limitation extension (LE)**. See WAC 182-501-0165.~~

~~(2) EPA is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies the criteria with specific codes, enabling providers to use that EPA number if a client meets the EPA criteria.~~

~~(a) The provider must create an authorization number using the process explained in the medicaid agency's physician-related billing instructions.~~

~~(b) Upon request, the provider must provide supporting clinical documentation to the medicaid agency showing how the authorization number was created.~~

~~(c) Selected nonemergency admissions to contract hospitals require EPA. These are identified in the medicaid agency billing instructions.~~

~~(d) Procedures allowing expedited prior authorization include, but are not limited to, the following:~~

~~(i) Reduction mammoplasties/mastectomy for gynecomastia;~~

~~(ii) Strabismus surgery for clients 18 years of age and older;~~

~~(iii) Meningococcal vaccine;~~

~~(iv) Placement of drug eluting stent and device;~~

~~(v) Cochlear implant devices;~~

~~(vi) Hyperbaric oxygen therapy;~~

~~(vii) Visual exam/refraction for clients 21 years of age and older;~~

~~(viii) Blepharoplasties; and~~

~~(ix) Neuropsychological testing for clients 16 years of age and older.~~

~~(3) The medicaid agency evaluates new technologies under the procedures in WAC 182-531-0550. These require prior authorization.~~

~~(4) Prior authorization is required for the following:~~

~~(a) Abdominoplasty;~~

~~(b) All inpatient hospital stays for **acute physical medicine and rehabilitation (PM&R);**~~

~~(c) Cochlear implant devices (refer to WAC 182-531-0375);~~

~~(d) Diagnosis and treatment of eating disorders for clients 21 years of age and older;~~

~~(e) Osteopathic manipulative therapy in excess of the medicaid agency's published limits;~~

~~(f) Panniculectomy;~~

~~(g) Bariatric surgery (see WAC 182-531-1600);~~

~~(h) Vagus nerve stimulator insertion, which also:~~

~~(i) For coverage, must be performed in an inpatient or outpatient hospital facility; and~~

~~(ii) For reimbursement, must have the invoice attached to the claim.~~

~~(i) Osseointegrated/bone anchored hearing aids (BAHA) for clients 20 years of age and younger;~~

~~(j) Removal or repair of previously implanted BAHA or cochlear implant devices for clients 21 years of age and older when medically necessary; and~~

~~(k) Gender reassignment surgery (see WAC 182-531-1675).~~

~~(5)~~)) (a) Procedures or services requiring PA are identified in applicable agency billing guides and fee schedules.

(b) When requesting PA, providers must follow WAC 182-501-0163 and 182-501-0169.

(c) The agency reviews PA requests according to WAC 182-501-0165.

(2) The agency evaluates experimental and investigational services under WAC 182-531-0550. Experimental and investigational services require PA.

(3) All hysterectomies performed for medical reasons may require ((~~prior authorization, as explained in subsection (2) of this section~~)) PA.

(a) Hysterectomies may be performed without ((~~prior authorization~~)) PA in either of the following circumstances:

(i) The client has been diagnosed with cancer(s) of the female reproductive organs; ((~~and/~~))or

(ii) A hysterectomy is needed due to trauma.

(b) The agency ((~~reimburses~~)) pays all attending providers for a hysterectomy procedure only when the provider submits an accurately completed agency-approved consent form with the claim for ((~~reimbursement~~)) payment.

((~~(6)~~)) (4) The ((~~medicaid~~)) agency may require a second opinion ((~~and/~~))or consultation before authorizing any elective surgical procedure.

((~~(7) Children six years of age and younger do not require authorization for hospitalization.~~))

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-531-0600 HIV/AIDS counseling and testing as physician-related services. The ((~~department~~)) medicaid agency covers one ((~~pre- and one post-HIV/AIDS~~)) presession and one postsession of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) counseling/testing ((~~session~~)) per client each time the client is tested for HIV/AIDS.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-531-0750 ((~~Inpatient hospital~~)) Physician-related services provided in a hospital inpatient observation setting. (1) The ((~~department~~)) medicaid agency separately ((~~reimburses the attending provider for inpatient hospital~~)) pays the physician or qualified health care professional (QHCP) for professional services ((~~rendered by the attending provider~~)) provided by the physician or QHCP in a hospital inpatient observation setting during the surgical follow-up period only if the services are performed for an emergency condition or a diagnosis that is unrelated to the inpatient stay.

(2) The ((~~department reimburses for only one inpatient hospital call~~)) agency pays for one physician or QHCP service provided in a hospital inpatient observation setting per client, per day for the same or related diagnoses. If a ((~~call~~)) service is included in the **global surgery reimbursement,** the ((~~department~~)) agency does not ((~~reimburse~~)) pay separately.

(3) The ((~~department reimburses~~)) agency pays for a hospital admission related to a planned surgery through the global fee for surgery, if applicable.

AMENDATORY SECTION (Amending WSR 15-03-041, filed 1/12/15, effective 2/12/15)

WAC 182-531-0800 Laboratory and pathology ((~~physician-related~~)) services. (1) The medicaid agency pays providers for laboratory services only when the provider:

(a) ((~~The provider~~)) Is certified according to Title XVII of the Social Security Act (medicare), if required; and

(b) ((~~The provider~~)) Has a clinical laboratory improvement amendment (CLIA) certificate and identification number.

(2) The agency ((~~includes a~~)) considers the cost for the handling, packaging, and mailing fee to be included in the ((~~reimbursement~~)) payment for lab tests and does not ((~~reimburse~~)) pay these separately.

(3) The agency pays for one blood drawing fee per client, per day. The agency allows additional ((~~reimbursement~~)) units for an independent laboratory when ((~~it~~)) the laboratory goes to a nursing facility or a private home to obtain a specimen.

(4) The agency pays for only one catheterization for collection of a urine specimen per client, per day.

(5) The agency pays for automated multichannel tests done alone or as a group, as follows:

(a) The provider must bill a panel if all individual tests are performed. If not ((~~all tests are~~)) every test in a panel is performed, the provider must bill individual tests.

(b) If the provider bills one automated multichannel test, the agency ((~~reimburses~~)) pays for the test at the individual procedure code rate, or the internal code maximum allowable fee, whichever is lower.

(c) Tests may be performed in a facility that owns or leases automated multichannel testing equipment. The facility may be any of the following:

(i) A clinic;

(ii) A hospital laboratory;

(iii) An independent laboratory; or

(iv) A physician's office.

(6) The agency allows a **STAT** fee in addition to the maximum allowable fee when a laboratory procedure is performed STAT.

(a) The agency pays for STAT charges for only those procedures identified by the clinical laboratory advisory council as appropriate to be performed STAT.

(b) Tests generated in the emergency room do not automatically justify a STAT order((~~, the physician~~)). Physicians must specifically order the tests as STAT.

(c) Refer to the fee schedule for a list of STAT procedures.

(7) The agency pays for drug screen charges only when medically necessary and when ordered by a physician as part of a total medical evaluation.

(8) ((~~The agency does not pay for drug screens for clients in the division of behavioral health and recovery (DBHR) within the department of social and health services (DSHS)-contracted methadone treatment programs. These are reimbursed through a contract issued by DBHR DSHS.~~

~~(9) The agency does not pay for drug screens to monitor for program compliance in either a residential or outpatient drug or alcohol treatment program.~~

~~(10)~~)) The agency may require a drug or alcohol screen ((~~in order~~)) to determine a client's suitability for a specific test.

((~~(11)~~)) (9) An independent laboratory must bill the agency directly. The agency does not pay a medical practitioner for services referred to or performed by an independent laboratory.

AMENDATORY SECTION (Amending WSR 15-03-041, filed 1/12/15, effective 2/12/15)

WAC 182-531-1050 Osteopathic manipulative therapy. (1) The medicaid agency pays for osteopathic manipulative therapy only when:

(a) Provided by an osteopathic physician licensed under chapter 18.57 RCW or naturopathic physicians licensed under chapter 18.36A RCW; and

(b) Billed using the appropriate current procedural terminology (CPT) codes that involve the number of body regions involved.

(2) The agency allows an osteopathic physician or naturopathic physician to bill the agency for an evaluation and management (E&M) service in addition to the osteopathic manipulative therapy when one of the following apply:

(a) The physician diagnoses the condition requiring osteopathic manipulative therapy and provides it during the same visit;

(b) The existing related diagnosis or condition fails to respond to osteopathic manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those included in the osteopathic manipulation codes; or

(c) The physician treats the client during the same encounter for an unrelated condition that does not require osteopathic manipulative therapy.

(3) The agency pays for ((~~ten~~)) 10 osteopathic manipulations per client, per calendar year. The agency evaluates a request for osteopathic manipulations that is in excess of the limitations or restrictions according to WAC 182-501-0169. Payment for each osteopathic manipulation includes a brief evaluation as well as the osteopathic manipulation.

(4) The agency does not pay for physical therapy services performed by osteopathic physicians or naturopathic physicians.

AMENDATORY SECTION (Amending WSR 24-21-163, filed 10/23/24, effective 11/23/24)

WAC 182-531-1300 Foot care services for clients 21 years of age and older. (1) This section addresses care of the lower extremities (foot and ankle) referred to as foot care and applies to clients 21 years of age and older.

(2) The ((~~department~~)) medicaid agency covers ((~~the~~)) foot care services listed in this section when those services are provided by any of the following health care providers and billed to the ((~~department~~)) agency using procedure codes and diagnosis codes that are within their scope of practice:

(a) Physicians ((~~or~~)), surgeons, and physician assistants, including osteopathic and podiatric specialties; or

(b) ((~~Osteopathic physicians, surgeons, or physician assistants;~~

~~(c) Podiatric physicians and surgeons; or~~

~~(d)~~)) Advanced registered nurse practitioners (ARNP).

(3) The ((~~department~~)) agency covers evaluation and management visits to assess and diagnose conditions of the lower extremities. Once diagnosis is made, the ((~~department~~)) agency covers treatment if the criteria in subsection (4) of this section are met.

(4) The ((~~department~~)) agency pays for:

(a) Treatment of the following conditions of the lower extremities only when there is an acute condition, an exacerbation of a chronic condition, or presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease and evidence that the treatment will prevent, cure or alleviate a condition in the client that causes pain resulting in the inability to perform activities of daily living, acute disability, or threatens to cause the loss of life or limb, unless otherwise specified:

(i) Acute inflammatory processes such as, but not limited to tendonitis;

(ii) Circulatory compromise such as, but are not limited to:

(A) Lymphedema;

(B) Raynaud's disease;

(C) Thromboangiitis obliterans; and

(D) Phlebitis.

(iii) Injuries, fractures, sprains, and dislocations;

(iv) Gout;

(v) Lacerations, ulcerations, wounds, blisters;

(vi) Neuropathies (e.g., reflex sympathetic dystrophy, secondary to diabetes, charcot arthropathy);

(vii) Osteomyelitis;

(viii) Post-op complications;

(ix) Warts, corns, or calluses in the presence of an acute condition such as infection and pain ((~~effecting~~)) affecting the client's ability to ambulate as a result of the warts, corns, or calluses and meets the criteria in this subsection ((~~(4) of this section~~));

(x) Soft tissue conditions, such as, but are not limited to:

(A) Rashes;

(B) Infections (fungal, bacterial);

(C) Gangrene;

(D) Cellulitis of lower extremities;

(E) Soft tissue tumors; and

(F) Neuroma.

(xi) Nail bed infections (paronychia); and

(xii) Tarsal tunnel syndrome.

(b) Trimming ((~~and/~~))or debridement, or both, of nails to treat, as applicable, conditions from the list in ((~~subsection (4)~~))(a) of this ((~~section~~)) subsection. The ((~~department~~)) agency pays for one treatment in a 60-day period. The ((~~department~~)) agency covers additional treatments in this period if documented in the client's medical record as being medically necessary;

(c) A surgical procedure to treat one of the conditions in this subsection ((~~(4) of this section~~)) performed on the lower extremities, and performed by a qualified provider;

(d) Impression casting to treat one of the conditions in this subsection ((~~(4) of this section~~)). The ((~~department~~)) agency includes 90-day follow-up care in the ((~~reimbursement~~)) payment;

(e) Custom fitted and/or custom molded orthotic devices to treat one of the conditions in this subsection ((~~(4) of this section~~)).

(i) The ((~~department's~~)) agency's fee for the orthotic device includes ((~~reimbursement~~)) payment for a biomechanical evaluation (an evaluation of the foot that includes various measurements and manipulations necessary for the fitting of an orthotic device); and

(ii) ((~~The department includes an evaluation and management (E&M) fee reimbursement in addition to an orthotic fee reimbursement if the E&M services are justified and well documented in the client's medical~~

~~record~~)) For further information on orthotic devices, see WAC 182-543-5000.

(5) The ((~~department~~)) agency does not pay for:

(a) The following radiology services:

(i) Bilateral X-rays for a unilateral condition; or

(ii) X-rays in excess of three views; or

(iii) X-rays that are ordered before the client is examined.

(b) Podiatric physicians or surgeons for X-rays for any part of the body other than the foot or ankle.

AMENDATORY SECTION (Amending WSR 24-08-061, filed 3/29/24, effective 5/1/24)

WAC 182-531-1450 Radiology physician-related services. (1) The medicaid agency ((~~reimburses~~)) pays for radiology services subject to the limitations in this section and ((~~under~~)) in WAC 182-531-0300.

(2) The agency does not make separate payments for contrast material. The exception is low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections. Clients receiving these injections must have one or more of the following conditions:

(a) A history of previous adverse reaction to contrast material. An adverse reaction does not include a sensation of heat, flushing, or a single episode of nausea or vomiting;

(b) A history of asthma or allergy;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;

(d) Generalized severe debilitation;

(e) Sickle cell disease;

(f) Preexisting renal insufficiency; ((~~and/~~))or

(g) Other clinical situations where the use of any media except LOCM would constitute a danger to the health of the client.

(3) The agency ((~~reimburses separately~~)) pays for radiopharmaceutical diagnostic imaging agents for nuclear medicine procedures when listed on the appropriate agency fee schedule as covered. ((~~Providers must submit invoices for these procedures when requested by the agency, and reimbursement is at actual acquisition cost.~~))

(4) The agency ((~~reimburses~~)) pays for general anesthesia for radiology procedures. See WAC 182-531-0300.

(5) The agency ((~~reimburses~~)) pays for radiology procedures in combination with other procedures according to the rules for multiple surgeries. See WAC 182-531-1700. The procedures must meet all of the following conditions:

(a) Performed on the same day;

(b) Performed on the same client; and

(c) Performed by the same physician or more than one member of the same group practice.

(6) The agency ((~~reimburses~~)) pays for consultation on X-ray examinations. The consulting physician must bill the specific radiological X-ray code with the appropriate professional component modifier.

(7) The agency ((~~reimburses~~)) pays for portable X-ray services furnished in the client's home or in nursing facilities, limited to the following:

(a) Chest or abdominal films that do not involve the use of contrast media;

(b) Diagnostic mammograms; and

(c) Skeletal films involving extremities, pelvis, vertebral column, or skull.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-531-1650 ((~~Substance abuse detoxification~~)) Withdrawal management physician-related services. (1) The ((~~department~~)) medicaid agency covers physician-related services for ((~~three-day alcohol detoxification or five-day drug detoxification services for a client eligible for medical care program services in a department-enrolled hospital-based detoxification center~~)) withdrawal management when determined to be medically necessary and when provided in an inpatient hospital setting in a hospital certified under chapter 246-320 WAC.

(2) ((~~The department covers treatment in programs certified under chapter 388-805 WAC or its successor.~~

~~(3) The department covers detoxification~~)) The agency pays for physician-related services for withdrawal management and medical stabilization services ((~~to chemically~~)) for people enrolled in the substance-using pregnant ((~~(CUP) women for up to twenty-seven days in an inpatient hospital setting~~)) people (SUPP) program as described in WAC 182-533-0730.

AMENDATORY SECTION (Amending WSR 15-17-066, filed 8/14/15, effective 9/14/15)

WAC 182-531-1900 Payment—General requirements for physician-related services. (1) The medicaid agency pays physicians and related providers for covered services provided to eligible clients on a fee-for-service basis, subject to the exceptions, restrictions, and other limitations listed in this chapter and other published issuances.

(2) To receive payment, physicians must bill the agency according to the conditions of payment ((~~under~~)) listed in WAC 182-502-0100.

(3) The agency does not pay separately ((~~reimburse~~)) for certain administrative costs or services. The agency considers these costs to be included in the payment. These costs and services include the following:

(a) Delinquent payment fees;

(b) Educational supplies;

(c) Mileage;

(d) Missed or canceled appointments;

(e) Reports, client charts, insurance forms, and copying expenses;

(f) Service charges;

(g) Take home drugs except as noted in published agency billing guides; and

(h) ((~~Telephoning (e.g.,~~)) Requests for prescription refills((~~)~~)).

(4) The agency does not routinely pay for procedure codes ((~~which have a "#" or "NC" indicator in~~)) not listed on the fee schedule. ((~~The agency reviews these codes for conformance to medicaid program policy only as an exception to policy or as a limitation extension. See WAC 182-501-0160 and 182-501-0165~~)) Providers may submit a prior authorization request for unlisted services for review by the agency in accordance with WAC 182-501-0163.

WSR 26-17-086
PERMANENT RULES
DEPARTMENT OF
LABOR AND INDUSTRIES

[Order 26-04—Filed August 18, 2026, 8:48 a.m., effective October 1, 2026]

Effective Date of Rule: October 1, 2026.

Purpose: The purpose of this rule making is to create additional means of calculating administrative assessments for active self-insured employers, and in doing so, facilitate fair and equitable funding for current and future self-insurance projects.

Citation of Rules Affected by this Order: Amending WAC 296-15-223.

Statutory Authority for Adoption: RCW 51.44.145 and 51.44.150 (chapter 57, Laws of 2025).

Adopted under notice filed as WSR 26-10-061 on May 5, 2026.

A final cost-benefit analysis is available by contacting Starla Treznoski, Department of Labor and Industries, Insurance Services, Self-Insurance, P.O. Box 44890, Olympia, WA 98504-4890, phone 360-902-5668, fax 360-902-6900, email Starla.Treznoski@Lni.wa.gov, website https://www.lni.wa.gov/rulemaking-activity/?query=296-15&cardNo=AO26-04.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: August 18, 2026.

Joel Sacks
Director

RDS-7135.1

AMENDATORY SECTION (Amending WSR 09-13-018, filed 6/5/09, effective 7/6/09)

WAC 296-15-223 Self-insurance administrative assessment. (1) The administrative assessment covers the department's administrative costs, including direct and indirect expenses of each department division, the University of Washington environmental research facility, and the board of industrial insurance appeals. The assessment is paid quarterly at the same time a self-insurer submits its quarterly report.

(2) The administrative assessment rate is determined annually for each fiscal year. Each self-insured employer uses one of three rates:

(a) The base administrative rate is based on the actual costs of the previous fiscal year and the anticipated costs of the upcoming fiscal year. This rate is used by any active self-insured employer certified after the fiscal year used for calculation.

(b) The adjusted administrative assessment rate includes the base rate with adjustments for over or under collections from prior periods. This rate is used by any active self-insured employer certified during or prior to the fiscal year used for calculation.

(c) Employers who have voluntarily surrendered their self-insurance certificate must pay the inactive rate until one year after all self-insurance liabilities and responsibilities are terminated. Usually, administrative assessment payments for inactive self-insurers can stop after reporting total claims costs of zero dollars for four consecutive quarters. Payments may again be due if any future costs are reported.

(3) In addition to the above rates, the department may bill active and inactive self-insured employers for the administrative costs of one-time projects requested by self-insured employers that will support the self-insured employer program per RCW 51.44.145. The director will calculate the assessment based on the most appropriate of the following method(s):

(a) To all self-insured employers, restricted to:

(i) Industry, business type, or NAICS code;

(ii) Risk classifications as described in chapter 296-17A WAC; or

(iii) Public entity, private, or group as defined by RCW 51.14.150; and

(b) Proportioned to each subject employer by:

(i) Total claims costs;

(ii) Total number of worker hours reported;

(iii) Total number of employees;

(iv) Total number or cost amount of pensions;

(v) Total payroll; or

(vi) Equal share.

(4) Except for assessments listed in subsection (3) of this section, the total administrative assessment due each quarter is calculated by multiplying the self-insurer's rate by their total claims costs during that quarter.

((~~(4)~~)) (5) The minimum quarterly administrative assessment for all self-insured employers is ((~~twenty-five dollars~~)) $25, unless the self-insurer is not required to make payment (see subsection (2)(c) of this section).

(6) Any self-insured employer who fails to pay this assessment will be subject to a penalty in accordance with RCW 51.48.210.

WSR 26-17-089
PERMANENT RULES
OFFICE OF THE
INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2025-05—Filed August 18, 2026, 9:15 a.m., effective October 18, 2026]

Effective Date of Rule: October 18, 2026.

Purpose: The office of the insurance commissioner (commissioner) is adopting rules to define unfair trade practices and to help clarify the minimum standards for claims handling in Washington state. The rule allows the insurance industry and Washington state consumers a more fair and transparent claim process. The rule clarifies and adds definitions and specific unfair claim practices concerning claims handling, particularly when the insurer is considering coverage determinations, and if coverage is available, the loss and damage valuation that is owed under the policy. The rule adds additional requirements for the insurer to provide detailed information to the claimant at certain points in the claim process.

The anticipated effects of the rule are that claimants have more transparency into their financial recovery, insureds have better access to the benefits of the insurance policy they have purchased, insurers appropriately investigate claims and make timely and accurate payments, and insurers and claimants have additional clarity on the minimum standards of claims handling activities that increasingly rely on technology for evaluation of claims.

While the state's total number of automobile and homeowners' insurance claims have remained consistent over the past six years, the commissioner has received an increase in consumer complaints and Insurance Fair Conduct Act notices, which indicate a consumer's dissatisfaction with the claims handling process and the intent to sue their insurer. The spike in consumer complaints and lawsuits against insurers indicate potential insurance code violations, and an increase in the use of practices that are unfair or deceptive in the context of processing claims.

The commissioner held a claims process public meeting in 2023 where consumers shared dozens of comments and hours of testimony outlining their difficulties with insurance claims. The commissioner also has received studies and reports from local and national observers of the claim environment detailing delays and inaccuracies from the insurance company that harm consumers. Furthermore, the commissioner has received articles, reports, and studies from insurance experts that the insurance industry is changing their claim process from an in-person, on-site, loss examination to the use of artificial intelligence and photo-based loss adjusting to maximize efficiencies.

A contract of insurance is a promise to provide the benefits of the policy when there is a covered event. When an insurer fails to properly investigate a claim to make timely and accurate payments, it either causes the claimant to have do their own investigation or receive less than what is owed under the policy. Either way, the insured does not receive the full benefit of the policy they have purchased. Claim process disputes can occur when the insurance company fails to fairly and fully investigate the loss, properly communicate to the claimant, or at times force the insured to complete the insurance company's investigative duties. With a changing technological and workforce environment, the proposed rule making will update and clarify requirements to maintain a fair claim environment for consumers and

provide transparency into the decisions that affect their financial recovery.

Citation of Rules Affected by this Order: Amending WAC 284-30-300, 284-30-320, 284-30-330, 284-30-340, 284-30-350, 284-30-355, 284-30-360, 284-30-370, 284-30-380, 284-30-390, 284-30-391, 284-30-392, 284-30-393, 284-30-394, and 284-30-395.

Statutory Authority for Adoption: RCW 48.02.060 and 48.30.010.

Adopted under notice filed as WSR 26-10-078 on May 5, 2026.

Changes Other than Editing from Proposed to Adopted Version: The commissioner removed the new definition of "undisputed amounts" in WAC 284-30-320 and the corresponding new subsection in WAC 284-30-330 relating to unfair claim practice. After multiple preproposal public drafts, these two subsections were first introduced in the initial CR-102 and comment was provided. The supplemental CR-102 included an exception for underinsured motorist and uninsured motorist bodily injury claims and comment was provided. By removing these two subsections, the commissioner is returning the rule language on this topic back to what it was before rule making began, and after providing for public comment in multiple preproposal rule drafts, the commissioner is no longer proposing edits to the rule on this topic.

After comments on potential inconsistencies and confusion, the commissioner removed "for property and vehicle damage" in WAC 284-30-380(7) when describing the insurer's nondelegable duty that they are responsible for the accuracy of their evaluations to determine amounts owed under the applicable insurance policy. The removal of this language is to prevent confusion and irregularities when applying the definition of "investigation" in WAC 284-30-320 and applicability of WAC 284-30-330(4) on the unfair practice of denying or refusing to pay claims in part or in full without conducting a reasonable investigation.

The commissioner simplified and matched language in WAC 284-30-392 (4)(d) and (e) to reflect the similar requirements on insurers to provide to the claimant the supporting photographs and documentation to demonstrate the condition of the comparable, or loss, vehicle when it reduces the value of the claim due to condition of either vehicle.

A final cost-benefit analysis is available by contacting Rules Coordinator, P.O. Box 40255, Olympia, WA 98504-7038, phone 360-725-7171, fax 360-586-3109, email rulescoordinator@oic.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 15, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 15, Repealed 0.

Date Adopted: August 18, 2026.

Patty Kuderer
Insurance Commissioner

RDS-7031.7

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-300 Authority and purpose. RCW 48.30.010 authorizes the commissioner to define methods of competition and acts and practices in the conduct of the business of insurance which are unfair or deceptive. The purpose of this regulation, WAC 284-30-300 through 284-30-400, is to define certain minimum standards which, if violated ((~~with such frequency as to indicate a general business practice~~)), will be deemed to constitute unfair claims settlement practices. This regulation may be cited and referred to as the unfair claims settlement practices regulation.

If any provision of this chapter, or the application of such provision of this chapter to any person or circumstances, shall be held invalid, the invalidity does not affect other provisions which can be given effect without the invalid provision or application, and to this end the provisions of these sections are severable.

AMENDATORY SECTION (Amending WSR 20-24-070, filed 11/24/20, effective 12/25/20)

WAC 284-30-320 Definitions. When used in this regulation, WAC 284-30-300 through 284-30-400:

(1) "Actual cash value" means the fair market value of the loss vehicle immediately prior to the loss.

(2) "Claimant" means, depending upon the circumstance, either a first party claimant, a third-party claimant, or both and includes a claimant's designated legal representative and a member of the claimant's immediate family designated by the claimant.

(3) "Comparable motor vehicle" means a vehicle that is the same make and model, of the same or newer model year, similar body style, with similar options and mileage as the loss vehicle and in similar overall condition, as established by current data. To achieve comparability, deductions or additions for options, mileage or condition may be made if they are itemized and appropriate in dollar amount.

(4) "Current data" means data within ((~~ninety~~)) 90 calendar days prior to or after the date of loss.

(5) "Documented expenses" means specific incurred expenses which are either paid by the group policyholder or paid on behalf of the group policyholder and for which documentation is obtained by the insurer. Such documented expenses include, but are not limited to, training, marketing, consumer awareness, information technology and computer programming and operations and administration. Such expenses must be specifically disbursed and actually incurred within the limits set forth in the policy or policy addendum.

(6) "File" means a record in any retrievable format, and unless otherwise specified, includes paper and electronic formats.

(7) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right as a covered person to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by a policy or contract.

(8) "Group policyholder" means a policy owner under a group policy which provides coverage to an entire group of ((~~fifty-one~~)) 51 or more individuals.

(9) "Insurance policy" or "insurance contract" mean any contract of insurance, indemnity, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer.

(10) "Insurer" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, fraternal mutual insurer, fraternal mutual life insurer, and any other legal entity engaged in the business of insurance, authorized or licensed to issue or who issues any insurance policy or insurance contract in this state. "Insurer" does not include health care service contractors, as defined in RCW 48.44.010, and health maintenance organizations, as defined in RCW 48.46.020.

(11) "Investigation" means all activities of the insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract. An investigation includes, but is not limited to, conducting a reasonable assessment of whether each claim or loss is covered under the policy, the scope and value of loss or damage caused by an event, and the reasonableness of the costs or expenses that have been or will be incurred to mitigate, treat, repair, replace, or recover the covered loss or damage.

(12) "Loss vehicle" means the damaged motor vehicle or a motor vehicle that the insurer determines is a "total loss."

(13) "Motor vehicle" means any vehicle subject to registration under chapter 46.16 RCW.

(14) "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to the insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.

(15) "Principally garaged area" means the place where the loss vehicle is normally kept, consistent with the applicable policy of insurance.

(16) "Shall describe any such payment" means the specific expenses that are described in the group policyholder's contract or subsequent contract addendum with the insurer and which establish the limits of acceptable expenses under the contract.

(17) "Third-party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of the insurer.

(18) "Total loss" means that the insurer has determined that the cost of parts and labor, plus the salvage value, meets or exceeds, or is likely to meet or exceed, the "actual cash value" of the loss vehicle. Other factors may be considered in reaching the total loss determination, such as the existence of a biohazard or a death in the vehicle resulting from the loss.

(19) "Written" or "in writing" means any retrievable method of recording an agreement or document, and, unless otherwise specified, includes paper and electronic formats.

AMENDATORY SECTION (Amending WSR 16-20-050, filed 9/29/16, effective 10/30/16)

WAC 284-30-330 Specific unfair claims settlement practices defined. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance, specifically applicable to the settlement of claims:

(1) Misrepresenting pertinent facts or insurance policy provisions.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(4) Denying or refusing to pay claims in part or in full without conducting a reasonable investigation. A reasonable investigation may not rely solely on the use of a database, which includes, but is not limited to, estimating software and benchmarks gathered from one or multiple databases.

(5) Failing to affirm or deny coverage of claims within a reasonable time after ((~~fully completed proof of loss documentation has been submitted~~)) receiving a notification of claim.

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In particular, this includes an obligation to promptly pay property damage claims to innocent third parties in clear liability situations. If two or more insurers share liability, they should arrange to make appropriate payment, leaving to themselves the burden of apportioning liability.

(7) Compelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings.

(8) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(9) Making a claim payment to a first party claimant or beneficiary not accompanied by a statement setting forth the coverage under which the payment is made.

(10) Asserting to a first party claimant a policy of appealing arbitration awards in favor of insureds or first party claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of a claim((~~s~~)) by requiring either a ((~~first party~~)) claimant ((~~or~~)), his or her ((~~physician~~)) service or medical provider, or both, to submit ((~~a preliminary claim report~~)) documents or information and then requiring subsequent submissions which contain substantially the same information.

(12) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(14) Unfairly ((~~discriminating against claimants~~)) treating a claimant differently because they are represented by a public adjuster. This includes, but is not limited to, failure to recognize a public adjuster as the legal representative of the insured, or failure to timely provide the requested pertinent claim information and insurance policy to either the insured, the public adjuster, or both.

(15) Failing to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three ((~~working~~)) business days after notice of receipt by the payor bank will constitute a violation of this provision. Dishonor of a draft for valid reasons related to the settlement of the claim will not constitute a violation of this provision.

(16) Failing to adopt and implement reasonable standards for the processing and payment of claims after the obligation to pay has been established. Except as to those instances where the time for payment is governed by statute or rule or is set forth in an applicable contract, procedures which are not designed to deliver payment, whether by check, draft, electronic funds transfer, prepaid card, or other method of electronic payment to the payee in payment of a settled claim within ((~~fifteen~~)) 15 business days after receipt by the insurer or its attorney of properly executed releases or other settlement documents are not acceptable. Where the insurer is obligated to furnish an appropriate release or settlement document to a claimant, it must do so within ((~~twenty working~~)) 20 business days after a settlement has been reached.

(17) Delaying appraisals or adding to their cost under insurance policy appraisal provisions through the use of appraisers from outside of the loss area. The use of appraisers from outside the loss area is appropriate only where the unique nature of the loss or a lack of competent local appraisers make the use of out-of-area appraisers necessary.

(18) Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.

(19) Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent. This does not prohibit routine inquiries to a first party claimant to identify the claimant or to obtain details concerning the claim.

(20) Failing to approve the first party claimant's scope of mitigation or to provide the first party claimant with an approved scope of mitigation within five business days after receipt of the scope of mitigation from the first party claimant when there is a duty in the policy for the first party claimant to protect the property from further damage after a loss event.

(21) Failing to disclose the reasons why the first party claimant's scope of mitigation does not meet either technical or industry standards, including a dollar amount itemization of the disapproved items, if the insurer rejects the first party claimant's scope of mitigation.

(22) Requiring an appraiser functioning under the appraisal clause in the policy to adjust either their actual cash value, their valuation of loss, or both, at any time during the appraisal process. This does not prohibit the insurer from applying the policy conditions to a completed appraisal award.

(23) Providing inaccurate information to a nationwide specialty consumer reporting agency. For the purposes of this subsection, "nationwide specialty consumer reporting agency" has the same meaning as

defined in the federal Fair Credit Reporting Act, 15 U.S.C. Sec. 1681 (2023).

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-340 File and record documentation. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the documentation of claims:

(1) The insurer's claim files are subject to examination by the commissioner or by duly appointed designees. The files must contain all notes and work papers pertaining to the claim in enough detail that pertinent events and dates of the events can be reconstructed.

(2) Insureds shall have the right from time to time and at reasonable intervals to request and receive from their insurance company any portion of the first party claim file including, but not limited to, all written reports, claim notes, estimates, bids, plans, measurements, drawings, engineer reports, contractor reports, statements, photographs, video recordings, or any other documents or communications. If any portion of the claim file contains a record that the insurance company prepared or used during its adjustment of the policyholder's claim is either legally privileged, contains third-party financial information, or is a specific investigative record where the nondisclosure of which is essential to reasonable investigation of alleged criminal activity, the insurer may redact such information from the record or withhold the record if the entirety of the document would otherwise be redacted. The insurer has 15 business days from receipt of the request to provide all of the appropriate requested claim documents to the insured. If the insurer determines an insured's request under this subsection is unreasonable, the insurer must provide written notice to the insured explaining all of the reasons for its determination.

The insurer must indicate to the insured, at the time the first party claim file is provided, whether any documents were withheld or redacted because the documents are either legally privileged, contain third-party financial information, or are a specific investigative record where the nondisclosure of which is essential to a reasonable investigation of alleged criminal activity.

AMENDATORY SECTION (Amending WSR 11-01-159, filed 12/22/10, effective 1/22/11)

WAC 284-30-350 Misrepresentation of policy provisions. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the representation of policy provisions during the investigation and settlement of claims:

(1) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(2) No insurance producer or title insurance agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(3) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(4) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(5) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

(7) No insurer shall make a payment of benefits without clearly advising the payee, in writing, that it may require reimbursement, when such is the case.

AMENDATORY SECTION (Amending WSR 12-09-052, filed 4/16/12, effective 5/17/12)

WAC 284-30-355 Certificates of insurance. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specific to communications with certificate holders:

(1) The following definitions apply to this section.

(a) "Certificate" or "certificate of insurance" means any document, without regard to title or description, that is issued by an insurer, insurance producer, or surplus line broker as evidence of property or casualty insurance coverage. Certificate or certificate of insurance as used in this section does not include an insurance policy, insurance binder, an automobile insurance identification or information card, or a certificate issued to a person or entity that has purchased coverage under a group master policy.

(b) "Certificate holder" means any person, other than a policyholder, that requests, obtains, or possesses a certificate.

(c) "Property" means the insurance coverages described in RCW 48.11.040.

(d) "Casualty" means the insurance coverages described in RCW 48.11.070.

(e) "Insurance binder" means a temporary document that serves as evidence of insurance until the insurance policy is issued.

(f) "Insurance policy" means the executed insurance policy issued to the named insured as part of an insurance transaction as defined in RCW 48.01.060.

(2) This section applies to all:

(a) Certificate holders, policyholders, insurers, insurance producers, surplus line brokers; and

(b) Certificates issued as evidence of insurance coverage for risks located in this state without regard to where a certificate

holder, policyholder, insurer, insurance producer, or surplus line broker is located.

(3)(a) If a certificate holder is named within the policy or endorsement and the policy or endorsement requires notice to be provided to the certificate holder, a certificate holder only possesses a right to notice of:

(i) Cancellation;

(ii) Nonrenewal; or

(iii) A material change, or any similar notice concerning the insurance policy.

(b) The insurance policy governs the terms and conditions of the notice, including the timing of the notice.

(4) No person may knowingly demand or require an insurer, insurance producer, surplus line broker, or policyholder to issue a certificate that contains any false or misleading information or that purports to alter, amend, or extend the coverage provided by the insurance policy.

(5) No person may knowingly issue or circulate a certificate that contains any false or misleading information or that purports to alter, amend, or extend the coverage provided by the insurance policy.

(6) No person may issue, demand, or require, either in addition to or in lieu of a certificate, a document that contains any false or misleading information or that purports to alter, amend, or extend the coverage provided by the insurance policy.

(7)(a) Nothing in this section affects or excuses a person's obligation to obtain an insurance policy for the benefit of a third party that conforms to specific contractual or legal requirements.

(b) Notwithstanding any requirement, term, or condition of any contract, the insurance coverage provided by the referenced policy of insurance is subject to all the terms, exclusions, and conditions of the policy. A certificate of insurance does not confer new or additional rights beyond what the referenced policy of insurance provides.

AMENDATORY SECTION (Amending WSR 13-12-079, filed 6/5/13, effective 1/1/14)

WAC 284-30-360 Standards for the insurer to acknowledge pertinent communications. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the communications concerning claims:

(1) Within ((~~ten working~~)) 10 business days after receiving a notification of ((~~a~~)) claim under an individual insurance policy, or within ((~~fifteen working~~)) 15 business days with respect to claims arising under group insurance contracts, the insurer must acknowledge its receipt of the notice of claim.

(a) If payment is made within that period of time, acknowledgment by payment constitutes a satisfactory response.

(b) If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment must be made in the claim file of the insurer describing how, when, and to whom the notice was made.

(c) Notification of claim given to an agent of the insurer is notification of claim to the insurer.

(2) Upon receipt of any inquiry from the commissioner concerning a complaint, every insurer must furnish the commissioner with an adequate response to the inquiry within ((~~fifteen working~~)) 10 business days after receipt of the commissioner's inquiry using the commissioner's electronic company complaint system.

(3) For all other pertinent communications from a claimant reasonably suggesting that a response is expected, an appropriate reply must be provided within ((~~ten working~~)) 10 business days for individual insurance policies, or ((~~fifteen working~~)) 15 business days with respect to communications arising under group insurance contracts.

(4) Upon receiving a notification of ((~~a~~)) claim, every insurer must promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within the time limits specified in subsection (1) of this section constitutes compliance with that subsection.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-370 Standards for prompt investigation of a claim. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the investigation of claims:

(1) Every insurer must complete its investigation of a claim within ((~~thirty~~)) 30 calendar days after a notification of claim, unless the investigation cannot reasonably be completed within that time. All persons involved in the investigation of a claim must provide reasonable assistance to the insurer in order to facilitate compliance with this provision.

(a) If the insurer needs more time to investigate the claim, it must notify the claimant in writing of the reasons it cannot complete the investigation of the claim within 30 calendar days from the notification of claim.

(b) If needed, additional written notice must be provided to the claimant every 30 days after the notice required in (a) of this subsection explaining why the investigation of the claim remains unresolved.

For the purposes of this subsection, the additional notice must include a summary of any decisions or actions that are substantially related to the disposition of a claim including, but not limited to:

(i) The amount of loss;

(ii) The retention or consultation of service and medical providers;

(iii) Each pertinent item the insurer is waiting for to complete its investigation of the claim; and

(iv) If a new adjuster has been assigned since last notice, confirmation that the new adjuster has reviewed the claim file and is prepared to timely continue the investigation.

(2) This section does not apply to medical professional liability claims.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-380 Settlement standards applicable to all insurers. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the settlement of claims:

(1) Within ((~~fifteen working~~)) 30 calendar days after receipt by the insurer of ((~~fully completed and executed proofs of loss~~)) a notification of claim, the insurer must notify the first party claimant whether the claim has been accepted or denied. This timeline does not apply to medical professional liability claims. The insurer must not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the specific provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer must contain a copy of the denial.

(2) If a claim is denied for reasons other than those described in subsection (1) of this section and is made by any other means than in writing, an appropriate notation must be made in the claim file of the insurer describing how, when, and to whom the notice was made.

(3) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it must notify the first party claimant within ((~~fifteen working~~)) 30 calendar days after ((~~receipt of the proofs of loss giving~~)) a notification of claim and give all of the reasons more time is needed. If after that time the investigation remains incomplete, the insurer must notify the first party claimant in writing stating ((~~the reason or~~)) all of the reasons additional time is needed for investigation. ((~~This notification must be sent within forty-five days after the date of the initial notification and,~~)) If needed, additional notice must be provided every ((~~thirty~~)) 30 calendar days after that date explaining why the claim remains unresolved. This subsection does not apply to medical professional liability claims.

(4) Insurers must not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(5) Insurers must not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. This notice must be given to first party claimants ((~~thirty~~)) 30 calendar days and to third-party claimants ((~~sixty~~)) 60 calendar days before the date on which any time limit may expire.

(6) The insurer must not make statements which indicate that the rights of a third-party claimant may be impaired if a form or release is not completed within a specified period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

(7) Insurers are responsible for the accuracy of their evaluations including, but not limited to, evaluations made on their behalf, to determine ((~~actual cash value~~)) the amounts owed under the applicable insurance policy.

(8) If an insurer uses a database, survey, estimating software, or benchmarks to account for either material pricing, labor rate, or both, and upon request of the claimant, the insurer must provide the claimant with the date the data was collected, where the data was collected from, and which businesses provided the cost data to the database, survey, estimating software, or benchmarks.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-390 Acts or practices considered unfair in the settlement of motor vehicle claims. In addition to the unfair claims settlement practices specified in this regulation, the following acts or practices of the insurer are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, specifically applicable to the settlement of motor vehicle claims:

(1) Failing to make a good faith effort to inspect the damaged vehicle and reasonably communicate with the claimant and the repair facility chosen by the claimant on the damage and needed repairs.

(a) Motor vehicle inspection standards for this section include, but are not limited to:

(i) Insurers shall not require the claimant to agree to only photo-based evaluation of damage as a condition of coverage.

(ii) If an insurer is unable to document damages in a submitted photograph by the claimant, the claimant's chosen repair facility, or both, the insurer must make reasonable efforts to request additional documentation prior to rejecting the coverage of the submitted damage.

(iii) When a claimant has utilized the virtual inspection process and there is a disagreement on the amount of loss, the insurer must accept the claimant's request for an in-person inspection and conduct the inspection of the vehicle within five business days or another agreed time between claimant and insurer.

(iv) The insurer is responsible for the documentation that supports how their estimate to repair the damaged vehicle meets policy language.

(b) Communication standards for this section include, but are not limited to:

(i) Upon notification of claim the insurer must disclose to the claimant the ability to request an in-person inspection of the vehicle from the insurer's adjuster or chosen repair expert.

(ii) Insurers must document in writing to the claimant any repair costs in their submitted estimate for repair not covered under the policy and cite relevant policy language.

If requested by the claimant, the insurer must provide in writing how the labor and material costs and repair processes were determined and cite relevant policy language.

(iii) Insurers must respond in writing to the claimant and claimant's repair facility with its determination of amounts covered within five business days of insurer's receipt of any supplemental damage estimates and final invoice. If the insurer rejects any damage within the supplemental damage estimate and final invoice, the insurer must either cite the applicable policy language, explain the insurer's position in relation to the facts of the loss, or both.

(iv) Insurers must not require any claimant or the claimant's repair facility to solely use an internet-based application as the platform to provide claim related information. Insurers must allow the claimant and claimant's repair facility to use electronic mail, postal mail, facsimile, or delivery in person to submit claims related information.

(v) When requested by the claimant, insurers must include the claimant in all communications with the claimant's repair facility relating to either the original or supplemental repair estimates or changes to covered items.

(vi) Insurers must provide a first party claimant with a clear written explanation of how applicable storage and towing fees are covered under the policy within five business days of the notification of claim.

(2) ((~~Arbitrarily~~)) Unreasonably denying a claimant's estimate for repairs.

((~~(a) A denial of the claimant's estimate for repairs to be completed at the chosen repair facility based solely on the repair facility's hourly rate is considered arbitrary if the rate does not result in a higher overall cost of repairs.~~

~~(b)~~)) If the insurer pays less than the amount of the estimate from the claimant's chosen repair facility, the insurer must promptly and fully disclose ((~~the reason or~~)) all of the reasons it paid less than the claimant's estimate, including a reasonable explanation of the cited policy provision to reject the claimant's repair estimate or invoice, and must thoroughly document the circumstances in its claim file.

(3) Requiring the claimant to travel unreasonably to:

(a) Obtain a repair estimate;

(b) Have the loss vehicle repaired at a specific repair facility; or

(c) Obtain a temporary rental or loaner vehicle.

(4) Failing to prepare or accept an estimate provided by the claimant that will restore the loss vehicle to its condition prior to the loss.

(a) If the insurer prepares the repair estimate, it must rely upon a competent person and provide a copy of the estimate to the claimant. "Competent" in this subsection means the person has the subject matter expertise, relevant training, and experience to make valuations and decisions relating to the repair process. An employee of the insurer may be considered competent if they meet the definition. The insurer is responsible for the accuracy of their repair documentation.

(b) If a claimant provides the repair estimate and the insurer, after evaluation of the claimant's estimate, determines it owes an amount that differs from the estimate the claimant provided, the insurer must fully disclose ((~~the reason or~~)) all of the reasons for the difference to the claimant. This includes a reasonable explanation of cited policy provision to reject the claimant's repair estimate or invoice, and must thoroughly document the circumstances in the claim file.

(c) If the claimant chooses to take the loss vehicle to a repair facility where the overall cost to restore the loss vehicle to its condition prior to the loss exceeds the insurer's estimate, the claimant must be advised that he or she may be responsible for any additional amount above the insurer's estimate.

(5) If requested by the claimant and if the insurer prepares the estimate, failing to provide a list of repair facilities within a reasonable distance of the claimant's principally garaged area that will complete the vehicle repairs for the estimated cost of the insurer prepared estimate.

(6) Failing to consider any additional loss related damage the claimant, or the claimant's repair facility discover((s)) after assessing the damage or during the repairs to the loss vehicle.

(7) Failing to limit deductions for betterment and depreciation to parts normally subject to repair and replacement during the useful life of the loss vehicle. Deductions for betterment and depreciation are limited to the lesser of:

(a) An increase in the actual cash value of the loss vehicle caused by the replacement of the part; or

(b) An amount equal to the value of the expired life of the part to be repaired or replaced when compared to the normal useful life of that part.

(8) If provided for by the terms of the applicable insurance policy, and if the insurer elects to exercise its right to repair the loss vehicle at a specific repair facility, failing to prepare or accept an estimate that will restore the loss vehicle to its condition prior to the loss at no additional cost to the first party claimant other than as stated in the applicable policy of insurance.

(9) If liability and damages are reasonably clear, recommending that claimants make a claim under their own collision coverage solely to avoid paying claims under the liability insurance policy.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-391 Methods and standards of practice for settlement of total loss vehicle claims. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the settlement of motor vehicle claims:

Unless an agreed value is reached, the insurer must adjust and settle vehicle total losses using the methods set forth in subsections (1) through (3) of this section. Subsections (4) through (6) of this section establish standards of practice for the settlement of total loss vehicle claims. If an agreed value or methodology is reached between the claimant and the insurer using an evaluation that varies from the methods described in subsections (1) through (3) of this section, the agreement must be documented in the claim file. The insurer must take reasonable steps to ensure that the agreed value is accurate and representative of the actual cash value of a comparable motor vehicle in the principally garaged area.

(1) Replacing the loss vehicle: The insurer may settle a total loss claim by offering to replace the loss vehicle with a comparable motor vehicle that is available for inspection within a reasonable distance from where the loss vehicle is principally garaged.

(2) Cash settlement: The insurer may settle a total loss claim by offering a cash settlement based on the actual cash value of a comparable motor vehicle, less any applicable deductible provided for in the policy.

(a) Only a vehicle identified as a comparable motor vehicle may be used to determine the actual cash value.

(b) The insurer must determine the actual cash value of the loss vehicle by using any one or more of the following methods:

(i) Comparable motor vehicle: The actual cash value of a comparable motor vehicle based on current data obtained in the area ((~~where the loss vehicle is principally garaged~~)) within a reasonable distance of the principally garaged area not to exceed 150 miles.

(ii) Licensed dealer quotes: Quotations for the cost of a comparable motor vehicle obtained from two or more licensed dealers within a reasonable distance of the principally garaged area not to exceed ((~~one hundred fifty~~)) 150 miles (except where there are no licensed dealers having comparable motor vehicles within ((~~one hundred fifty~~)) 150 miles).

(iii) Advertised data comparison: The actual cash value of two or more comparable motor vehicles advertised for sale in the local media if the advertisements meet the definition of current data as defined in WAC 284-30-320(4). The vehicles must be located within a reasonable distance of the principally garaged area not to exceed ((~~one hundred fifty~~)) 150 miles.

(iv) Computerized source: The insurer may use a computerized source to establish a statistically valid actual cash value of the loss vehicle. The source used must meet all of the following criteria:

(A) The source's database must produce values for at least ((~~eighty-five~~)) 85 percent of all makes and models for a minimum of ((~~fifteen~~)) 15 years taking into account the values of all major options for such motor vehicles.

(B) The source must produce actual cash values based on current data within a reasonable distance of the principally garaged area, not to exceed ((~~one hundred fifty~~)) 150 miles.

(C) The source must rely upon the actual cash value of comparable motor vehicles that are currently available or were available in the market place within ((~~ninety~~)) 90 calendar days prior to or after the date of loss.

(D) The source must provide a list of comparable motor vehicles used to determine the actual cash value. If more than ((~~thirty~~)) 30 comparable motor vehicles are located, the insurer need list only ((~~thirty~~)) 30 but may list more.

(v) Cash settlement search area: If none of the methods in subsection (2)(b)(i) through (iv) of this section produce a comparable motor vehicle to establish an actual cash value within a reasonable distance of the principally garaged area, the search area may be expanded in increasing circles of ((~~twenty-five~~)) 25 mile increments, up to ((~~one hundred and fifty~~)) 150 miles, until two or more comparable motor vehicles are located. If no comparable motor vehicles can be located within ((~~one hundred fifty~~)) 150 miles, the search area may be expanded with the agreement of the first party claimant.

(3) Appraisal: If the first party claimant and the insurer fail to agree on the actual cash value of the loss vehicle and the insurance policy has an appraisal provision, either the insurer or the first party claimant may invoke the appraisal provision of the policy to resolve disputes concerning the actual cash value.

The insurer must advise their appraiser of the total loss calculations in this section, and when applying an appraisal award to the policy, the insurer shall not consider any valuation that is not compliant with this section.

(4) Settlement requirements: When settling a total loss vehicle claim using methods in subsections (1) through (3) of this section, the insurer must:

(a) Communicate its settlement offer to the claimant by phone or in writing and information about this communication must be documented in the claim file, including the date, time, and name of the person to whom the offer was made.

(b) Base all offers on itemized and verifiable dollar amounts for vehicles that are currently available, or were available within ((~~ninety~~)) 90 calendar days of the date of loss, using appropriate deductions or additions for options, mileage or condition when determining comparability.

(c) Consider relevant information supplied by the claimant when determining appropriate deductions or additions.

(d) Provide a true and accurate copy of any "valuation report," as described in WAC 284-30-392, if requested.

(e) As part of the settlement amount, include all applicable government taxes and fees that would have been incurred by the claimant if the claimant had purchased the loss vehicle immediately prior to the loss. These taxes and fees must be included in the settlement amount whether or not the claimant retains or subsequently transfers ownership of the loss vehicle.

(5) Settlement adjustments: Insurers may adjust a total loss settlement through the following methods only:

(a) The insurer may deduct from a first party claim the amount of another claim payment (including the applicable deductible) previously made to an insured for prior unrepaired damage to the same vehicle.

(b) Deductions other than those made pursuant to (a) of this subsection may be made for other unrepaired damage as long as the amount of deduction is no greater than the decrease in the actual cash value due to prior damage.

(c) If the claimant retains the total loss vehicle, the insurer may deduct the salvage value from the settlement amount, as described in subsection (4)(e) of this section. Upon a request by the claimant, the insurer must provide the name and address of a salvage entity or dismantler who will purchase the salvage for the amount deducted with no additional charge. This purchase option must remain available for at least ((~~thirty~~)) 30 calendar days after the settlement agreement is reached and the claimant must be advised that the salvage entity may not honor its offer if the condition of the salvage has changed.

(d) Any additions or deductions from the actual cash value must be explained to the claimant and must be itemized showing specific dollar amounts.

(6) Reopening a claim file:

(a) The insurer must reopen the claim file if within the first ((~~thirty-five~~)) 35 calendar days after the date final payment is sent to the first party claimant, lienholder, or both, the claimant is not able to purchase a comparable motor vehicle for the agreed amount but was able to locate, but did not purchase a comparable motor vehicle that costs more than the agreed settlement amount.

(b) If the claimant has satisfied (a) of this subsection, and if the appraisal section of the policy has not been utilized, the insurer must do one of the following:

(i) Locate a comparable motor vehicle that is currently available for the agreed settlement amount;

(ii) Pay the claimant the difference between the agreed settlement amount and the cost of the comparable motor vehicle;

(iii) Purchase the comparable motor vehicle for the claimant; or

(iv) Conclude the loss settlement in the manner provided in the appraisal section of the insurance policy in force at the time of the loss.

(c) The insurer is not required to reopen the claim file if:

(i) The claimant received written notification of the location of a specific comparable motor vehicle available for purchase for the agreed settlement amount and the claimant did not purchase this vehicle within five business days after the date final payment is sent to the claimant, lienholder, or both; or

(ii) The appraisal provision was previously exercised.

(7) If there is an agreed amount of loss and the first party claimant has rental coverage available, the insurer shall not limit the ability to use rental coverage for the lesser of seven calendar days after payment is sent to the claimant or until the rental coverage has been exhausted.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-392 Information that must be included in the insurer's total loss vehicle valuation report. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to motor vehicle claims:

The insurer's total loss vehicle valuation report must include:

(1) All information collected during the initial inspection assessing the condition, equipment, and mileage of the loss vehicle;

(2) All information the insurer used to determine the actual cash value of the loss vehicle;

(3) A list of the comparable motor vehicles used by the insurer to arrive at the actual cash value. This list must include:

(a) The source of the information used;

(b) The date of the information;

(c) The contact information for the seller, the comparable motor vehicle's vehicle identification number, or both;

(d) The seller's asking price;

(e) The sold price, if available; and

(f) The location or contact information for each comparable motor vehicle at the time of the valuation.

(4) When the insurer uses a computerized source for determining statistically valid actual cash values after meeting the requirements of WAC 284-30-391 (2)(b)(iv):

(a) The source must provide a list of comparable motor vehicles used to determine the actual cash value. If more than ((~~thirty~~)) 30 comparable motor vehicles are used, only ((~~thirty~~)) 30 must be listed.

(b) Any supplemental information must be clearly identified with a separate heading.

(c) Any weighting of identified vehicles to arrive at an average must be documented and explained.

(d) Upon request from the claimant, and if the insurer used condition of a comparable motor vehicle to reduce a payment to the claimant, then the insurer must provide to the claimant supporting photographs and documentation to demonstrate its determination of the condition.

(e) If the insurer makes a deduction of value of the loss vehicle's condition, it must provide to the claimant supporting photographs and documentation to demonstrate its determination of the condition.

AMENDATORY SECTION (Amending WSR 11-13-029, filed 6/7/11, effective 7/8/11)

WAC 284-30-393 Insurer must include an insured's deductible in its subrogation demands. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the settlement of motor vehicle claims:

The insurer must include the insured's deductible, if any, in its subrogation demands. Any recoveries must be allocated first to the insured for any deductible(s) incurred in the loss, less applicable comparable fault. Deductions for expenses must not be made from the deductible recovery unless an outside attorney is retained to collect the recovery. The deduction may then be made only as a pro rata share of the allocated loss adjustment expense. The insurer must keep its insured regularly informed of its efforts related to the progress of subrogation claims. "Regularly informed" means that the insurer must contact its insured within ((~~sixty~~)) 60 calendar days after the start of the subrogation process, and no less frequently than every ((~~one hundred eighty~~)) 180 days until the insured's interest is resolved.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-394 Denial of storage and towing costs. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the settlement of motor vehicle claims:

Prior to denying storage ((~~and~~)) or towing costs, the insurer must do all of the following:

(1) Advise the ((~~first party~~)) claimant by phone or in writing before it stops payment for storage of the loss vehicle. This communication must be documented in the claim file. If it is a phone call, the documentation must include the date, time, name of the person contacted and a summary of the conversation;

(2) Provide reasonable time for the claimant to move the loss vehicle before stopping payment for storage. Five calendar days is considered reasonable time unless the claimant agrees to a shorter time period; and

(3) Pay any and all reasonable towing charges unless otherwise provided in the applicable insurance policy.

AMENDATORY SECTION (Amending WSR 12-19-081, filed 9/18/12, effective 4/1/13)

WAC 284-30-395 Standards for prompt, fair and equitable settlements applicable to automobile personal injury protection insurance. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the settlement of personal injury protection claims:

The commissioner finds that some insurers limit, terminate, or deny coverage for personal injury protection insurance without adequate disclosure to insureds of their bases for such actions. ((~~To eliminate unfair acts or practices in accord with RCW 48.30.010, the following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance specifically applicable to automobile personal injury protection insurance.~~)) The following standards apply to an insurer's consultation with health care professionals when reviewing the reasonableness or necessity of treatment of the insured claiming benefits under his or her automobile personal injury protection benefits in an automobile insurance policy, as those terms are defined in RCW 48.22.005 (1), (7), and (8), and as prescribed at RCW 48.22.085 through 48.22.100. This section applies only where the insurer relies on the medical opinion of health care professionals to deny, limit, or terminate medical and hospital benefit claims. When used in this section, the term "medical or health care professional" does not include an insurer's claim representatives, adjusters, or managers or any health care professional in the direct employ of the insurer.

(1) Within a reasonable time after receipt of actual notice of an insured's intent to file a personal injury protection medical and hospital benefits claim, and in every case prior to denying, limiting, or terminating an insured's medical and hospital benefits, an insurer shall provide an insured with a written explanation of the coverage provided by the policy, including a notice that the insurer may deny, limit, or terminate benefits if the insurer determines that the medical and hospital services:

(a) Are not reasonable;

(b) Are not necessary;

(c) Are not related to the accident; or

(d) Are not incurred within three years of the automobile accident.

These are the only grounds for denial, limitation, or termination of medical and hospital services permitted pursuant to RCW 48.22.005(7), 48.22.095, or 48.22.100.

The written explanation responsive to an insured's intent to file a personal injury protection medical and hospital benefits claim must also include contact information for the office of the Washington state insurance commissioner's consumer protection services, including the consumer protection division's hotline phone number and the agency's website address, and a statement that the consumer may contact the office of the insurance commissioner for assistance with questions or complaints.

(2) Within a reasonable time after an insurer concludes that it intends to deny, limit, or terminate an insured's medical and hospital benefits, the insurer shall provide an insured with a written explanation that describes the reasons for its action and copies of pertinent documents, if any, upon request of the insured. The insurer shall in-

clude the true and actual reason for its action as provided to the insurer by the medical or health care professional with whom the insurer consulted in clear and simple language, so that the insured will not need to resort to additional research to understand the reason for the action. A simple statement, for example, that the services are "not reasonable or necessary" is insufficient.

(3)(a) Health care professionals with whom the insurer will consult regarding its decision to deny, limit, or terminate an insured's medical and hospital benefits shall be currently licensed, certified, or registered to practice in the same health field or specialty as the health care professional that treated the insured.

(b) If the insured is being treated by more than one health care professional, the review shall be completed by a professional licensed, certified, or registered to practice in the same health field or specialty as the principal prescribing or diagnosing provider, unless otherwise agreed to by the insured and the insurer. This does not prohibit the insurer from providing additional reviews of other categories of professionals.

(4) To assist in any examination by the commissioner or the commissioner's delegatee, the insurer shall maintain in the insured's claim file sufficient information to verify the credentials of the health care professional with whom it consulted.

(5) An insurer shall not refuse to pay expenses related to a covered property damage loss arising out of an automobile accident solely because an insured failed to attend, or chose not to participate in, an independent medical examination requested under the insured's personal injury protection coverage.

(6) If an automobile liability insurance policy includes an arbitration provision, it shall conform to the following standards:

(a) The arbitration shall commence within a reasonable period of time after it is requested by an insured.

(b) The arbitration shall take place in the county in which the insured resides or the county where the insured resided at the time of the accident, unless the parties agree to another location.

(c) Relaxed rules of evidence shall apply, unless other rules of evidence are agreed to by the parties.

(d) The arbitration shall be conducted pursuant to arbitration rules similar to those of the American Arbitration Association, the Center for Public Resources, the Judicial Arbitration and Mediation Service, Washington Arbitration and Mediation Service, chapter 7.04 RCW, or any other rules of arbitration agreed to by the parties.

WSR 26-17-092
PERMANENT RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Developmental Disabilities Administration)
[Filed August 18, 2026, 12:20 p.m., effective September 18, 2026]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The purpose is to update the rules regarding certified residential providers and how they use professional treatment plans when providing services to people in the community protection program. This will align the rule with federal waiver requirements regarding restrictive procedures and person-centered supports and is currently in place via emergency rule filed under WSR 26-11-041.

Citation of Rules Affected by this Order: Amending WAC 388-101D-0485 and 388-101D-0490.

Statutory Authority for Adoption: RCW 71A.12.030 and 71A.12.280.

Adopted under notice filed as WSR 26-14-001 on June 17, 2026.

A final cost-benefit analysis is available by contacting Destinie Buzzard, P.O. Box 45310, Olympia, WA 98504-5310, phone 360-791-4787, TTY 711 relay services, email Destinie.Buzzard@dshs.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 2, Repealed 0.

Date Adopted: August 18, 2026.

Katherine I. Vasquez
Rules Coordinator

SHS-5123.2

AMENDATORY SECTION (Amending WSR 16-14-058, filed 6/30/16, effective 8/1/16)

WAC 388-101D-0485 ((~~Community protection—Treatment~~)) How does a provider use a treatment plan((~~.~~)) when developing restrictive procedures? ((~~The community protection service provider must implement the client's~~)) A provider must use the treatment plan ((~~as written by a qualified professional/therapist in accordance with any procedures published by the department~~)), if available, when gathering information for a functional assessment related to a target behavior. To implement a restrictive procedure based on the recommendations in a treatment plan, the provider must still meet the requirements in WAC 388-101D-0430.

AMENDATORY SECTION (Amending WSR 16-14-058, filed 6/30/16, effective 8/1/16)

WAC 388-101D-0490 Community protection—Client records. In addition to all other client record requirements in this chapter, community protection service providers must include the following in the client's record:

(1) Psychosexual ((~~and/~~))or psychological evaluations or both and risk assessments;

(2) Plans and assessments including:

(a) The written individual plan;

(b) The functional assessment;

(c) The positive behavior support plan; and

(d) A therapist approved treatment plan, if available.

(3) The client's sex offender registration with law enforcement authorities when required by law;

(4) Notice to the division of developmental disabilities of the client's sex offender registration; and

(5) Agreements, requirements, and plans, including the chaperone agreement, with individuals who support the client.

WSR 26-17-096
PERMANENT RULES
DEPARTMENT OF LICENSING
[Filed August 18, 2026, 4:36 p.m., effective August 20, 2026]

Effective Date of Rule: August 20, 2026.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: RCW 46.12.600(5) requires the department of licensing to update rules regarding the vehicle market value thresholds by July 1st of the year after there has been an increase in the annual average value over the previous year.

Purpose: Aligning rule with the market value threshold amount in the current federal consumer price index report.

Citation of Rules Affected by this Order: Amending WAC 308-56A-460.

Statutory Authority for Adoption: RCW 46.12.600.

Adopted under notice filed as WSR 26-13-107 on June 17, 2026.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: August 18, 2026.

Ellis Starrett
Rules and Policy Manager

RDS-7257.1

AMENDATORY SECTION (Amending WSR 23-16-052, filed 7/26/23, effective 8/26/23)

WAC 308-56A-460 Destroyed or wrecked vehicle—Reporting—Rebuilt. (1) **What are total loss, destroyed, salvage, and wrecked vehicles?** For the purposes of this section:

(a) A total loss vehicle is one whose destruction has been reported to the department as described in RCW 46.12.600 by an insurer (insurance companies and self-insurers as described in RCW 46.29.630);

(b) A destroyed vehicle is one whose destruction has been reported to the department as described in RCW 46.12.600 by the vehicle's owner;

(c) A salvage vehicle as defined in RCW 46.04.514;

Note: When used in this section, the terms "destroyed" and "destroyed vehicle" include total loss, destroyed, and salvage vehicles.

(d) A wrecked vehicle as defined in RCW 46.80.010(6).

Note: A vehicle may be considered destroyed or wrecked when the evidence of ownership is a salvage certificate/title, insurance company bill of sale, or wrecker bill of sale from any jurisdiction, or when the evidence of ownership indicates the vehicle may be a destroyed vehicle not reported to the department.

(2) **How are vehicles reported to the department as total loss, destroyed, salvage, or wrecked?**

(a) Insurers may report total loss vehicles to the department:

(i) Electronically through the department's online reporting system. Insurers must destroy ownership documents for a vehicle reported this way; or

(ii) By submitting the certificate of title or affidavit in lieu of title indicating the vehicle is "DESTROYED"; or

(iii) By submitting a completed total loss claim settlement form.

Note: Reports of total loss vehicles must include the insurer's name, address, and the date of loss.

(b) Registered or legal owners report a vehicle as destroyed by submitting the certificate of title or affidavit in lieu of title indicating the vehicle is "DESTROYED," and must include the registered owner's name, address, and date of loss.

(c) Licensed wreckers report wrecked vehicles as required in RCW 46.80.090.

(d) For vehicles six through 20 years old a statement whether or not the vehicle meets the market value threshold amount as defined in RCW 46.12.600 is also required.

(3) **What is the current market value threshold amount?** The current market value threshold amount is $((~~11,780~~)) 12,220.

(4) **How is the market value threshold amount determined?** Using the current market value threshold amount described in RCW 46.12.600 each year the department will add the increased value if the increase is equal to or greater than $50.

(5) **What if the "market value threshold amount" is not provided as required?** If the market value threshold amount is not provided when required, the department would treat the report of destruction as if the market value threshold as described in RCW 46.12.600 has been met. The certificate of title will be branded according to WAC 308-56A-530.

(6) **What documentation is required to obtain a certificate of title after a vehicle is destroyed?** After a vehicle has been reported destroyed or wrecked and is rebuilt, you must submit the following documentation to the department in order to obtain a new certificate of title:

(a) Application for certificate of title as described in RCW 46.12.530;

(b) Certificate of vehicle inspection as described in WAC 308-56A-150;

(c) Bill of sale from the insurer, owner, or wrecker who reported the vehicle's destruction to the department.

(i) Bills of sale from insurers must include a representative's signature and title of office;

(ii) Bills of sale from insurers and wreckers do not need to be notarized;

(iii) Bills of sale from owners shown on department records must be notarized or certified;

(iv) A bill of sale is not required when owners shown on department records retain a destroyed vehicle and apply for a new certificate of ownership;

(v) Releases of interest from lien holder(s) or proof of payment such as a canceled check bearing a notation that it has been paid by the bank on which it was drawn or a notarized statement on a receipt

from the legal owner that the debt is satisfied are required when the vehicle is retained by the registered owner(s).

(d) Odometer disclosure statement, if applicable.

(7) **What is required of a Washington licensed vehicle dealer prior to selling a destroyed or wrecked vehicle?** Except as permitted by RCW 46.70.101 (1)(b)(viii), before a dealer may sell a destroyed or wrecked vehicle under their Washington vehicle dealer license, the dealer must:

(a) Rebuild the vehicle to standards set by the state of Washington or the federal government pertaining to the construction and safety of vehicles; and

(b) Obtain a vehicle inspection by the Washington state patrol; and

(c) Apply for and receive a certificate of ownership for the vehicle, issued in the name of the vehicle dealer.

(8) **Once a destroyed or wrecked vehicle is rebuilt, do the license plates remain with the vehicle?** Whether or not the license plates remain with the vehicle depends on the circumstance:

(a) Standard issue license plates may remain with a destroyed vehicle unless they are severely damaged or the vehicle was issued a department temporary license plate described in WAC 308-56A-140;

(b) Replacement license plates are required for wrecked vehicles since Washington licensed wreckers are required by WAC 308-63-070 to remove them;

(c) Special license plates may remain with or be transferred to a destroyed or wrecked vehicle;

(d) Applicants may retain the current license plate number as provided for in RCW 46.16A.200, unless the vehicle was issued a department temporary license plate as described in WAC 308-56A-140.

(9) **Will the certificate of ownership or registration certificate indicate "WA REBUILT"?** Salvage or wrecked vehicles meeting the criteria described in WAC 308-56A-530 will be branded "WA REBUILT."